CITY & HACKNEY
PUBLIC HEALTH

The City of London's Joint Strategic Needs Assessment

November 2026

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Acknowledgements

We would like to sincerely thank everyone who has contributed towards the production. This includes staff across The City of London Corporation and Hackney London Borough Council. We thank all the organisations who attended our engagement event for their invaluable contribution.

Cite this report as:

City and Hackney Public Health. City of London Joint Strategic Needs Assessment. (November 2026)

Version control

Version 1.0, published November2026.

CITY OF LONDON

Hackney

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Executive Summary

Background

The City of London Joint Strategic Needs Assessment (JSNA) provides insight on how health is shaped for residents and workers. The JSNA aims to map service provision, and highlight unmet need and health inequalities to inform future strategies and service design.

Methods

The report uses the population health system framework, which recognises that our health is shaped by four key pillars: the wider determinants of health, the places and communities we live in, our lifestyles and health behaviours, and the health and care system.

By applying this framework to a range of quantitative data, the JSNA explores how health is shaped for City residents and workers. Qualitative insights were gathered during an engagement event with 13 Voluntary and community sector (VCS) representatives.

Key findings

A unique population

The demographic makeup is unique, pairing a small resident group with a large weekday resident workforce. Both worker and resident populations are diverse. Around a third of residents and a third of workers come from Global Majority backgrounds. Out of all the local authorities in England, the City of London has the second largest proportion of residents (10.3%) that identify as LGBTQ+. Also, 6.5% of the workforce identifies as LGBTQ+.

Giving children a strong start

Local children get a strong start, with early health visits consistently delivered on time. The Best Start in Life programme offers diverse early years support. However, service uptake shows potential disparities as access varies by residence and ethnicity. Targeted outreach can improve existing uptake.

School attendance in City schools remains consistently strong, and is higher than the averages for London and England. The City also has the lowest rate of young people not in education, employment or training of any local authority in England.

Overall youth mental health needs align with the North East London (NEL) average. However, eating disorders are slightly higher among girls residing in the City, and diagnosis rates are rising among young men.

Healthy ageing

There is a higher proportion of older residents living in the City of London (aged 65 and over) who are healthy compared to the NEL average. However, some older residents are living with complex health needs, such as long term conditions and frailty.

Residents living with dementia (2.6% of the older aged population) are often diagnosed with multiple conditions. Dementia is also one of the primary reasons residents enter the adult social care system. Health, social care, and community sectors deliver a coordinated response to support residents and help people before they require extensive care, enabling them to live independent lives for longer.

Promoting geographical equity

Residents in the east of the City have strong community connections. However, this population faces intersecting barriers to living healthy, happy lives. This area experiences the highest levels of local deprivation and residents here are overrepresented in accessing the City Advice service for debt support.

Furthermore, this area's health outcomes and access to health care services differs from the rest of the population. This area records the highest smoking prevalence for tobacco products, but has the lowest access to stop-smoking services. The highest rates of hypertension, obesity, depression, and type 2 diabetes, are also seen in the east of the City. Specific GP catchment areas create barriers for many residents, limiting referral pathways to local City-based support services.

The local environment

The City's green spaces and designated walking routes are a vital community asset, promoting active travel for many workers and residents. The Health Creation Alliance project showed that this differs for Portsoken residents who have less green space than other City areas.

This same engagement showed Portsoken residents have excellent transport links. However, built-up physical layouts and missing cross-area bus routes restrict some individuals and they feel confined by local boundaries. This limits their ability to travel across the Square Mile for services or community spaces, affecting their health and social connections.

Homelessness and rough sleeping

The City supports around 750 individuals who are experiencing homelessness or sleeping rough. This group experiences complex, multifaceted needs, including physical and mental health, and drug and alcohol use and multimorbidity.

Significant care barriers persist, as services like the Greenhouse GP and Turning Point are located outside the borough in Hackney, while no local City pharmacies offer opioid substitution treatments or needle exchange services. Although there are specialised offers, gaps remain in understanding their specific health needs and service access rates due to poor data. Establishing a local, accessible, specialist primary care hub with co-located services could help to provide this population with effective, targeted care.

Health outcomes

Over a quarter (28%) of City residents had been diagnosed with at least one long term condition.

Multimorbidity in the City is in line with the NEL average. However, prevalence is higher for Global Majority groups. GP records show 24% of residents with Bangladeshi heritage and 32%

for residents with Black Caribbean heritage are living with more than one long term condition. This compares to 12% of the total City population.

Recommendations

Following a collaborative process with relevant City Corporation service leads and public health colleagues, 10 evidence-led recommendations were developed based on the core findings:

1. Securing City-specific health and demographic data to enable evidence-based service design.
2. Co-produce communications with residents to maximise service awareness and uptake.
3. Identify and support young carers to reduce caregiving burdens.
4. Develop and implement local delivery models to bring health services closer to home.
5. Promote targeted awareness of Sexual and Reproductive Health (SRH) services to increase uptake and reduce health inequalities.
6. Investigate and improve access to healthy, affordable, and culturally appropriate food.
7. Map and clarify cross-border referral pathways to improve system navigation and coordination.
8. Improve equitable access to mental health support.
9. Reduce access barriers for all inclusion health groups requiring substance use, alcohol, and homelessness support.
10. Reduce health inequalities for inclusion health groups by improving local access to primary care.

Recommendations

Following a collaborative process with relevant City Corporation service leads and public health colleagues, 10 evidence-led recommendations were developed based on the core findings.

These recommendations will sit alongside existing local plans and strategies, including the City and Hackney Sexual and Reproductive Health Strategy, City and Hackney Immunisations Strategic Action Plan, Homelessness and Rough Sleeping Strategy, Living Well Ageing Well Strategy, and the Children and Young People's Mental Health Strategy.

Cross cutting

1. **Securing City-specific health and demographic data to enable evidence-based service design.**

Ensure data is routinely disaggregated for the City of London rather than combined with Hackney data. Capture health and demographic data focusing on the utilisation of health services to identify inequalities and understand service reach across different communities. This requirement must be embedded into service contracts and commissioned service agreements.

Gathering this data is essential to identify specific community needs, map user journeys, and support the design of services, such as the Best Start in Life programme.

2. **Co-produce communications with residents to maximise service awareness and uptake.**

By collaborating with the newly established Community Advisory Group to test, refine, and co-produce messaging, the City can ensure that communications are designed by residents, for residents. To be effective, this communication strategy must be expanded to ensure it reaches hard to reach or underrepresented individuals, and those with protected characteristics.

This targeted, co-designed approach will improve the effectiveness of local messaging, increase community awareness, and drive higher uptake of services and programmes, such as Food Clubs, Best Start in Life, and sexual health services.

Children, Families and Young People

3. **Identify and support young carers to reduce caregiving burdens.**

Conduct targeted awareness campaigns to identify young carers and connect them to dedicated local support services.

Places & Communities

4. Local delivery models to bring health services closer to home.

Embed flexible service models, such as mobile outreach, peer-led ambassadors, and recurring health drop-in clinics, at community sites like the Artizan Street Library and Portsoken Community Centre

By bringing routine health checks, mental health support, and targeted SEND interventions directly into neighbourhoods, the City will provide accessible, localised care and improve equitable uptake among underrepresented groups.

5. Promote targeted awareness of Sexual and Reproductive Health (SRH) services to increase uptake and reduce health inequalities.

Cascade SRH messaging through City communication channels and community spaces to promote the Sexual Health London (SHL) service, local pharmacies, and the Neaman Practice clinic.

This targeted promotion will improve service access and reduce inequalities in outcomes, such as STI testing and uptake of PreP.

By tailoring our awareness campaigns to address these specific inequalities, we will increase service engagement, reduce health gaps, and improve overall SRH outcomes across the City.

6. Investigate and improve access to healthy, affordable, and culturally appropriate food.

Leverage community connections developed through the Health Creation Alliance to assess the logistical, psychological, and mobility barriers preventing residents from accessing healthy food.

By identifying these root barriers, the City can pilot targeted solutions that increase the local availability and uptake of nutritious, culturally appropriate food options.

The Health & Care System

7. Map and clarify cross-border referral pathways to improve system navigation and coordination.

Map and communicate care pathways to ensure residents, workers, and practitioners understand how to navigate referrals and access services, regardless of a resident's postcode or GP registration.

This targeted coordination is essential to ensure seamless, equitable access to specialised support, such as maternity care, mental health, eating disorder services, and SEND provision.

8. **Improve equitable access to mental health support.**

To address inequities in access across both adult and children's mental health services, the City must collaborate directly with community groups to deliver targeted, culturally appropriate support.

Empowering and involving residents will help to engage underrepresented demographics, including men, LGBTQIA+ communities, and residents from global majority backgrounds.

Needs & Inclusion

9. **Reduce access barriers for all inclusion health groups requiring substance use, alcohol, and homelessness support.**

City residents and inclusion health groups, such as people experiencing homelessness, face geographic and systemic barriers to essential care. To overcome these barriers for all high-need groups, the City must establish accessible, local drop-in clinics to deliver harm reduction and treatment services directly within the Square Mile.

10. **Reduce health inequalities for inclusion health groups by improving local access to primary care.**

To support people sleeping rough and individuals experiencing multiple disadvantages, advocate to establish a local, accessible specialist primary care hub.

City and Hackney Public Health anti-racist and structural inequalities statement

Differences shown by characteristics such as ethnicity or deprivation reflect unequal living conditions shaped by structural factors, including poverty, racism, access to housing, education and employment, access to and experience of healthcare, and greater exposure to harm such as crime, environmental risks, unsafe housing, or financial insecurity. As such they should not be interpreted as natural, unavoidable or expected.

When data are broken down by a single characteristic, they show only part of a much more complex picture. For example, patterns by deprivation often reflect a social gradient, meaning that people living in more disadvantaged circumstances tend to experience worse health and shorter lives than those who are more advantaged. Differences by ethnicity frequently reflect the impact of systemic racism and wider structural inequalities, rather than ethnicity itself.

These findings should always be interpreted in context and alongside other evidence, including qualitative insight and lived experience. They are intended not only to support understanding of structural inequality, but to inform action: shaping local public health policy, strategy, service design and decision-making in ways that reduce inequality and target the underlying causes affecting groups most impacted.

Chapter 1: Introduction

Background & Aims

A Joint Strategic Needs Assessment (JSNA) is a statutory process through which local authorities analyse the current health and wellbeing needs of their communities. The evidence and insights within this JSNA will directly inform local commissioning strategies, helping to design services, improve health outcomes, and reduce health inequalities.

There are two key aims of this needs assessment, as described below.

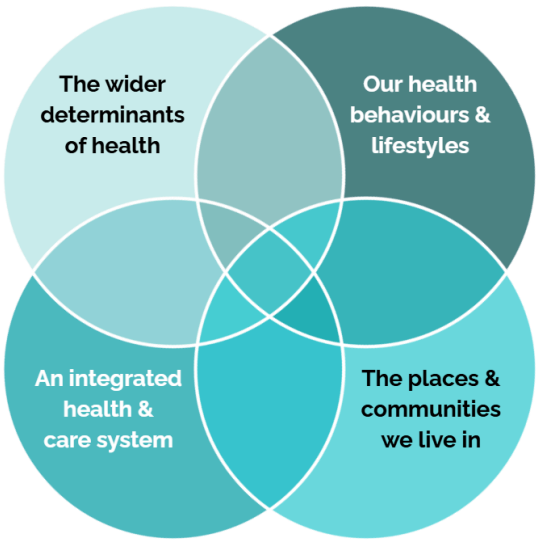
1. To establish a clear, evidence-based picture of health and wellbeing needs for these populations living and working in the City of London.
2. To collaboratively build recommendations with system partners to meet these needs, which align with the evidence. While it is not always possible to address every identified need simultaneously, this report serves as a crucial strategic tool to help partners prioritise resources and interventions where they will have the greatest impact.

Methodology

Evidence Framework

Our health is shaped by a range of factors. These include the wider determinants of health, the places and communities we live in, our lifestyles and health behaviours, and the health and care system [1].

Figure 1: A population health system: the four pillars of population health



Source: Adapted from the population health system, The King's Fund, 2018.

Together these four pillars create the population health system: a framework to improve health outcomes and reduce health inequalities at the population level (Figure 1).

This framework is used to understand how health is shaped in the City of London. The four pillars intersect. Throughout the report, these links are highlighted, outlining the intersectionality of the factors impacting our health.

Health inequalities are unfair and avoidable. They are systematic differences in health between different groups of people, and are experienced across the entire population health system [1]. Throughout this report, health inequalities are a central focus, particularly regarding:

1. Specific characteristics (for example, ethnicity or sexuality);
2. Geography (for example, small-areas in the City);
3. Socially excluded groups (for example, people experiencing homelessness).

Evidence Base

To construct the local picture, this report integrates quantitative data analysis to understand the prevalence of health conditions, inequalities, and risk factors within the City of London. This is complemented by qualitative data gathered from voluntary and community sector (VCS) engagement to contextualise evidence with lived experience.

The quantitative analysis within this report relies on a variety of national, regional, and local data sources to reflect the City's unique resident and worker populations. Key data sources used in the development of this needs assessment can be found in Appendix 1.

Geographical mapping

The City of London can be broken down into six small areas or lower super output areas (LSOA) and these have been used to examine geographical variations in the population. These geographies are set by the Office for National Statistics and based on the number of residents living in each area.

The six small areas have been named in line with the Index of multiple deprivation 2019 report published by the City of London Corporation (Figure 2). A map and table of the small-areas and the wards they include can be found in Appendix 2.

Figure 2: Small areas in the City of London



Source: Index of multiple deprivation 2019 report, City of London Corporation

Limitations

Framework Limitations

This report is structured into chapters based on the four pillars of the population health system. While this framework provides a systematic approach to evaluating the wider determinants of health, it can compartmentalise highly intersectional issues. The reality of health and wellbeing in the City of London involves greater complexity and overlap than this structured approach may suggest, meaning some cross-cutting inequalities may not be fully captured within the confines of a single chapter.

Quantitative Data Limitations

The unique demographic profile and administrative boundaries of the City of London present several inherent challenges regarding quantitative data analysis:

- Primary care data and local service data often involve small patient counts. This can impact statistical accuracy and reliability, meaning small fluctuations can appear as major trends. Furthermore, small counts often require data suppression to protect patient anonymity.
- In many national and regional datasets, City of London data is missing, incomplete, or routinely joined with the London Borough of Hackney. This aggregation can mask City-specific trends and obscure local health needs.
- The Office for National Statistics (ONS) Mid-Year Estimates (MYE) are less accurate for the City of London due to its unique residential makeup, making it difficult to accurately measure and track the true denominator population year-on-year. To mitigate this, Census 2021 estimates in conjunction with GP records are used to estimate the population.

However the Census only offers one point in time and is difficult to analyse trends. These data source limitations are discussed in more detail in the Appendix 3.

- Annual Population Survey (APS) data frequently lacks the required granularity for accurate small-area analysis within the City. Furthermore, the ONS has indicated that the quality of APS data is expected to decrease over the next 12 months, before improving with the introduction of new survey methodologies in 2027. Consequently, certain survey-based metrics must be interpreted with caution.
- Obtaining accurate quantitative data for individuals experiencing homelessness in the City is challenging. This population is often transient and lacks a fixed residential address, therefore they are frequently excluded from routine administrative datasets and geographic population estimates. Consequently, it is difficult to accurately locate this cohort within the City or reliably measure their specific health outcomes and needs through standard data collection methods.

Community Engagement

To enrich the quantitative data, qualitative engagement was conducted with 13 Voluntary and Community Sector (VCS) organisations. This qualitative insight is invaluable, the findings are based on a targeted sample and may not be representative of the entire City of London population. Instead, the aim of this engagement was to capture a wide range of lived experiences to highlight hidden inequalities masked by high-level population averages. More details on the community engagement, including organisations attended, can be found in Appendix 4.

Direct engagement with individual residents was not conducted as part of this specific JSNA process. This decision was taken to prevent consultation fatigue, acknowledging the resident engagement already taking place across ongoing City of London Corporation projects.

Chapter 2: Population

Introduction

To understand health needs, develop appropriate strategies and commission services, we must clearly understand who we serve.

The City has a highly unique demographic makeup. A small resident group sits alongside a massive weekday resident workforce. These distinct groups have different public health needs. They also require different types of services. For example, weekday resident workers often need quick access to preventative care. Meanwhile, older residents require accessible community support near their homes.

By mapping both the City's resident and worker population, resources can be targeted more effectively. This works towards everyone getting the right support to live healthy and happy lives.

The City's unique population

Estimating the population in the City of London is complex for several reasons:

1. There are high levels of population mobility with 27% of City residents reporting in the 2021 Census that they lived at a different address 12 months earlier.
2. The City has a large population of weekday resident workers and visitors which makes measuring the total population at any given time challenging.
3. The City's housing stock has a large proportion of second homes. As of 2026 there were 2,013 second homes, accounting for 25% of the number of dwellings on the valuation list. This is larger than the national average of 1% [2].

Notes on the data

For this report, the resident population is based on GP registrations and Census estimates. GP registration data provides the resident count by age and sex over time. We use this data for two main reasons:

- The Census likely underestimates the population. It took place during the COVID-19 pandemic. At this time, many weekday workers were living outside the City instead of at their usual City address.
- GP records capture all City residents who are registered with a GP in England. This provides an accurate picture of City residents even if they were not in the City during Census day.

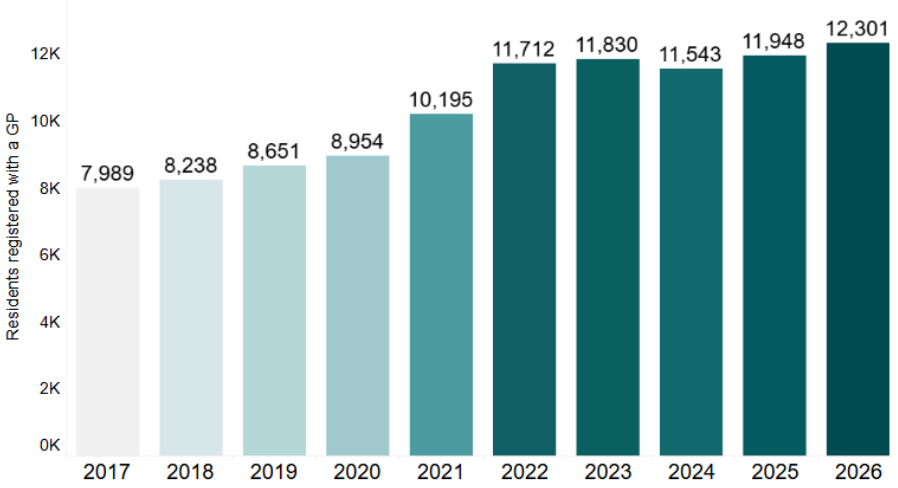
In addition, Census 2021 estimates have been included, offering wider insight on broader demographics, such as ethnicity and sexual orientation.

It is important to note neither dataset should be viewed as definitive, as both have inherent limitations. As a comparison, in 2021, the Census recorded 8,583 residents, whereas in the same year GP registrations listed 10,195 individuals. For more information about the characteristics of these two data sources please see Appendix 3.

City residents

Since 2022 the resident population has remained stable, reaching 12,301 in 2026 based on GP registrations[1] (Figure 3).

Figure 3: Number of City of London residents registered with a GP, 2017 to 2026



Source: Patients Registered at a GP Practice, NHS England, 2026

Note: Each year is a snapshot as of 1st July with exception to 2026 which is a snapshot on 1st January

A working-aged population

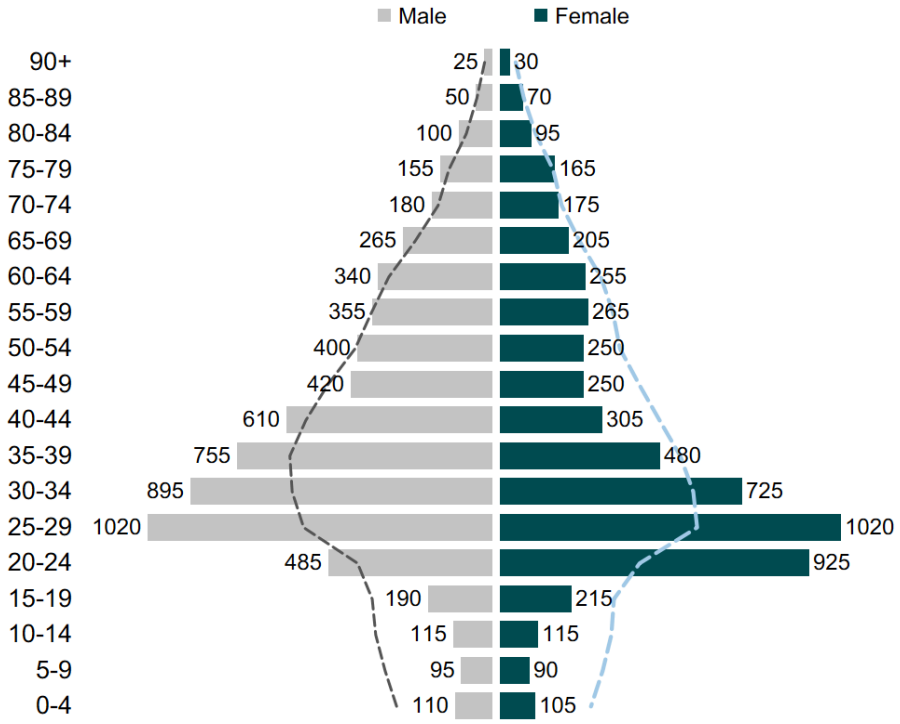
Unlike most areas in England, the City of London's population is mostly made up of working-age adults. People aged 25 to 29 form the largest single group of residents, with just over 2,000 individuals split evenly between men and women (Figure 4).

There are twice as many young women registered with a local GP compared to young men (aged 20 to 24). This gap is unlikely to mean there are fewer young men living in the City. Instead, it suggests that young men are less likely to register with a GP or seek out primary care. For local health planners, this may mean a portion of young men may be hidden from the system, putting them at risk of missing out on healthcare.

There is a small population of children in the City relative to the regional average. Further details on the population of children and young people can be found in the relevant section in this report.

[1] Individuals who are registered with a GP in England with a home postcode located in the City of London boundaries are included in this count.

Figure 4: GP registered population by age and sex, City of London compared to London, 2026



Source: GP registration via Hospital Episode Statistics (HES), NHS England, 2026 Note: Values have been rounded to the nearest 5.

Note: The dotted line shows the proportion of patients by age group and sex for London.

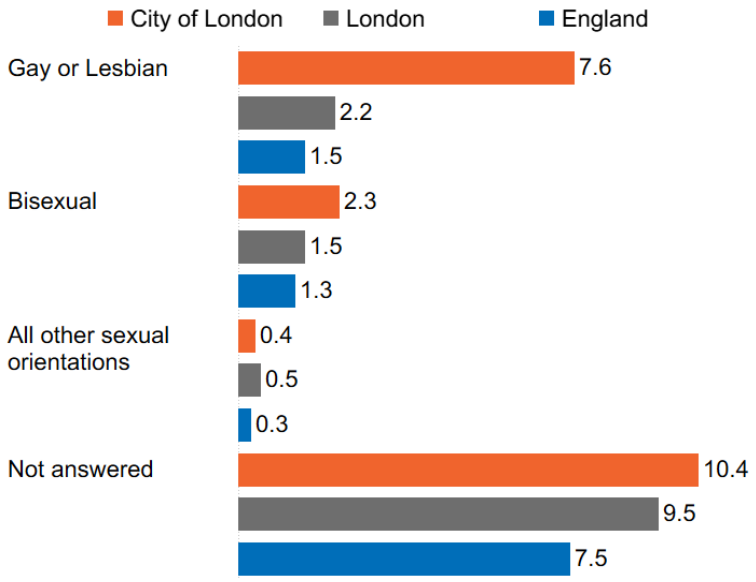
Second largest proportion of LGBTQ+ residents in England

Out of all the local authorities in the country, the City of London has the second largest proportion of residents that identify as either Gay or Lesbian, Bisexual or other sexual orientations (LGBTQ+) (Figure 5) [3].

The proportion of residents who identify as LGBTQ+ is higher for men (15%), compared to women (5%).

It is worth noting 10% of City residents did not provide their sexual orientation when completing the Census. This proportion is the same for male and female residents. This suggests the true size of the City's LGBTQ+ population may be even larger as missing data often highlights hidden populations who may fear stigma or face barriers to care, leading to disproportionately worse outcomes such as higher HIV prevalence [4,5]. This is addressed in the City and Hackney Sexual Reproductive Health strategy. Further details are available in Chapter 6.

Figure 5: Proportion of LGBTQ+ residents by sexual orientation, City of London, 2021



Source: Census 2021, Office for National Statistics, 2021

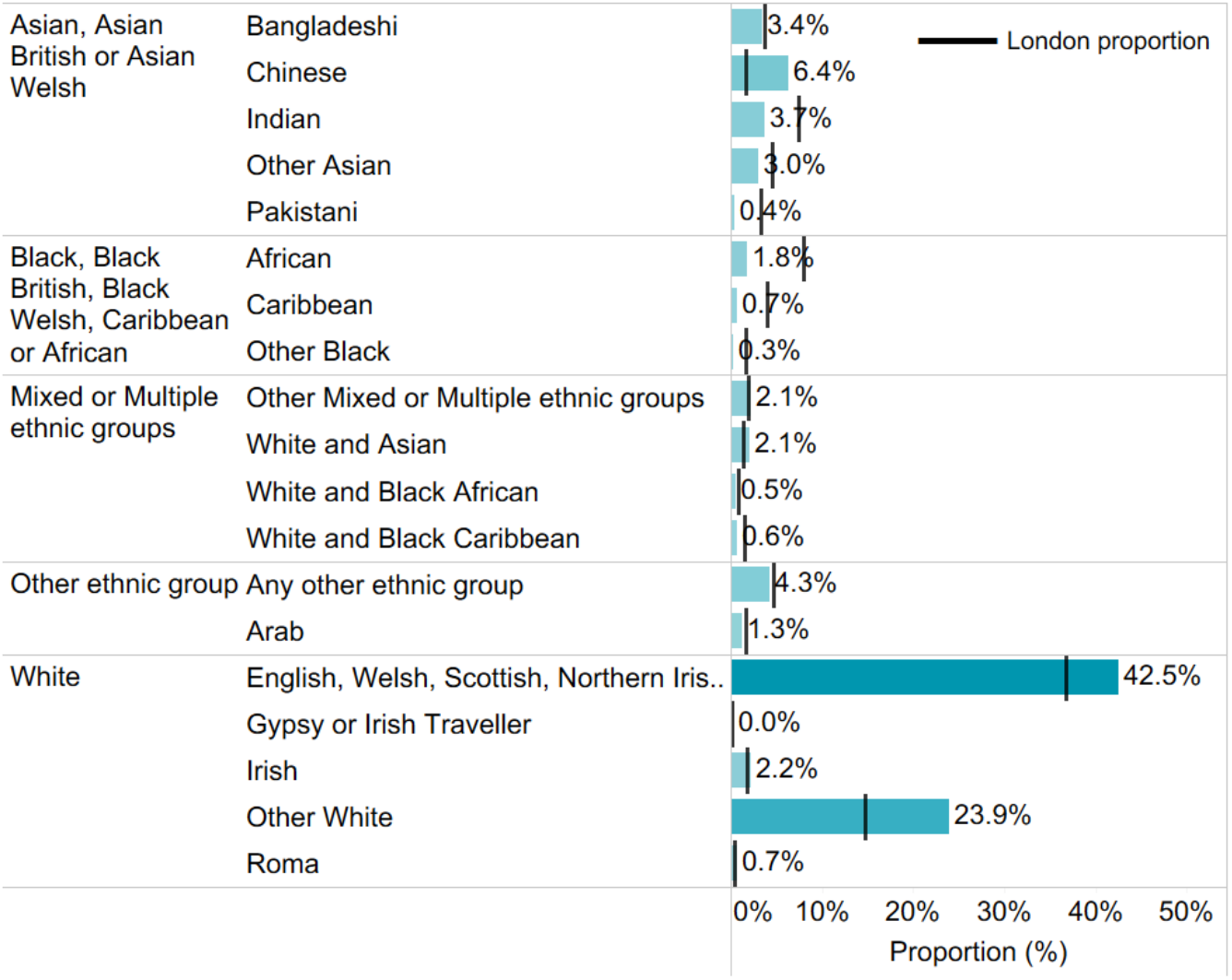
City residents mostly identify as White

In 2021, almost 7 in 10 City of London residents identified as White. More specifically, White British residents make up the City's largest ethnic group, making up a larger proportion than the London average [6].

The ethnic group who has seen the greatest increase in size is the Asian residents, growing from 13% to 17%, aligning with the overall trend in London [7]. The majority of this growth comes from adults aged 25 to 49 years.

Census data shows that around 1 in 5 residents identifying as Asian (20%), Black (19%), or Mixed ethnic groups (18%) are students, compared to just 7% of the White population. Student cohorts are typically younger and are transient, therefore they will have different health needs compared to other population groups.

Figure 6: Proportion of residents by ethnic group, City of London compared to London, 2021



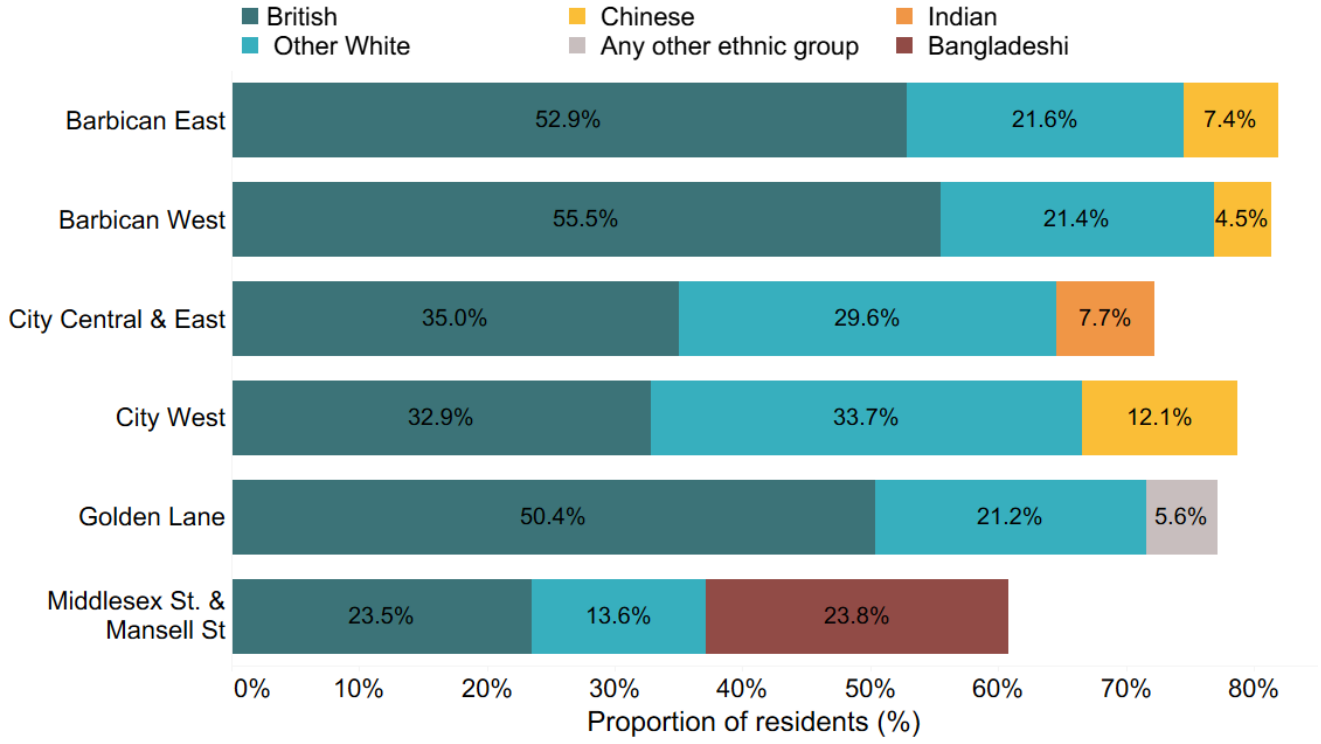
Source: Census 2021, Office for National Statistics, 2021

Ethnicity varies across the City

Northern and western areas mirror the City's overall ethnic makeup. However, central and eastern areas show distinct demographic differences. For example, City Central & East has a larger proportion of Indian residents (8%).

The eastern area has highly concentrated diversity. In Middlesex Street and Mansell Street, 1 in 4 residents identify as Bangladeshi and this area has the highest proportion of African residents (Appendix 5).

Figure 7: Proportion of residents for the 3 most common ethnic groups by small-area, 2021



Source: Census 2021, Office for National Statistics, 2021

A Latin and South American community is also based in the East. In the 2021 Census, 190 residents identified with this group. However, insight from City Healthwatch suggests this group makes up a large proportion of the area's essential workers. To support this workforce, the City Belonging Project recently launched Latinos in the City. Further details are available in the workforce chapter.

English proficiency varies across the City

The majority of City residents report their main language as English (77%) with the second most common main language reported as Spanish (3%). Over a quarter of Middlesex St & Mansell St residents self-reporting that English is not their main language.

English proficiency also varies across the City with 7% of residents in Middlesex St & Mansell St self-reporting that they 'do not speak English' or 'do not speak English well'. For adults aged 55 years and over this increases to just under a third of the population (31%) (Appendix 6). This data likely reflects residents where English is a second language.

For residents with limited English proficiency, language barriers can limit access to services. During the VCS engagement event, it was highlighted that navigating local systems, such as housing services, and communicating health concerns, such as mental health, in a second language often leaves residents feeling overwhelmed.

VCS organisations and engagement with Portsoken residents has highlighted how children often translate for their parents during medical and social care appointments. This practice could place

an added burden on young people, especially in areas where residents' ability to speak English well is limited.

To mitigate this, VCS representatives recommended increasing access to interpreters to improve accessibility.

Deprivation

Deprivation is linked to increased risk of illness, lower access to care and worse health outcomes. Therefore living in a deprived area can impact the health and wellbeing of residents [8]. Based on the Index of Multiple Deprivation (IMD) 2025, the City of London is one of the least deprived areas in England, ranking 147 out of 153 local authorities by average IMD score [9].

These rankings are useful for understanding inequality, but standard administrative data excludes certain groups. For example, official figures include statutory homelessness but omit rough sleepers Yet, this hidden group faces some of the greatest barriers to housing, services, and health care.

Box 1: What is the Index of Multiple Deprivation?

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England. The Indices relatively rank each small area in England from most deprived to least deprived, where 1 is the most deprived area.

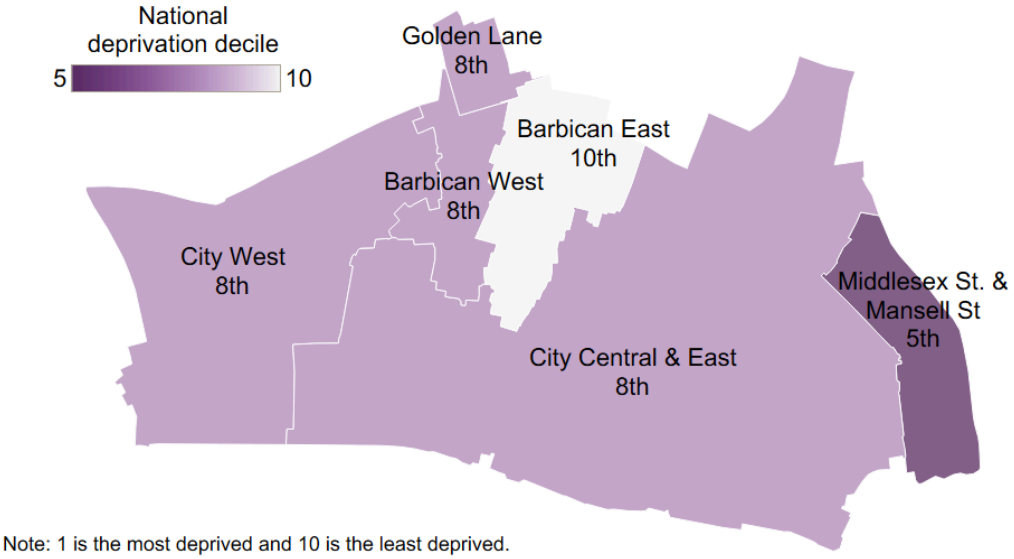
The rank is a weighted combination of seven domains: Income, Employment, Health & Disability, Education & Skills, Barriers to Housing & Services, Crime, and Living Environment.

These specific domains have been explored throughout this report where they are most relevant to the local context and insight. A full breakdown of deprivation domains and ranking of areas can be found in Appendix 7.

The majority of the Square Mile is less deprived compared to the England average. However, there is variance between different areas of the City.

Barbican East is the least deprived area in the City with around 1,745 residents. Middlesex Street & Mansell Street in the east remains the most deprived area and is home to approximately 2,550 residents (Figure 8).

Figure 8: National deprivation decile[2] of small areas in the City of London (IMD 2025)



Source: Index of Multiple Deprivation (IMD) 2025, Ministry of Housing, Communities & Local Government, 2025

Since 2019, Middlesex Street & Mansell Street has become relatively less deprived compared to the rest of the country. See Appendix 7 for more detail.

The contrast between the Barbican and the more deprived Middlesex Street and Mansell Street (which includes the Middlesex Street Estate) is felt by residents. Feedback from VCS organisations during an engagement session in February highlights a West-East gap. For example, residents can feel constrained by their local boundaries and are reluctant, or practically unable, to travel across the Square Mile to access services in other areas. This contributes to a fragmented City.

Table 1: Number and proportion of residents by national deprivation deciles (IMD 2025), City of London, 2024

National deprivation decile	Number of residents	Proportion of residents
5th	2,550	20.7%
8th	8,015	65.1%
Least deprived - 10th	1,745	14.2%

Source: GP registrations via Hospital Episode Statistics, 2026. Index of Multiple Deprivation (IMD) 2025, Ministry of Housing, Communities & Local Government, 2025.

Note: 1st is the most deprived area and 10th is the least deprived. Data is rounded to the nearest 5 to comply with disclosure controls.

[2] Deciles are calculated by ranking the 33,755 small areas in England, from most deprived to least deprived, and dividing them into 10 equal groups.

City workers

The City of London's population profile is unique, functioning as a global business district with 676,000 workers that outnumber the residents (estimates range from 8,583 to 10,195 in 2021). This creates three challenges and opportunities for local public health.

A worker-integrated local democracy

The City Corporation has a unique electoral structure due to the large workforce. Businesses and organisations are entitled to nominate voters, ensuring workers can have a say on the way the City Corporation is run alongside registered residents.

Part-time residents

A cohort of professionals reside in the Square Mile only during the week. While they might not require child or older adult social care, they may access certain aspects of public health services (e.g. mental health, sexual health, GPs). This population is likely to be of working age, economically active, and more affluent. This will impact demand for public health provision.

Challenges to community cohesion

The large weekday resident workforce can impact traditional community structures, such as local associations, faith groups, and sports clubs. Residential structures may be looser, making it harder to engage underrepresented or isolated individuals. Addressing this is a core priority of the City Corporation's Corporate Plan 2024-29, which aims to connect residents and workers to build "Diverse Engaged Communities" (Box 2).

Despite this, on residential estates there is a strong sense of community. The City's Stronger Community Grants and Neighbourhood programme funds a range of activities across the Square Mile.

Box 2: City Corporation's initiatives to build diverse engaged communities

The City Belonging Project

This project aims to create a more inclusive Square Mile. 'City Belonging Networks' connect individuals and employee groups. Specific networks support mental health, disability, and underrepresented groups. This improves wellbeing by amplifying historically marginalized voices.

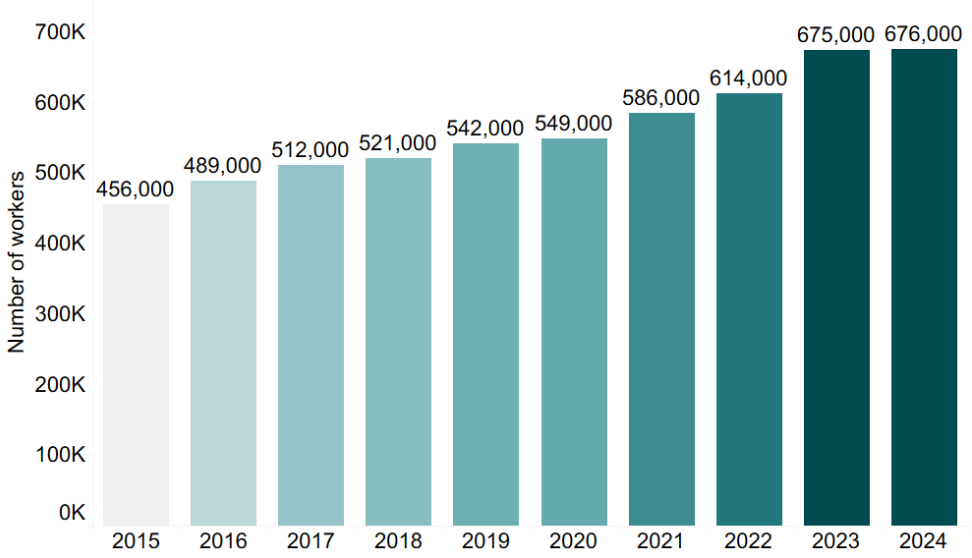
Destination City Programme

Aims to make the City an inclusive and welcoming destination. It focuses on wellbeing and upskilling to attract the next generation of talent. The programme also improves the City Corporation's understanding of the worker population, by engaging with the ONS and commissioning an annual survey.

The workforce continues to grow

The City has experienced continuous job growth since 2015. The workforce has expanded by 0.2% in the latest year, reaching 676,000 workers. Since the COVID-19 pandemic the workforce has grown by 23% (Figure 9)

Figure 9: Number of workers employed in the City of London, 2015 to 2024



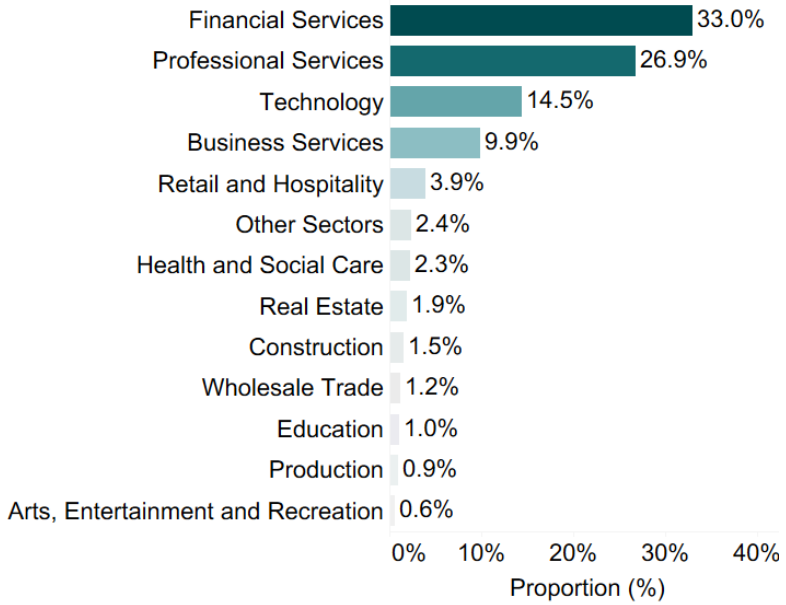
Source: Business Register and Employment Survey, Office for National Statistics, 2025

Note: Employment defined as anyone aged 16 years or over that an organisation directly pays from its payroll as well as working owners (self-employed registered for VAT or PAYE schemes).

Data has been rounded to the nearest thousand.

A third of employees work in the financial sector

Figure 10: proportions of workers employed in the City of London by occupation, 2024



Employment in the City of London is concentrated in a few industries.

Over 80% of the local workforce is employed across four sectors: Financial Services, Professional Services, Business, and Technology (FPSBT) (Figure 10).

Retail and hospitality is the largest of non-FPSBT sectors, employing over 20,000 workers (4% of the total workforce). More details can be found in Appendix 8.

Source: Business Register and Employment Survey, Office for National Statistics, 2025

Note: Employment defined as anyone aged 16 years or over that an organisation directly pays from its payroll as well as working owners (self-employed registered for VAT or PAYE schemes).

City's essential workers often experience health inequalities

While the City's workforce is concentrated in professional services, a large proportion makes up the 'essential workforce', such as cleaners and security. Since 2019, Business Healthy has been working to better understand the health needs of this essential workforce and supporting this population by sharing resources to improve wellbeing. The Lord Mayor also led campaigns, such as Mental Health at Work: This is Me Campaign.

These roles are often filled by Global Majority groups, including the City's Latin American community. These workers are more likely to experience health inequalities, such as long-term conditions and poor mental health [10]. Anecdotal evidence suggests that many Portsoken residents are employed in zero hour contracts and/or work shifts.

A report published by the Institute of Health Equity shows essential workers often lack access to corporate wellbeing packages and adequate sick pay. This creates a barrier to healthcare. Fear of losing wages often prevents these workers from attending GP appointments or preventative screenings. Alongside this, long and anti-social working hours impact physical health, sleep

quality, and family relationships. Addressing the health and wellbeing gap for this essential population is a primary public health challenge for the City [10].

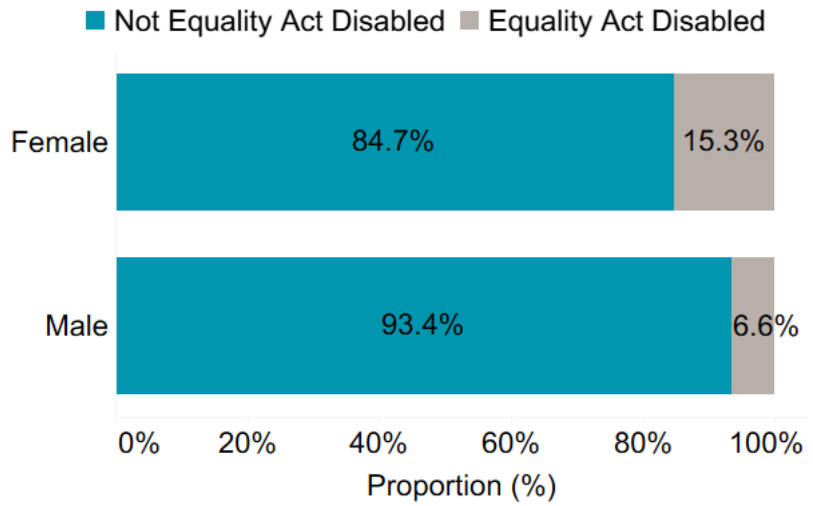
The City workforce is diverse

The makeup of the City's workforce directly dictates our public health priorities. Detailed breakdowns and charts are available in the Appendix 9.

Almost two-thirds of City workers are aged 25 to 44. Men make up 63% of this total workforce. This concentration drives demand for working-age health interventions. Priority areas include sexual health, substance use prevention, and targeted mental health support.

An estimated 10% of the workforce (roughly 66,400 people) are disabled under the Equality Act. Female workers are twice as likely to report a disability as men. This highlights a need for accessible workplaces and inclusive occupational health services (Figure 11).

Figure 11: Proportion of workers employed in the City of London by disability status and sex, financial year 2024/25



Source: Annual Population Survey, April 2024 to March 2025 (weighted 2022), Office for National Statistics, 2026.

Note: Estimates are based on a small sample size. This may result in less precise estimates, which should be used with caution. Under the 2010 Equality Act, you are defined as disabled if you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities.

Over a third of all workers come from Global Majority backgrounds. There is some variation when looking at ethnicity by sex; there are a higher proportion of men amongst Asian workers and White workers. In contrast, there is a higher proportion of women amongst Black and Mixed or Multiple ethnic groups workers

Roughly 6.5% of the workforce identifies as LGBTQI+. This high level of diversity requires culturally competent health interventions to prevent hidden health inequalities.

Chapter 3: Children, Young People & Families

Introduction

The environment in which a child grows up is a significant determinant of their lifelong health, wellbeing, and future life chances. Ensuring that children are supported during these crucial early developmental stages is the most effective way to prevent long-term health inequalities [11].

The City of London Children And Young People's Plan 2026-29 sets out a vision that children and young people who live in the City of London have the best start in life and get the right support when they need it as they move into adulthood. The plan includes five high-level outcomes that children and young people:

1. are and feel safe
2. are physically healthy
3. are happy with good emotional wellbeing and mental health
4. can learn in a way that works for them and have access to activities and opportunities that support their development
5. experience positive relationships and feel part of their community.

This chapter covers the City's children and young people population, births, early years settings, schools and vulnerable groups, such as children in care or with emotional wellbeing concerns.

Other chapters detail health behaviours, including childhood healthy weight, oral health, smoking, and STI testing. A review of where children and young people are registered with primary care is provided in the access to health services section of this report.

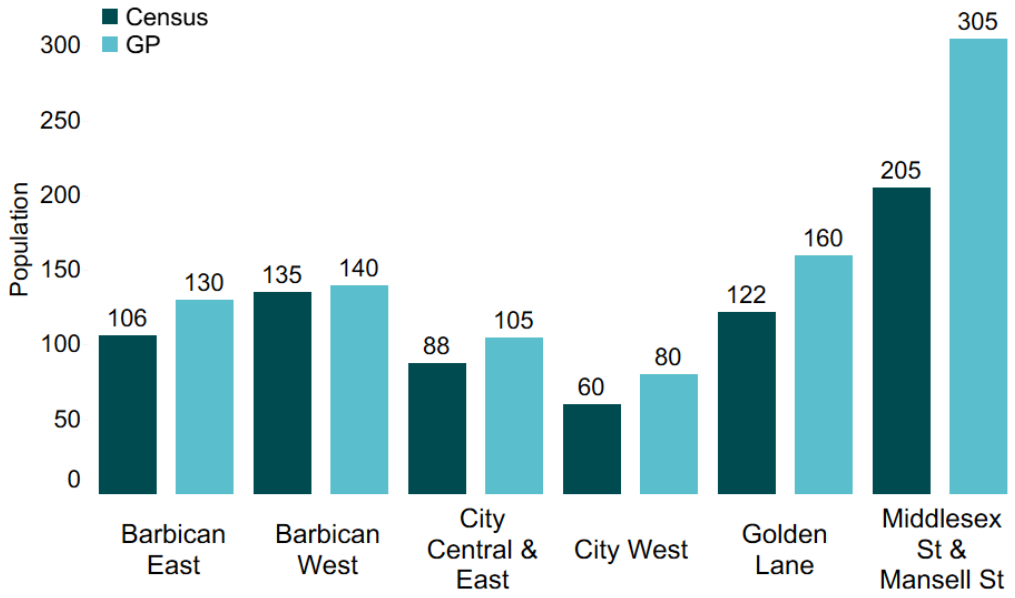
Children and young people population

Children and young people under the age of 24 make up approximately 20% of the total population, with those 18 and under accounting for 8%.

These proportions are consistent across GP records and Census 2021. However, the overall number of children differs. Appendix 10 details these discrepancies.

Families live across the City of London but there are certain areas where more children and young people live. According to the 2021 Census, a third of children and young people live in the east of the City, in Middlesex Street & Mansell Street. Some children and young people live in the North (Golden Lane and Barbican communities) (Figure 12).

Figure 12: Number of children living in the City, aged 18 and under, Census compared to GP records, by small-area



Source: Census 2021, Office for National Statistics. GP registration via Hospital Episode Statistics (HES), NHS England, 2026.

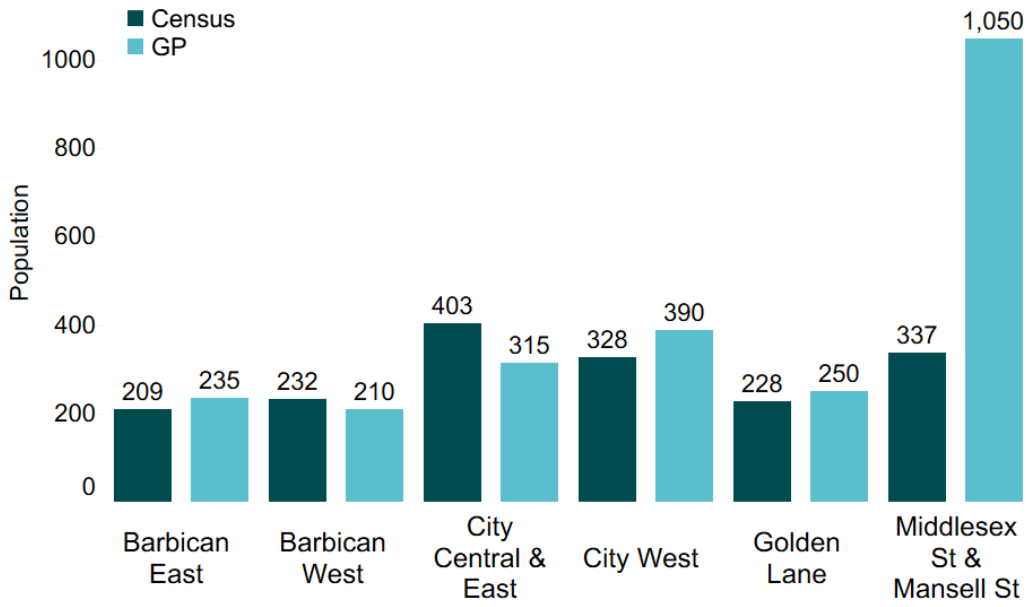
Note: GP records have been rounded to the nearest 5 to comply with disclosure controls. As a result, the sum of individual age groups or small area breakdowns may not match the aggregate totals.

When expanding the age group to include young adults (aged 24 and under), the distribution across the City shifts slightly. Middlesex St & Mansell St remains the area with the largest population. City Central & East and City West see a notable increase in its share compared to the 18 and under group, with around 328 residents (Figure 13).

There is a substantial discrepancy between Census and GP records for the Middlesex Street & Mansell Street area for those aged 0 to 24 years, with GP records estimating almost three times as many young people as the Census. These GP records are for City residents who are registered with a NHS GP in England.

This discrepancy could be driven by the local student population. Of the 19 to 24 year olds living in this area, 65% are registered at the King's College Health Centre, a dedicated GP practice for university staff and students.

Figure 13: Number of children living in the City, aged 24 and under, Census compared to GP records



Source: Census 2021, Office for National Statistics. GP registration via Hospital Episode Statistics (HES), NHS England, 2026.

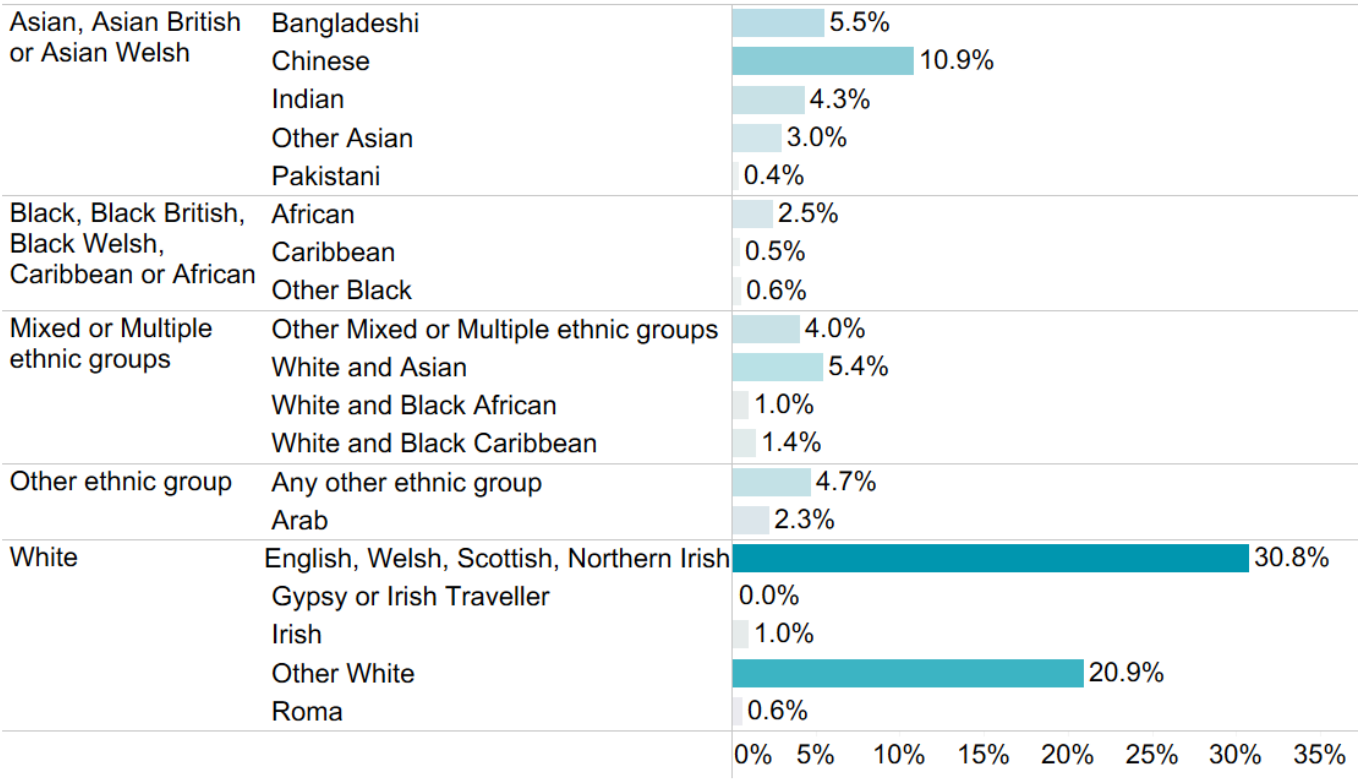
Note: GP records have been rounded to the nearest 5 to comply with disclosure controls. As a result, the sum of individual age groups or small area (LSOA) breakdowns may not exactly match the overall aggregate totals.

The younger population is ethnically diverse

White British and Other White residents make up over half of residents aged 0 to 24. However, the proportion of White residents in this age bracket is lower than their proportion in the City overall. This means the younger generation is more ethnically diverse than the older generations.

There is a slightly higher proportion of children and young people from the Global Majority compared to residents of all ages. The third largest ethnic group is Chinese (11%), followed by Bangladeshi (6%) and White and Asian (5%).

Figure 14: Proportion of residents aged 24 years and under by ethnic group, City of London, 2021



Source: Census 2021, Office for National Statistics, 2021

Starting well

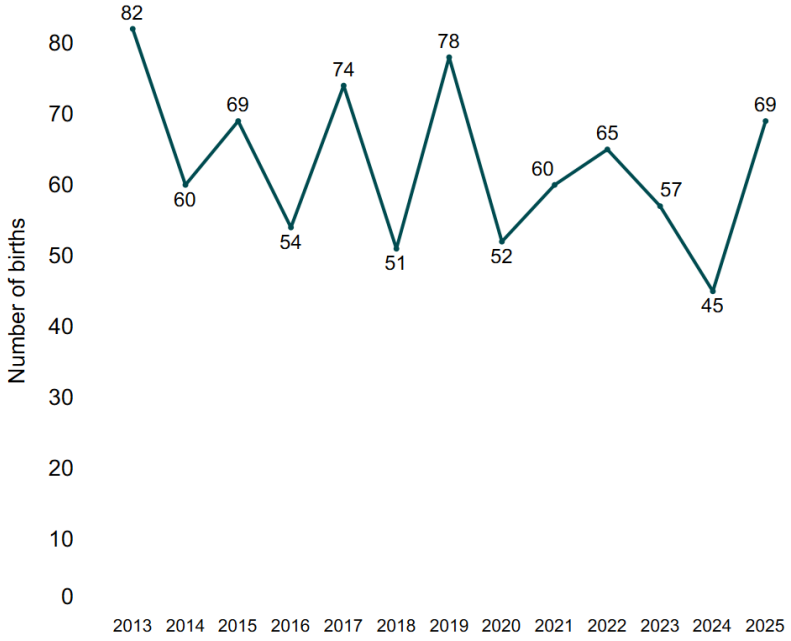
The City has the lowest fertility rate in England

In January to December 2024, City of London residents has a lower total fertility rate[3] (0.32) compared with England, which is consistent with other London boroughs. However, since 2021, the City has had the lowest fertility rate in England [12]. This low fertility rate is likely explained by the unique characteristics of the area.

In 2025, NHS Digital reported approximately 69 live births for City of London residents, up from 45 in the previous year. Since 2023, 0 stillbirths have been recorded.

[3] Total fertility rate measures the number of children born per woman of childbearing age. This metric is also age standardised.

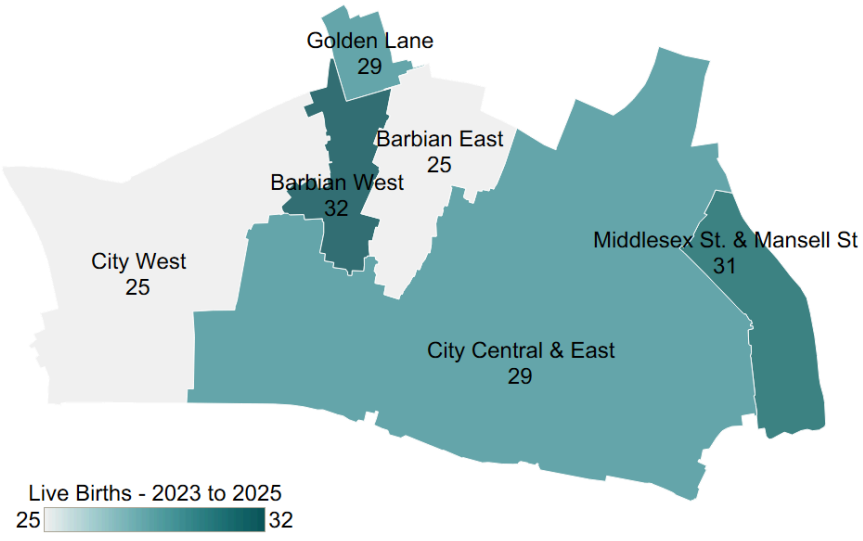
Figure 15: Number of live births, City of London residents, 2013 to 2025



Source: Live births, Nomis, 2026

Live birth data provides insight for planning early years interventions. Recent births are distributed evenly across the City, contrasting with the broader youth demographic. The number of births range from 25 to 32 births per area (Figure 16). This indicates young families with infants reside in all neighbourhoods. There are slightly more births recorded in the north of the City (Barbican West and Golden Lane) and in the East.

Figure 16: Number of live births by small area of residence, City of London, 2023 to 2025



Source: Live births, Nomis, 2026

The premature birth rate is low

Babies born before 37 weeks are considered premature. Monitoring these births is a public health priority. This is because premature babies often require extra medical care and targeted support for their early development [13].

Between 2022 and 2024, 10 babies were born prematurely to City residents. This is an estimated rate of 65 per 1,000 births. This local rate remains lower than both the regional average (75 per 1,000) and the national average (77 per 1,000) [14].

Health visits are mostly happening on time

Health visitors are nurses or midwives with specialist training in family and public health. They help parents and their families to improve health and wellbeing during pregnancy, after the birth and up to 5 years old. The Health Visiting Service in the City is provided by Homerton Healthcare NHS Foundation Trust.

In 2025/26, there were 63 new mothers with all being eligible for a new birth visit. Of these, 62 (98%) received their visit within the first 14 days of birth, exceeding the 95% target (Table 2). Families are receiving appropriate support and care when they are needing it most.

Table 2: Proportion and number of families who received universal health visiting, City of London residents, 2025/26

Universal health visiting development reviews	Number	Percentage	Target comparison
Face to face new birth visit within 14 days	62	98.4%	Higher (95%)
Infants who received a 6-8 week review by the time they were 8 weeks	60	91.0%	Higher (90%)
Children who received a 12 month review by the time they turned 12 months	28	90.3%	Higher (90%)
Children who received a 2-2.5 year review	21	100%	Higher (80%)

Source: Health visiting key performance indicators, City and Hackney Public Health Team. 2026

Most vulnerable mothers are receiving the support they need

Health visitors can provide additional one to one support aimed at individuals with additional risk factors and health needs.

In 2025/26, 11 vulnerable or new mothers were identified as needing a targeted or specialist assessment. This includes families and children that require support from multiple services or organisations, for example children and babies with SEND. Of these 11 mothers, 90% received a health visit within 4 weeks of the birth, exceeding the local target (85%).

In the same year, 8 families were identified as needing targeted or specialist support at 3 to 4 months and 87.5% had their assessment on time.

In 2025/26, zero City families accessed the highly intensive, one-to-one Home Service offered by Homerton Healthcare. While this may suggest that local needs generally do not escalate to the highest thresholds of vulnerability, low service uptake can also reflect hidden needs, referral barriers, or a lack of service awareness rather than an absolute absence of acute need. Continuous monitoring is required to ensure highly vulnerable families are not missed.

Addressing service access

Evidence from practitioners has highlighted some Golden Lane residents may be excluded from accessing maternity services as they live on the City's border with Islington. Currently, work is being undertaken to understand and address this.

The City hosts a number of early years services

The Best Start Family Hub

National children's social care reforms are actively shaping how the City delivers early years support. The 2025 Families First Partnership reform requires local authorities to transition toward a proactive system. Another element of this reform is the development of Best Start Family Hubs.

The Best Start Family Hub is the single place for family support in the Square Mile. It supports children from pregnancy up to age 25, including those with SEND. This hub provides the essential building blocks families need to give children a healthy start. Data from this report will directly shape and improve the local hub offer.

Best Start in Life Programme

The City has an extensive Early Years offer as part of the Best Start In Life programme:

- The core Best Start In Life offer available to families across the City, including Stay and Play/Rhyme time sessions, baby massage, sensory room, baby clinic, infant feeding and mental health support.
- The City of London Talks and Listens Enthusiastically Programme provides information and strategies for early years practitioners and parents/carers to support children's speech, language and communication skills.
- New Birth contact and Early Intervention support by Family Involvement Workers ensure support is available as early as possible within the Universal Offer.
- Visits, meetings and strategies to support children under-five whose development is causing concerns is available.

Between September 2025 to June 2026, 165 City families engaged with Best Start in Life services. Most of these families were living in Cripplegate and Aldersgate, located in the North of the City. Portsoken residents had the fourth highest uptake, with 11 families accessing services.

Two of the City's libraries are located near these areas with higher engagement rates (Barbican Library and Artizan Street Library), suggesting the effectiveness of library-based or localised delivery.

Engagement is strong, but this varies across the City. To actively improve uptake, the Family Hub network operates across multiple sites to maximise community reach. Furthermore, the Hub is

rolling out an evidence-based engagement plan to target under-engaged families, supported by a wider communications campaign to promote the Best Start in Life offer.

Early Education Services

There are seven early years settings in the City. In June 2026, 94 children accessed City-based local early years settings. Of these, 23 were confirmed City residents, split evenly between boys and girls. White children made up 65% of this group, slightly higher than local Census estimates.

Free Early Education Entitlement

Eligible families can access government-funded childcare blocks for 38 weeks per year. Offerings vary depending on the child's age and household income.

During Spring 2026, 31 City children accessed these early education offers:

- 13 children aged between 9 months to two years accessed either working family funding or government support funding.
- 18 children aged 3-4 years accessed entitlements and received 15 hours of early years a week

Additionally, children under 5 who receive support from social care or early help can get extra funded childcare hours. This helps to reduce stress on their families.

Responding to local family needs

The City Corporation conducted engagement around the Best Start in Life offer. Parents and carers praised the diverse activities provided across the City. To build on this, the Best Start Local Plan commits to continuously developing early years services in response to local needs.

Families and young people also shared positive feedback on Family Hub and holiday activities. The Early Help and Virtual School teams deliver these in partnership with Kids Activities and Bootcamps. These hub network offers are inclusive and free for children with SEND.

Growing well

Education

The City's Education Strategy sets the vision for the City's Family of Schools. It focuses on five core priorities:

- Educational excellence
- Personal development
- Safety and wellbeing
- Employability
- Cultural engagement.

The strategy extends beyond standard school ages. It covers early years provision and lifelong learning through the Adult Skills and Education Service. It is underpinned by a commitment to Equity, Equality, Diversity and Inclusion. A major focus is also placed on environmental and outdoor learning to boost student wellbeing.

The City's 'Family of Schools' (including the City of London Academies Trust) actively supports many disadvantaged students living outside the Square Mile.

Local schools

Within the City itself, there is one maintained primary school, The Aldgate School, and five independent schools. These are the City of London School, City of London School for Girls, Charterhouse Square School, St Paul's Cathedral School, and David Game College.

Pupil numbers

As of March 2026, the City tracks 308 resident pupils. Because of the City's unique geography, many resident children travel outside the Corporation boundary for their education. As of April 2026, 208 local children attended over 60 different schools across neighbouring boroughs (Table 3).

Table 3: School attendance location of City of London resident pupils, aged 5 and over (March 2026)

School Type	Attending within the City	Attending outside the City	Total Pupils
Maintained Schools	47	179	226
Independent Schools	53	29	82
Total	**100**	**208**	**308**

Source: City of London Corporation, 2026

School attendance

Attendance levels in City schools remain consistently strong, exceeding both London and national averages across primary and secondary phases. This reflects the commitment of schools, families and local services to promoting regular attendance and responding early when concerns emerge.

School attendance levels are 95.3% for City-based schools, exceeding the London and national figure (Table 4).

The majority of City of London resident pupils travel outside the Square Mile for education. This requires close collaboration between schools, local authorities, and support services to identify emerging concerns early and provide timely intervention.

Table 4: School attendance rates in the City schools, compared with London and National average, September 2025 to July 2026

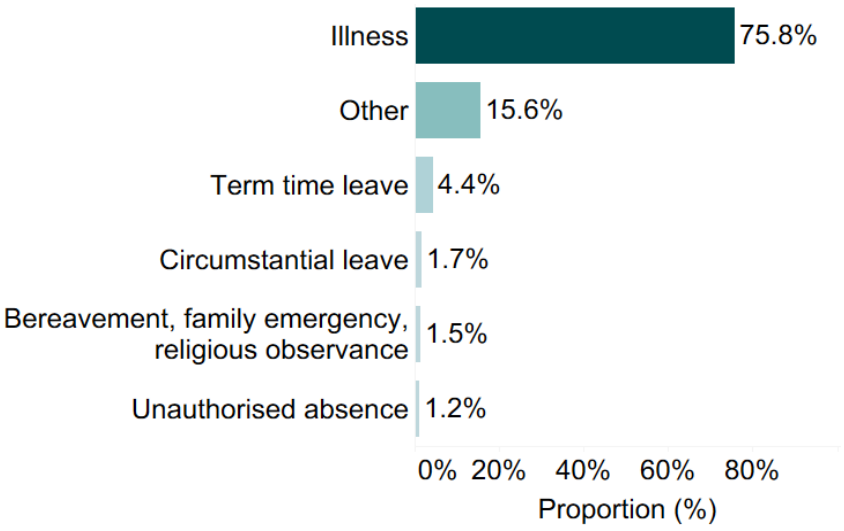
Year to date	City of London	London	National
Primary	96.4%	94.7%	94.7%
Secondary	94.3%	92.8%	91.5%
Total	**95.3%**	**93.8%**	**93.1%**

Source: City of London Corporation and gov.uk, 2026.

Note: Data is for maintained and independent schools located within the City of London.

Securing regular attendance enables good educational achievement, promoting children's current and future wellbeing. The majority of absence in City schools was for illness (Figure 17). Currently, zero City pupils experience severe absence, lower than both regional and national averages.

Figure 17: Proportion of pupils attending City schools by absence reason, September 2025 to April 2026



Source: City of London Corporation, 2026.

Note: Data is for maintained and independent schools located within the City of London.

Supporting children with school transition

Anecdotal evidence also shows it is difficult to coordinate SEND support from primary to secondary school. To address this, the Early Help team has worked closely alongside the SEND team to actively strengthen this specific transition process.

The City of London Corporation developed specialised transition packs which were distributed in June 2026 to early years settings and community libraries. The packs aim to support parents of children moving from early years to primary school in September 2026. They contain dedicated information and resources for families navigating SEND support.

Not in education, employment or training (NEET)

The relationship between a young person's health and their employment or education status is cyclical. Poor health can be a major barrier to work and study, while being out of work or education can make health worse [15].

Being NEET can also lead to isolation, financial stress, a lack of routine and a loss of purpose. Over time, this environment can trigger new mental health issues or worsen existing health conditions [15].

In 2025, in the City of London there are zero children aged 16 to 17 years NEET. This is the lowest rate of all local authorities and below the England average (4%) [16].

Youth services

Society Links

SocietyLinks is a youth service co-designed with local children, young people and families. It provides spaces where young people aged 8 to 19 (and up to 25 for those with SEND or who are care-experienced) can build confidence, develop life skills, and improve their wellbeing through a variety of activities.

Between 2022 and 2026, 142 children accessed youth services in the City of London. Of these 52 were City of London residents.

Addressing young people's feedback

During consultation for the children and young people's plan 2026-2029, families shared valuable feedback. Young people requested more extracurricular activities, more places to play, and easier ways to discover local events. The City Corporation is actively increasing targeted involvement to reach a diverse range of families.

Vaccinations and Vaccine-Preventable Diseases

The City of London is included within the City and Hackney Immunisation Strategic Action Plan (2024-27) which provides the overarching framework for improving vaccination uptake, reducing inequalities and strengthening resilience against vaccine-preventable diseases (VPDs). The Plan

brings together system-partners across Public Health, the NHS, primary care, education and community organisations to address barriers to vaccination through targeted communications, engagement and outreach, alongside service improvement and coordinated system action.

Available data, reviewed as part of the Plan suggest that childhood immunisation within the City is generally higher than the London average, although coverage falls below the 95% herd immunity threshold for some programmes and age groups, consistent with both the London and national picture.

Most immunisation data continues to be aggregated at the City and Hackney level. Due to data availability, immunisation coverage is estimated using information from the most common GP practices accessed by City of London residents:

- The Neaman Practice which serves approximately 51% of the resident population
- Goodman's Field Medical Practice
- Spitalfields Practice in Tower Hamlets.

Therefore, this information, presented in Table 5, should be used as a proxy measure. Further information on GP access by residents can be found in the Primary care services chapter.

Table 5: Average childhood immunisation coverage rate by GP practice across the indicators, 2024/25

GP practice	Average at 12 months	Average at 24 months	Average at 5 years
Neaman Practice	94.6%	80.9%	80.5%
Goodman's Field Medical Practice	85.1%	83.6%	82.0%
Spitalfields Practice	82.9%	81.6%	78.4%

Source: Cover of vaccination evaluated rapidly (COVER) programme, GOV.uk, 2026.

Note: Immunisation data is currently only available for GP practices. Therefore, data in this table should be used as a proxy for City of London residents. Vaccination coverage rate is the average of all the routine childhood immunisations given respectively at 12 months, 24 months and 60 months.

Given the City's high levels of population mobility and international travel, and the occurrence of measles outbreaks across neighbouring London boroughs since 2024, maintaining high vaccination coverage remains important to reducing the risks of disease importation and transmission. Despite these wider regional risks, there were very few to no reported measles cases in the City during 2025 and no reported cases between 1 January and 18 June 2026.

The City continues to benefit from the partnership activities delivered through the City and Hackney Immunisation Strategic Action Plan (2024–27), alongside broader system-wide measures to prevent, detect and respond to VPDs and outbreaks.

Targeted Support

Special Educational Needs and Disabilities

The City's SEND and Alternative Provision Strategy 2025-2029 sets five core priorities, including getting the right help at the right time, supporting transitions to adulthood, ensuring a skilled workforce, promoting community inclusion, and securing high-quality alternative provision.

Local context

As of June 2026, there are 26 resident children and young people with an Education, Health and Care Plan (EHCP), almost double the number recorded in 2019 (14).

Of those 26 residents who have an EHCP:

- 18 (69%) are male
- 10 (38%) are of primary school age and 14 (54%) were of secondary school age,
- 13 (54%) are from Global Majority communities (Bangladeshi, Black African, Indian, Any other Asian, White and Black, any other mixed)

The primary need (71% of children and young people supported) is Autistic Spectrum Disorder and 88% of those with an EHCP attend educational settings outside of the City of London.

Additionally, as of May 2026, there are 40 children and young people attending The Aldgate School and receiving SEN Support[4] This data includes school children who reside outside of the City.

Of these 40 children:

- 26 were male (65%) and 14 were female (35%).
- 30 (75%) were from Global majority backgrounds and within this cohort 20 were Bangladeshi (50%)

There are 34 children receiving SEN support who live in the City and attend schools outside of the City. Of these children, 21 (62%) are male and 16 (47%) are from Global Majority backgrounds[5]. Figures should be treated with caution due to its reliance on data collected and reported by other local authorities.

More details on SEND prevalence and support can be found in the City and Hackney Joint Strategic Needs Assessment for Children and Young People with Special Educational Needs and Disabilities.

Delivering positive outcomes

In autumn 2025, Ofsted and the Care Quality Commission reported City's partnerships lead to positive outcomes for children and young people with SEND.

A strong culture of collaboration exists across education, health, and care. The report also highlights that children's needs are identified in a timely manner and are carefully considered.

[4] Spring School Census, 2026
[5] View Your Education Data, 2026

Their needs, voices and lived experiences are used to understand how best to support children and their families.

Addressing barriers to SEND services

Hackney Ark is a specialist outpatient NHS service for children and young people with disabilities and additional needs. The centre brings together services from across education, health and social care to provide multi-disciplinary oversight and responses to the needs of disabled children and their families.

This service is available for City residents who are registered with a GP in City or Hackney. Portsoken residents face a potential geographical barrier when accessing support services as these residents fall outside the Neaman Practice catchment area.

This requirement may limit children with SEND in the east from accessing Hackney Ark. The City Corporation is working with partners to remove this barrier. We recommend mapping clear referral pathways with North East London boroughs to remove existing uncertainty around which services, within and out-of-area, are available to City residents.

GP registrations for all children and young people is explored further in the primary care services section of the report.

Improving educational insight for children with SEND

The City uses the View Your Education Data (VYED) platform to access high-level educational data. This covers resident children attending The Aldgate School, out of borough maintained, free and academy schools.

This system provides information regarding SEN support and school attendance. Under the new attendance strategy, the City will use this platform to hold schools to account and provide constructive challenge on improving attendance and educational attainment for children with SEND. The City also plans to investigate and reduce inequalities in educational outcomes, specifically for children from Global Majority backgrounds.

Children's Social Care

Strong partnership working across health, education and social care underpins the City's universal and targeted offer. Throughout the 2025/26 academic year, 59 children were known to social care. At the end of April 2025, in the City there were 13 Early Help cases, 12 children in need, 8 children in care and 44 care leavers.

The multi-agency Early Help service identifies needs early and supports families from pre-birth through to 18 years. As part of our targeted provision, 18 children with disabilities receive dedicated support through the Short Breaks offer.

Children in care

The City of London children in care population is 0.7% of the overall children and young people 0-18 population. This is in line with the national average (0.7%) and slightly above the regional average (0.5%) [17].

The number of children in care has fluctuated primarily due to changes in numbers of unaccompanied asylum-seeking children. There has also been a recent increase in the percentage of resident population being in care.

Care leavers

Care leavers often face unique, intersecting challenges as they transition into adulthood [18]. To support these children, the City hosts monthly 'supper clubs' in various locations to help young people explore their areas, build networks, and find safe spaces to visit with friends.

The survey also revealed that more care leavers felt they had experienced discrimination due to their care experience. To actively combat this stigma and improve long-term outcomes, the City of London now recognises care experience as a protected characteristic, and specifically ring-fences certain local apprenticeships for those with care experience.

The Virtual School

The City of London Virtual School promotes the educational achievement of children and young people (aged 0 to 25 years) who have a social worker or have previously been supported by social care. This includes supporting children to achieve the best educational outcomes, providing training for social workers, teachers, and support staff, and supporting care leaves attending university. In 2025/26, the Virtual School supported 10 children.

Emotional Health and Wellbeing

Mental Health Needs

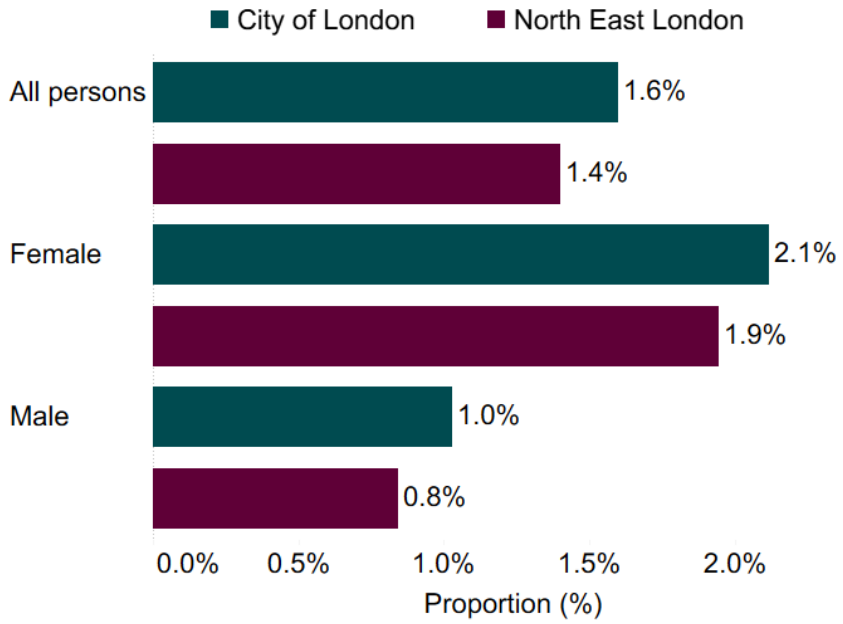
The national prevalence of mental health needs among children and young people has increased over the past five years and varies depending on the type of condition and by personal characteristics. In the City, mental health conditions affect 1.6% of children aged 5 to 18 years. This rate is comparable to the North East London (NEL) average of 1.4% (Figure 18)

Anxiety is the most common condition among local children, followed by eating disorders. These disorders are more commonly reported among females. The largest difference between genders is seen in eating disorders.

Children in need, looked after children and care leavers have an increased likelihood of developing poorer mental health outcomes due to their exposure to adverse childhood experiences.

Due to data quality and a high proportion of missing ethnicity data it is not possible to investigate prevalence by ethnic group.

Figure 18: Proportion of diagnosed mental health condition for residents aged between 5 and 18 years old, by sex, City of London compared to North East London, 2023-2025



Source: Clinical Effectiveness Group, East London Database, 2026

Notes: This data relates to City of London residents registered with a GP Practice in North East London between the years 2023 to 2025. Mental health conditions, include anxiety, depression and eating disorders, and have been grouped due to small counts.

Access to services

There are many mental health services available to children and young people in the City of London, primarily under the umbrella of the City of London and Hackney Children and Adolescent Mental Health Mental Health Services (CAMHS). These include specialist CAMHS delivered by East London NHS Foundation Trust, Mental Health Support Teams in Schools, First Steps, and others. The Primary Care Network of Shoreditch and the City, which includes the City of London, had the second greatest number of referrals (7.9%).

The Children and Young People Mental Health Needs Assessment outlines that female children and young people are more often overrepresented than male children and young people across most services, including eating disorder services.

White children and young people tend to be overrepresented in the early intervention and prevention focused services while Asian children and young people are often underrepresented. These differences point to potential inequities in access and highlight a hidden inequality where certain demographics miss out on vital early interventions. This must be addressed through targeted, culturally appropriate outreach [19].

City-specific interventions

The City of London also offers access to City Chorus who provides free emotional wellbeing and mental health support to local families. In addition, the City Wellbeing Centre is based on Middlesex Street, offering a range of mental health and psychological services. This service is

eligible for people who live or work in the City or live in surrounding boroughs. It is a paid service, which may limit accessibility for some families, although a sliding scale of payment amounts is offered. Of the 374 registrants with the service in 2025/26, 13% were residents of the City of London.

The City also offers a weekly Systemic Family Therapy Clinic. This supports anyone receiving early help or social care, from pre-birth up to age 25.

System improvement

The Children and Young People Mental Health Needs Assessment published in 2025 included recommendations for future action.

A new strategy and action plan for Children and Young People Emotional Health and Wellbeing from 2027-2032 is now being developed for the City of London and Hackney. This includes recommendations to improve the mental health of children and young people in the City with:

- System coordination and strategy for monitoring outcomes, integrating VCS engagement, and collaboration on early intervention in school settings
- Supporting care leavers through digital passports, warm handovers and peer-led pilot work
- Improving transitions by improving resources for parents and students.

Lifestyle and health care access

Children and young people's health behaviours, including childhood healthy weight, oral health, smoking, and STI testing, are detailed in chapter 6. Where children and young people are registered with primary care is provided in the access to health services section of this report (chapter 7).

Chapter 4: Older People & Healthy Ageing

Introduction

The World Health Organisation defines healthy ageing as the process of developing and maintaining the functional ability that enables wellbeing in older age. This extends beyond managing medical conditions. It means ensuring older residents can continue doing the things that matter to them.

The City of London's Adult Social Care Strategy - Living Well Ageing Well (2025-2029) sets a clear ambition. This is to enable residents to lead healthy, independent lives, with a focus on preventing care needs and promoting independence.

This section will cover the following topics:

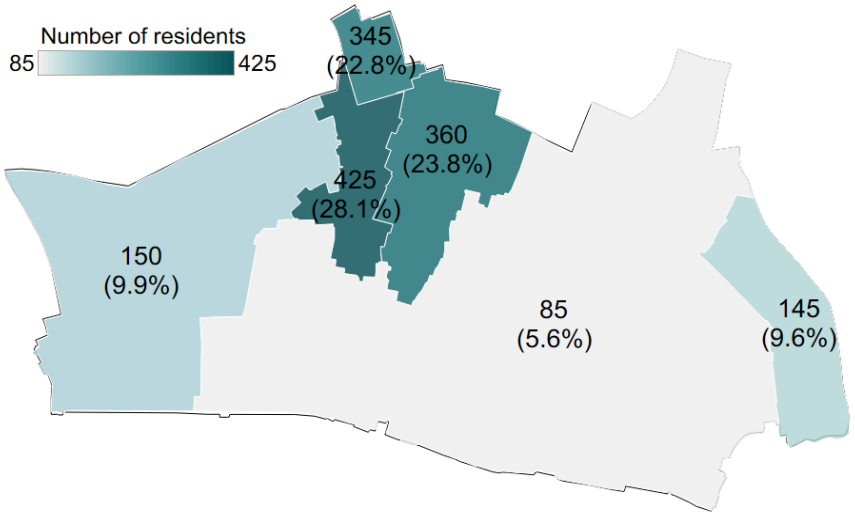
- Older aged population and demographics
- Health needs, include long term conditions
- Adult social care
- Carers

Older aged resident population

There are 1,512 residents aged 65 and over living in the City. This equates to 13% of the population, which is higher than the North East London average (10%).

The majority of older residents live in the North of the City (Barbican West, Barbican East, and Golden Lane account for 75%) (Figure 19). The East of the City has a smaller population with this area being home to the majority of children, young people and students (see chapter 3 for more details).

Figure 19: Number and proportion of older people registered with a GP, aged 65 and over, in the City of London by small-area, 2026



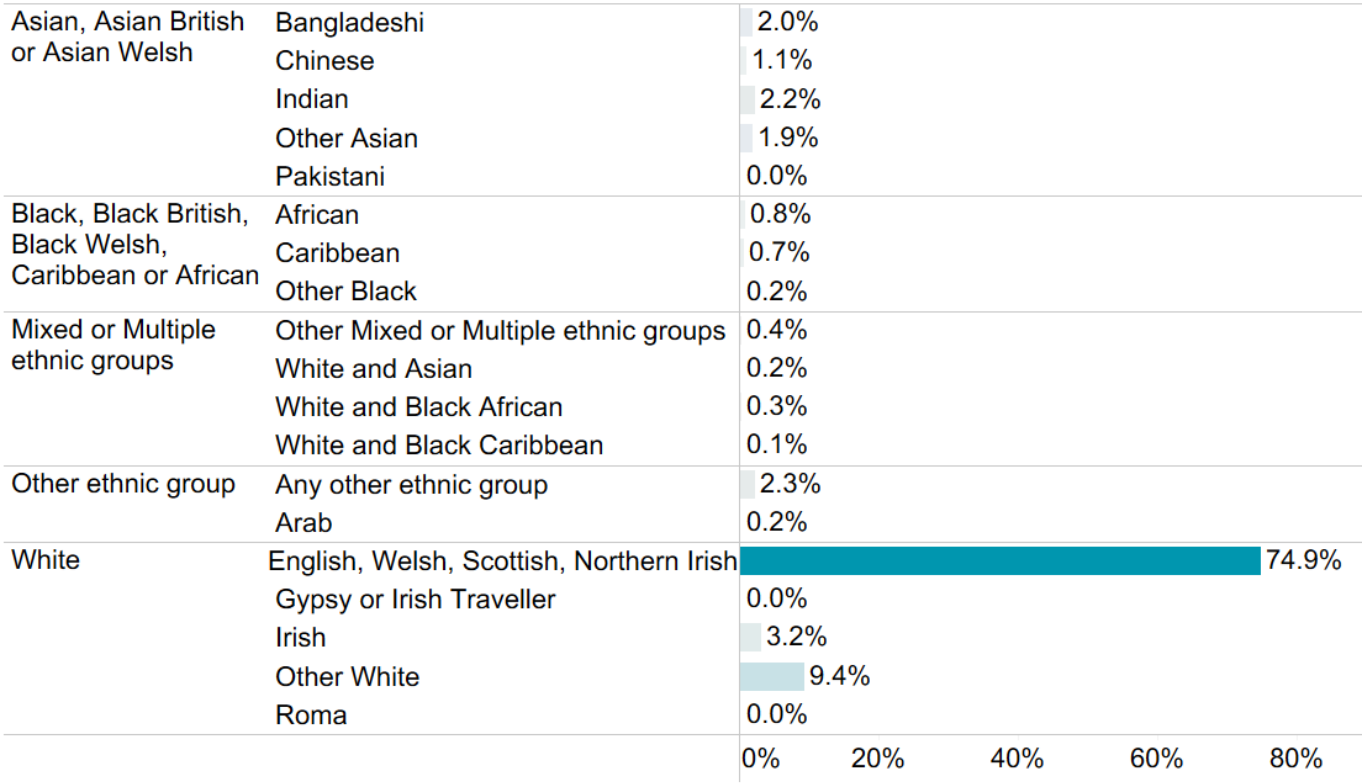
Source: GP registration via Hospital Episode Statistics (HES), NHS England, 2026

The older population mostly identify as White

In 2021, White residents represented 88% of the population aged 65 and older, making up a larger proportion of residents in this age group compared to the overall City population (69%).

A smaller proportion of older adults identified with Global Majority groups. Among Global Majority the largest demographic groups were residents from Any other ethnic group, Indian and Bangladeshi ethnic groups.

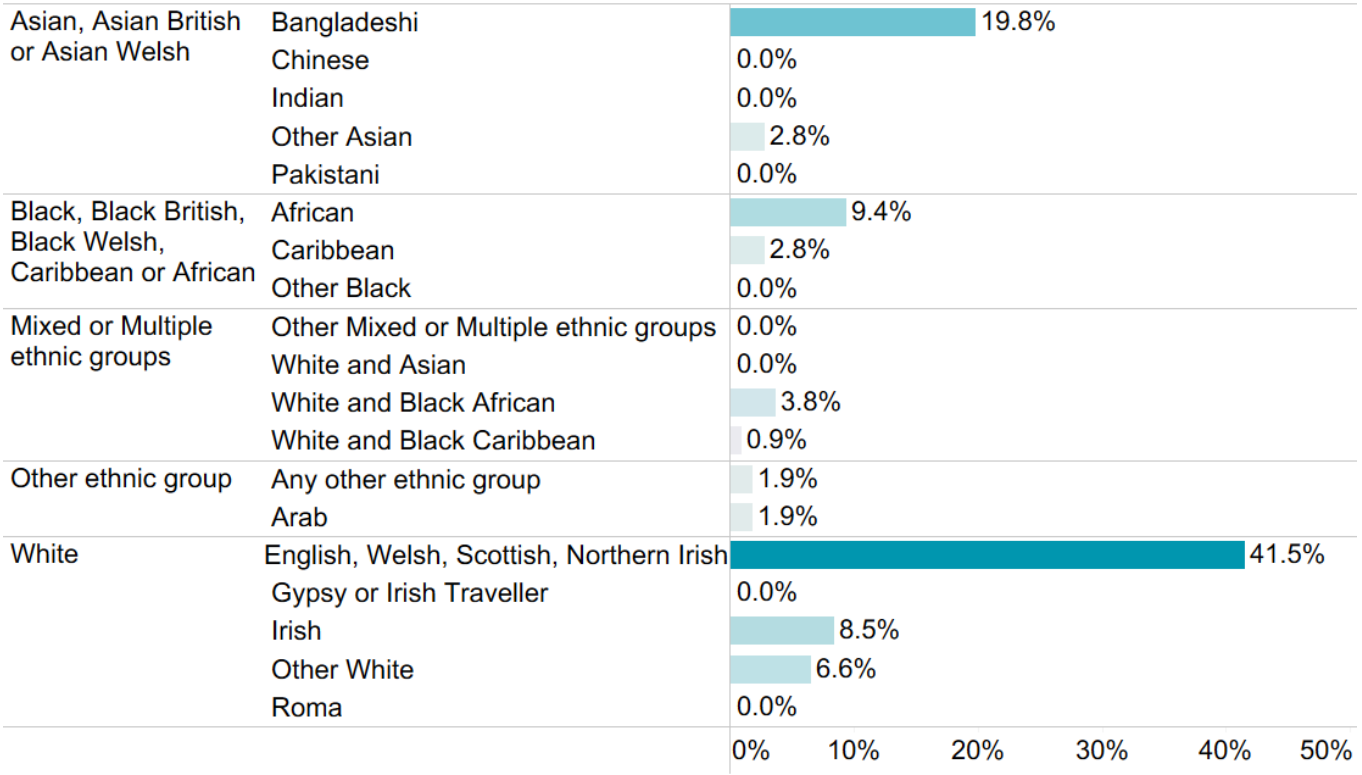
Figure 20: Proportion of residents aged 65 years and over by ethnic group, City of London, 2021



Source: Census 2021, Office for National Statistics, 2021

Most small areas mirror the demographic makeup of the City of London overall. The City's eastern area, Middlesex Street and Mansell Street, has a higher proportion of Global Majority groups. For example, residents who identify as Bangladeshi represent 20% of this older group and those who identify as African represent 9%.

Figure 21: Proportion of residents aged 65 years and over by ethnic group, Middlesex Street and Mansell Street, 2021



Source: Census 2021, Office for National Statistics, 2021

Language

Across the City of London, 2% of residents aged 65 and over do not speak English well. This increases to 18% for residents in Middlesex Street & Mansell Street (Appendix 6).

Language barriers can restrict access to services. Older residents may require tailored support, such as translated health information, to ensure they have equal access to resources and services.

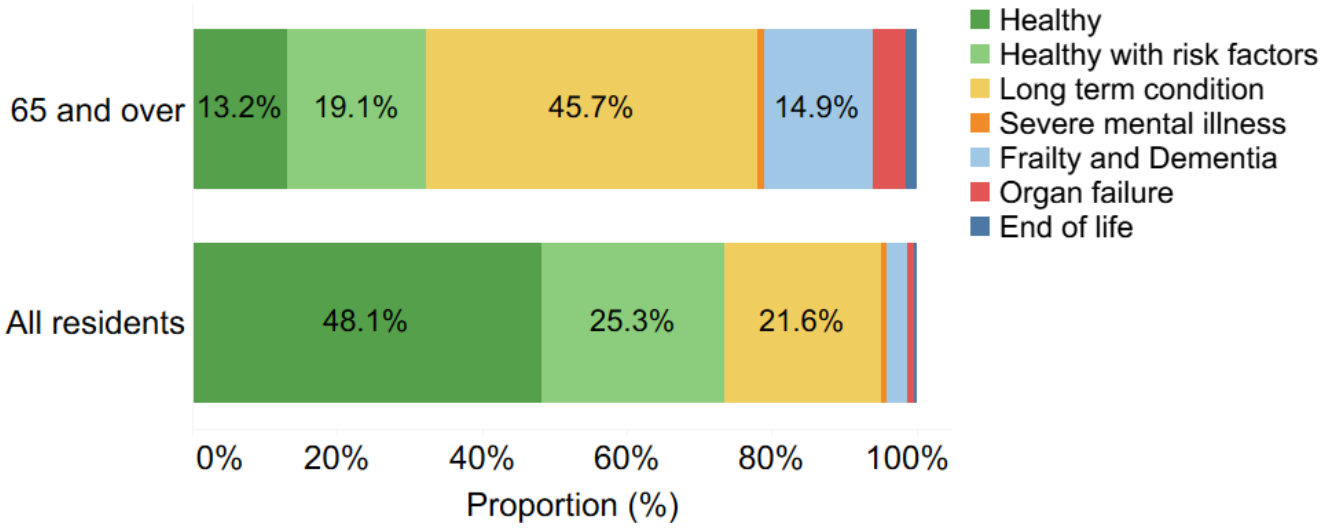
Health needs

The population in the City is ageing and the risk of poor health generally increases with age. Common conditions in older age include diabetes, depression and dementia. As people age, they are more likely to experience several conditions at the same time[6].

Based on the North East London ICB segmentation model[7], in 2025 61% of City residents aged over 65 were diagnosed with either a long term condition, frailty or dementia. This compares to 24% of all residents (see Long term conditions chapter for more detail).

However, the proportion of residents with these diagnoses is lower than the NEL average (70%) and the proportion of healthy 65+ is higher (13% vs 5%).

Figure 22: Proportion of residents by health segmentation, City of London, 2025



Source: Primary Care data, North East London ICB. 2026.
Note: City residents are those registered with a GP in North East London with a City of London home postcode.

Long term conditions

Long term conditions or chronic diseases are conditions for which there is currently no cure, and are managed with drugs and other treatments.

[6] WHO. Ageing and Health. Available at: https://www.who.int/news-room/fact-sheets/detail/ageing-and-health
[7] The North East London population segmentation model is a population health management tool used by the NHS North East London ICB to categorise residents based on their predominant health needs, All people registered with a North East London GP practice are and exclusively assigned to a single segment.

Local picture

In 2025, hypertension is the most prevalent condition with 43% of older residents being diagnosed. This is lower than the NEL average (63%).

Table 6 shows older City residents record lower prevalence across multiple long-term conditions compared to NEL regional averages. The lower rates for long term conditions for the overall City population demonstrate the impact of age on these conditions.

In 2025, 13% of residents, aged 65 and over, living in Shoreditch Park and the City Primary Care Network were living with severe frailty risk. This is higher than the NEL average (7%).

Table 6: Long term conditions, proportion of residents aged 65 and over compared to total population, City of London, 2025

Condition	City residents aged 65 and over	NEL residents aged 65 and over	All City residents
Hypertension	43.4%	63.1%	11.3%
Chronic kidney disease	16.5%	23.4%	3.6%
Cancer	14.8%	16.9%	3.9%
Type 2 Diabetes	10.8%	30.2%	3.6%
Depression	10.1%	20.5%	9.1%
Coronary Heart Disease	9.9%	17.6%	2.2%
Stroke/TIA	6.1%	-	1.3%

Source: Primary Care data, North East London ICB. 2026.
Note: City residents are those registered with a GP in North East London with a City of London home postcode.

Health inequalities

Ethnicity

There is a variation in health conditions for older residents by ethnicity. As mentioned above, hypertension is diagnosed for 43% of City residents in 2025. This increases to 55% and 53% for residents identifying as Asian and Black, respectively.

There are also higher rates of diabetes and chronic kidney disease for Black older residents, compared to all older residents.

Sex

Disparities also exist based on sex. In 2025, more male older residents (14%) were living with diabetes compared to female older residents (7%). This is also the case for coronary heart disease.

However, 12% of female older residents were living with depression, compared to 8% of male older residents.

Dementia

Dementia is listed as one of the high priority cohorts to improve health outcomes within the Neighbourhood Health Framework. This long term condition is characterised by a decline in memory, thinking, behaviour, and the ability to perform everyday activities. Social care plays a crucial role in supporting people with dementia to live independent and fulfilling lives for as long as possible.

Local picture

Age is the primary risk factor for dementia. Nationally, 4.2% of people aged 65 and older had a diagnosis in 2024. In the City, between 0.3% and 0.5% of the total population lives with dementia which is in line with the NEL average (0.4%). Age-standardised rates in the City are 4 per 1,000 and these rates fall below the NEL average of 8 per 1,000.

For City residents aged 65 and older, dementia prevalence increases from approximately 0.3%-0.5% to 1.9%-2.6% (Table 7). See Box 3 and Appendix 11 for information on how rates were calculated.

Table 7: Proportion of residents diagnosed with dementia, comparison by area and data source, 2025

Metric	City of London (GP records only)	City of London (GP and ASC records)	North East London	England*
Aged 65+ diagnosis proportion	1.9%	2.6%	-	4.2%
Total population proportion	0.3%	0.5%	0.4%	-
Total population age standardised rate	4 per 1,000	-	8 per 1,000	-

Source: Primary care records, Client Level Data, North East London ICB, 2026. Fingertips, 2025.

Note: Data for England is for 2024.

Box 3: Calculating local dementia rates

To build a more comprehensive picture of dementia in the City of London, two data sources were combined:

1. In 2025, local GP records show a 0.3% dementia rate for all residents and 1.9% for older adults (25 individuals diagnosed with dementia).
2. However, a quarter of City patients are registered with a GP outside North East London (NEL) and will be missing from the records.
3. GP data was combined with adult social care records, identifying individuals where on either record they were a City resident.
4. Within this combined dataset, 36 individuals have a recorded diagnosis of dementia, raising the estimate to **0.5% overall and 2.6% for older adults**.

However, some individuals may still be missing from these estimates. Some residents use a GP outside NEL and are also unknown to adult social care, therefore this data does not capture everyone living with dementia.

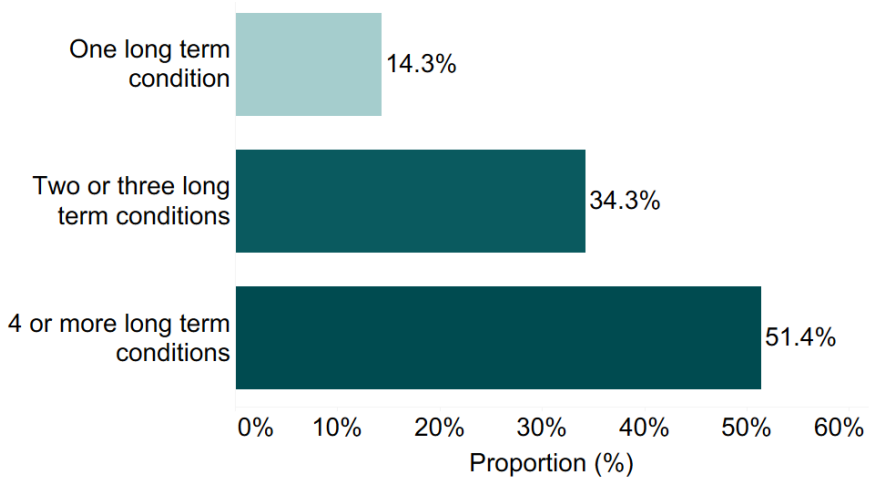
See Appendix 11 for further details.

Dementia and multimorbidity

Among older residents with dementia, 30 individuals (86%) manage another long-term condition. These conditions include cancer, depression, or chronic kidney disease.

More than half (51%) of this group are living with four or more conditions, showing this group manages a complexity of need. Addressing these high needs requires integrated health and social care services.

Figure 23: Proportion of dementia patients by number of long-term conditions, City of London, 2025



Source: Primary care records, Client Level Data, North East London ICB, 2026.
Note: Those with 1 LTC have only been diagnosed with dementia.

Local response

A Neighbourhood Approach
A proactive, neighbourhood-led approach is currently being embedded across the City and Hackney. This includes improving and building on existing coordination of clinical, social, and community support.

Local data is being used to actively identify individuals who are at a risk of needing support or developing long term conditions. This ensures multi-disciplinary teams can step in sooner, helping residents to live healthier, independent lives for longer and meeting needs appropriately.

Coordination of support services
The Shoreditch Park and City multi-disciplinary team demonstrates how different professionals can coordinate around an individual with dementia, bringing together clinical, community and practical support. This includes existing care arrangements, adult nursing, and falls and mobility support. This type of joint casework is essential for providing effective support.

Partnership working is also evident in Adult Social Care Sectors. For example, social workers attend The Neaman Practice multi-disciplinary meetings, integrating social care with primary medical care. Further details on Adult Social Care can be found in the next chapter.

Community support and Wider Organisations
There are a range of organisations who offer wider community support to City residents. Two examples are provided below.

Age UK City of London enhances wellbeing and builds social connections. They help older residents maintain an active, independent life. The charity supports people to develop new friendships and local interests, offering diverse health and wellbeing activities.

Age UK provides a bridge between health and social care. A dedicated Care Navigator supports residents during hospital discharges. They ensure a safe return home with appropriate equipment. This targeted intervention prevents delays and protects resident independence.

The AgeUK Older People's Reference Group provides a voice for residents. A representative sits on the City and Hackney Safeguarding Adults Board, embedding lived experience into strategic safeguarding decisions.

Volunteer Centre Hackney's Community Befrienders service supports lonely and isolated adults in both Hackney and the City, providing one-to-one support in person or by telephone, with volunteers matched around factors such as interests, availability and language. Local resident insight also describes the positive difference that befriending and community groups can make to people's sense of connection and wellbeing.

City & Hackney Dementia Alliance
The City of London is part of the award-winning City and Hackney Dementia Alliance which was formed to bring together health, social care and voluntary sector organisations to work within a framework of formal partnership. The aim, to achieve greater collaboration and integration. The

City of London is fully committed to the alliance and its aims to improve the lives of people living with dementia and their carers.

City & Hackney Dementia Service

The East London Foundation Trust, as well as being a key member of the Dementia Alliance, runs the City and Hackney Dementia service. It is a new model of dementia care which provides a diagnostic service that holds patients from diagnosis to end of life, or out of local authority placement. It ensures everyone living with dementia has a timely diagnosis, with greater access to ongoing help, advice and support for them, their carers and families.

Adult Social Care

Adult social care (ASC) services form an integral part of integrated health and care systems. ASC refers to the system of support provided to adults who, due to physical or mental illness, disability, or old age, require assistance with the practicalities of daily life. The core purpose of ASC support is to help people to achieve the outcomes that matter to them in their life.

The City of London's approach to ASC is defined by the Adult Social Care Strategy - Living Well Ageing Well (2025-2029) [20].

Local picture

Demand and need

In 2025/26, the City received 215 new requests for support[8]. Overall requests rose by 31% over four years, with the fastest rate of growth among working-age adults (53% increase for those aged 18 to 64). However, older adults still account for the majority of new requests.

In the year 2023/24, of those who are receiving care, 26% required mental health support and 8% have been diagnosed with dementia[9].

Multimorbidity complicates this care. Around 86% of older residents living with dementia have at least one other chronic illness and over half live with four or more conditions. Managing these complex needs requires integrated, person-centred medical and social teams.

Adult social care placements

In 2025/26, the majority of service users (110 residents) receive care in their own neighbourhoods or their own homes through community care, while 21 residents currently require full-time residential placements.

[8] New requests to help relate to Adult Contact Assessment and Referral records received by Adult Social Care. These are contacts or requests for support received by the service. These can result in a range of outcomes, including information and advice, occupational therapy screening, a carer's assessment, an Adult Social Care assessment, referral to another agency, or no further action.
[9] An overview of the delivery of and interfaces with Mental Health Services, The City of London Corporation, 2024

There are no residential, nursing or supported living facilities[10] within the City of London's boundaries. Instead, the City Corporation uses a flexible spot-purchasing model to secure placements. This model is intended to ensure care is centred around individual needs. For example, some residents who live in the City on weekdays, but not on weekends, choose out-of-city placements to live closer to their families.

The City's Market Sustainability Plan outlines that local provision of residential care is not viable within the Square Mile due to the small population size, alongside geographical and real estate factors. Within the plan the Corporation commits to sub-regional partnership approaches with NEL authorities. By collaborating on commissioning and comparing care costs, the City can access a wider pool of quality-assured providers.

A single City care home also could not cater to the diverse and complex needs of all service users. Examples of these complex requirements include support for nursing, dementia, frailty, and homelessness.

For example, as of June 2025, over a third of the adults (38%) placed in residential care were individuals who used to sleep rough. These individuals often have highly complex needs and work with specialist partners to address mental health issues, past trauma, and substance use.

Resident experiences and VCS representative feedback

The City of London Corporation regularly analyses resident feedback to drive continuous improvement. In 2025/26, residents shared they felt listened to, supported and respected. Services were seen to make a positive difference to independence, safety and overall quality of life[11]. During the February engagement, VCS representatives praised the City as having the potential to become a "centre of excellence" in social care.

However, VCS representatives also shared that in some cases residents have had negative experiences with services, including not hearing back when an issue has been raised, and they have felt undervalued.

During the February 2026 VCS engagement event, representatives reported that in some cases residents who are placed out of the area find it difficult to feel part of the community. Representatives flagged this can lead to anxiety and social isolation. This does not represent the majority of cases as many adults transition from isolated, bed-bound situations in single-occupancy City accommodation into residential placements that offer communal rooms, activities, faith-themed environments, and more frequent family contact.

However, because any level of social isolation can negatively impact health, it remains a focus for improvement. The City aims to address this for all social care users by strengthening links with community and voluntary services and ensuring social inclusion is considered in all assessments and support planning.

[10] Residential care means long-term care and support provided in a care home. It's for people who need substantial help with their personal care and can also include nursing homes for those with higher medical needs

[11] Feedback analysis April 2025 and April 2026, The City of London Corporation, May 2026

Working to improve affordability

Affordability of social care support for self-funders was raised during the same engagement event. Some feedback included that high costs are preventing residents from accessing personalised care. To actively support these residents, the City has an active workstream on self-funder brokerage under section 18(3) of the Care Act to help individuals navigate care costs.

Furthermore, the limit for self-funders is set by the National Government for residential care, whereas the Corporation sets a higher cost limit for homecare before residents pay the full-cost of their care. Ongoing prevention-centred approaches in the City should continue to ensure residents live healthy, independent lives for longer.

As mentioned in the limitations of this report, the VCS engagement event included 13 organisations and direct resident engagement was not conducted. This qualitative feedback was used to gather a range of perspectives from key partners, however, it is unlikely to be representative of the entire adult social care population.

Early intervention and support

Under the Care Act 2014, local authorities must actively promote wellbeing and intervene early. To achieve this, the City's adult social care team uses a strengths-based approach. This protects an individual's independence and delays the need for formal care.

Reablement and Occupational Therapy
The City Reablement Team reviews people receiving or recently discharged from reablement alongside quality, safeguarding, moving and handling and wider care considerations. This provides an existing interface between health and social care focused on recovery, independence and avoiding or delaying unnecessary long-term care following illness or hospital discharge.

Data indicates encouraging outcomes for this service. Across 51 completed reablement episodes between April 2022 and December 2024, 66% resulted in the individual requiring no ongoing formal support immediately following the intervention. A further 20% resulted in a reduction of their required support hours.[12]

The Early Intervention Scheme

To foster independence, practitioners can purchase low-cost, one-off interventions for residents, such as wheeled walkers, dementia clocks, or microwaves. From April 2023 to December 2024, the scheme supported 19 adults. Practitioners conduct a review six weeks after the purchase to capture resident feedback and assess the item's practical impact on the individual's wellbeing. Based on these 6-week reviews, 18 of the 19 interventions were judged to be successful in achieving their preventative aims[12].

[12] Early Intervention and Prevention in Adult Social Care, The City of London Corporation, February 2025.

Community Support

To prevent hospital admissions, a commissioned Rapid Response service provides up to 72 hours of intensive home support[12]. Community connections are also prioritised to protect mental wellbeing. For example, the Forget Me Not Memory Café runs weekly sessions aiming to reduce loneliness among residents.

Unpaid carers

A carer is 'an adult who provides or intends to provide care for another adult' [21]. Carers can provide a range of support including help with daily tasks, personal care, and emotional support [22].

Unpaid carers are not paid, do not have a contract or volunteer as part of an organisation. Many of this group do not identify themselves as carers and it can be difficult to separate their caring role from the relationship they have with the person they are caring for.

Addressing carer needs

To address local needs, the City of London Carer's Strategy (2023-27) outlines five core priorities [23]. These priorities reflect carers' feedback about what is important to them:

1. Tailored and universal services that work for carers.
2. The health and emotional wellbeing of carers.
3. Early identification of carers.
4. Information and advice for carers.
5. Engaging with carers

Services to support carers

Imago delivers the City's support service for unpaid carers aged 16 and over. Over time, this service has supported nearly 100 individuals. The team provides information, advice, and guidance throughout the care journey. Carers receive specific advice regarding finance, debt, grants, and benefits. Imago also coordinates contingency planning, crisis support, and weekly drop-in sessions. Furthermore, they offer free training, regular peer groups, and flexible health activities.

Residents also established the City Carers Community during the pandemic. This provides a valuable local peer support network.

For mental health, carers can access targeted support from the East London Foundation Trust. Additional services include Mind and the Volunteer Centre Hackney Community Befrienders. The City and Hackney Carers Centre also provides counselling and listening services. However, this may temporarily close when managing long waiting lists.

Improving early identification

The City works to better identify carers and improve access. The Shoreditch Park and City Primary Care Network is currently collaborating with GPs. They are actively reviewing data at the Neaman Practice to improve carer identification.

Current challenges

Tailoring services to meet carers' needs

The JSNA engagement event highlighted challenges. Feedback included a lack of structured support for young adult carers and this group faces higher risk of social isolation. In addition, a carer counselling pilot at the City Wellbeing Centre saw low uptake. Feedback indicated the service did not feel tailored enough to carer-specific needs.

As the engagement event showed there was a request for more carer-centred support, this highlights an ongoing challenge: either residents are unaware of services, or provisions require improved customisation.

The Shoreditch Park and City PCN hosts a new Carer's Care Coordinator position using Health Inequalities funding. The coordinator works to identify unpaid carers across the community and connects these individuals to targeted local support.

Supporting emotional wellbeing

VCS representatives requested local, condition-specific support groups. These would cover complex conditions like dementia, Parkinson's, cancer, and disabilities. Currently there are options for both patients and their carers via St Joseph's Hospice and the Compassionate Neighbour programme.

The City of London Corporation conducted two focus groups and the Shoreditch Park and the City Primary Care Network conducted a survey around carer emotional wellbeing to identify where improvements can be made.

Overcoming national barriers

Evidence gathered from the VCS engagement event highlighted a national systemic gap in employment and educational support. Residents on Carers' Allowances miss out on the free courses and employment opportunities available to those on means-tested benefits.

As mentioned above, the City's dedicated carer support service, Imago, offers valuable training, education, employment, and volunteering opportunities tailored to carers aged 16 and over.

There is an opportunity to scale up targeted outreach and promotion. By enhancing the visibility of Imago's offer, the City can actively bridge this national gap to ensure eligible carers who may be unaware of these services are fully supported to access them locally.

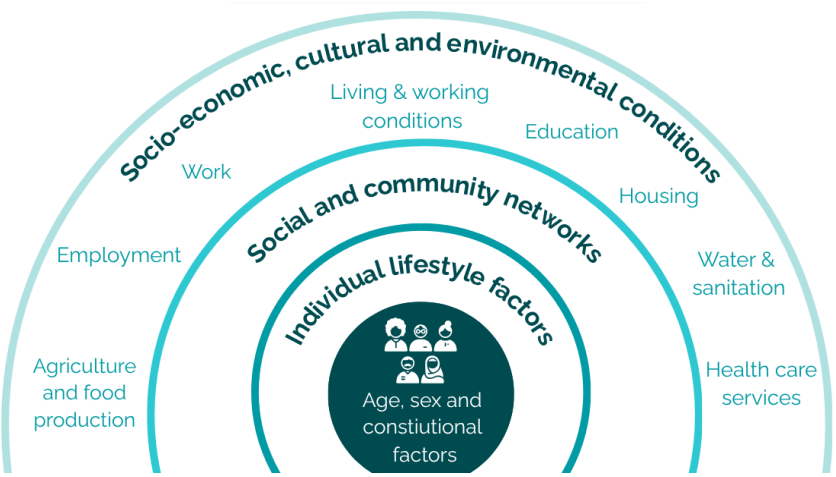
Chapter 5: Place & Communities

Introduction

Good health is about more than just healthcare. Up to half of our health is shaped by the building blocks of our daily lives, such as a secure home, steady income, and clean air [24].

A widely used public health model (Figure 24) illustrates this, showing that our health is strongly impacted by these wider determinants rather than individual choices alone.

Figure 24: the Dahlgren and Whitehead model of health determinants



Source: Dahlgren and Whitehead (1991), adapted from The King's Fund

Locally, the City of London Corporation's Corporate Plan 2024–2029 establishes interconnected outcomes that protect public health, rather than treating services in isolation. It targets social mobility to improve financial security, treats quality housing as a prerequisite for independent living, accelerates the transition to net zero to protect environmental health, and prioritises diverse, engaged communities to combat loneliness and improve safety. By embedding these goals across all its activities, the City Corporation strives to ensure that economic and structural growth translates directly into better health for all residents.

Overall, City of London residents benefit from a high standard of living, strong civic infrastructure, and life expectancy rates that exceed national averages. However, this high baseline can obscure the stark disparities experienced by specific vulnerable cohorts.

This chapter explores how these hidden disparities impact residents across five core areas:

- Income and employment
- Housing and living conditions
- Air quality and pollution
- Community safety
- Social connection

Income and employment

A stable income and meaningful employment provide the financial security needed to afford a good standard of living, while also offering a sense of purpose that supports mental wellbeing. Conversely, economic insecurity and unemployment are closely linked to poorer health outcomes [25].

In the City of London, the Joint Local Health and Wellbeing Strategy 2024-28 prioritises increasing financial resilience of the City, especially amongst essential workers.

Local Picture

High averages obscure localised financial need

When looking at broad income measures, the City of London ranks as one of the most affluent areas in England. However, there are sharp local disparities.

Four of its six small areas consistently rank among the top 10% wealthiest areas nationally. The Golden Lane area, however, is more deprived, and has recently seen its employment and income deprivation levels worsen compared to the rest of the country[13]. Even greater challenges exist in the Middlesex Street and Mansell Street area. It is the most deprived neighbourhood in the City for both income and employment. See Appendix 7 for full local data.

Addressing overlapping financial and health needs

The City Advice service gives free guidance on welfare, debt, and legal rights to residents facing financial difficulty. This service is a powerful community asset that protects residents before detailing the complex hardships they face.

Data from this service[14] shows how a lack of essential building blocks, such as stable income and secure housing, traps residents in complex financial hardship. Over the past six years, 36% of clients needed help for overlapping challenges. This highlights that financial difficulty rarely happens in isolation. When one building block is missing, others are often affected, meaning residents need wide-ranging support to stabilise their lives.

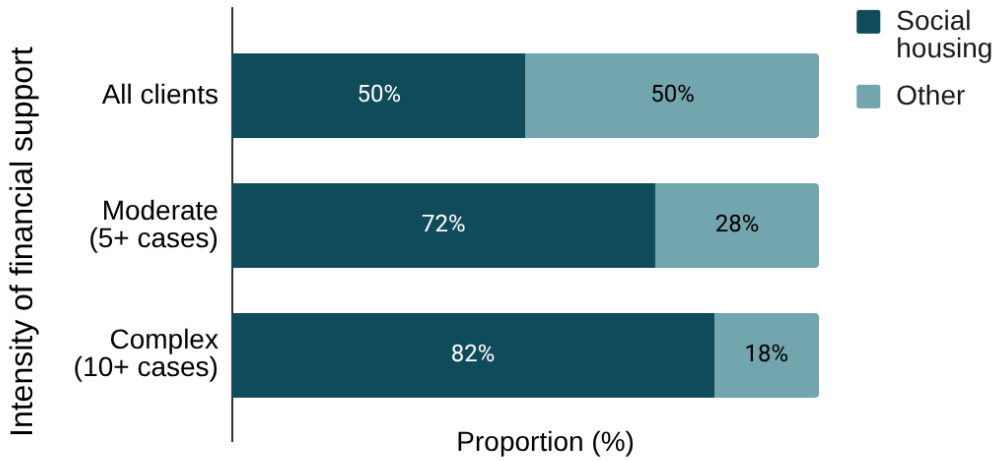
The data also indicates a link between financial challenges and ill health. Residents who are classed as "unfit for work" due to illness require the most intensive financial support from City Advice. While this group makes up only 15% of total clients, they account for 40% of the people who return for help ten or more times.

These individuals overwhelmingly live in social housing (Figure 25) and frequently report living with long-term illnesses or poor mental health. While City of London social tenancies provide

[13] The IMD's Employment Deprivation domain only measures the working-age population and excludes anyone over state pension age.
[14] This data is from the City Advice and Toynbee Halls' Frequent Fliers Analysis Report from 2021-2026

long-term security, residents in this cohort often face compounding challenges. These factors are deeply intertwined: living in poor or overcrowded housing is linked to poor physical or mental health, which is frequently associated with an inability to work, which closely correlates with ongoing financial hardship.

Figure 25: Proportion of City Advice clients by housing status, 2021 to 2026



Source: City Advice by Toynbee Hall, 2021-2026

Structural barriers and financial need in Middlesex and Mansell Street

The data also suggests that a high proportion of those needing financial support from City Advice are from Asian backgrounds, particularly Bangladeshi. However, deeper analysis reveals that this is closely tied to housing and economic circumstances rather than ethnicity alone. When accounting for what type of housing clients lived in, differences between ethnic groups largely disappear.

This reflects the structural makeup of the local area. There is a high concentration of residents of Bangladeshi heritage in the Middlesex Street and Mansell Street neighbourhood, and this population make up a quarter of the residents. Alongside this demographic concentration, this specific neighbourhood relies heavily on social housing and ranks as the most employment-deprived part of the Square Mile.

This data highlights that where residents live matters. Because the Middlesex Street and Mansell Street neighbourhood experiences the highest levels of employment and income deprivation in the City, its residents are disproportionately at risk of financial hardship due to their local environment. It shows how wider vulnerabilities, such as living in social housing within an area of high unemployment, stack together to create complex challenges for these specific communities.

Housing and living conditions

A secure, warm, and high quality home is a fundamental building block of health. Poor living conditions, such as damp, mould, or overcrowding, are directly linked to respiratory diseases and poor mental health [26].

Box 4: National and pan-London strategies focused on housing and health

London Social and Affordable Homes Programme 2026-2036

This programme allocates £11.7 billion regionally to boost affordable housing supply and enforce high design standards, explicitly targeting the disproportionate health burdens placed on low-income Londoners by overcrowding and poor-quality housing.

National Housing Quality and Health Regulations

These include the Decent Homes Standard 2026, Awaab's Law, and the Warm Homes Plan (2026). Together, these mandate strict timescales to repair emergency hazards like cold, damp, and mould, treating housing as a public health intervention to reduce the £1.4 billion annual cost to the NHS.

Locally, the City of London Housing Strategy 2024-2029 sets a clear direction to tackle housing needs through five priorities:

1. Improve the quality of housing services.
2. Improve housing quality.
3. Engage and listen to residents.
4. Improve building safety.
5. Increase the supply of housing.

Local Picture

The City of London Corporation is the landlord for 1,923 social rented properties. Crucially for health and wellbeing, the Corporation provides lifetime tenancies beyond the introductory period, offering residents long-term housing stability and security. Within the Square Mile, most of these social housing residents live on the Golden Lane, Middlesex Street, and Mansell Street estates (Figure 26). However, three-quarters of the Corporation's social housing sits outside the City boundary across 11 estates in neighbouring boroughs.

In addition to its social housing provision, the Corporation also acts as the principal landlord and managing agent for the predominantly private leasehold Barbican Estate.

Figure 26: Map of Golden Lane, Spitalfields and Middlesex street estates



Improving housing quality to support mental wellbeing

Overall, the City Corporation performs strongly as a landlord, with 71% of tenants satisfied that their home is well maintained, nearly 12% above the London average. However, a recent stock condition survey evaluating thermal comfort, damp, and mould risks revealed geographical variations in housing quality.

While the proportion of non-decent homes on the Middlesex Street estate is low, the combined average across assessed estates was driven up to 46% because every home assessed on the Golden Lane estate was classed as either non-decent or potentially non-decent. This high rate is largely due to complex, delayed window replacement projects on Grade-II listed buildings. Plans to address this are explained below.

These infrastructural challenges overlap with local health data. Primary care records show that the Golden Lane area, alongside Middlesex Street and Mansell Street, experiences the highest local rates of depression and Severe Mental Illness (SMI) in the Square Mile (Appendix 12). While it can be difficult to prove a causal link between the two, the geographical overlap between poor housing conditions and poorer mental health highlights a compounding vulnerability for these specific residents allowing for more targeted, preventative interventions.

Furthermore, these issues align with feedback from the JSNA engagement event., where voluntary organisations reported that damp, mould, and long wait times for basic repairs are contributing to physical and mental health impacts for residents. Interestingly, the correlation between poor housing conditions and asthma prevalence across these specific estates is less apparent in current local data, although still significantly higher than some other small areas within the Square Mile (Appendix 12).

Investing in housing to protect public health

To address these infrastructure challenges, a 10-year Major Works programme was approved in late 2025, including a specific Golden Lane Estate investment programme to refurbish window

frames and roofs starting in 2027. To support residents while longer-term solutions are progressed, the City Corporation has implemented practical mitigation measures. These include Winter Measures Payments for Golden Lane residents, a newly developed Damp, Mould & Condensation Policy and a new repairs service introduced in April 2025.

As of March 2026, the Tenancy Sustainment Team was supporting 34 residents in the Square Mile out of a total caseload of 67, with the remainder outside the borough across the City of London's wider estate portfolio. They work closely with the City Advice service to provide holistic support to help residents manage overlapping housing, debt, and welfare challenges [15]. Families are also supported with housing and financial challenges by the City Early Help team, specifically with overcrowding, bidding for properties, and planned moves out of the City.

To shift toward proactive prevention, the Corporation launched the Inside Every Home survey. By visiting every tenanted social property between November 2025 and May 2026, teams aim to identify hidden housing and accessibility needs early. This allows services to intervene before living conditions negatively impact residents' health.

Streamlining complex housing systems to reduce hidden barriers

While the Corporation provides comprehensive housing support, navigating these statutory processes can be complex and stressful. For vulnerable residents who struggle to advocate for themselves, administrative complexities act as a hidden barrier to good health. Also voluntary organisations at the February engagement event reported that a high turnover of housing staff causes frustration and makes support services difficult to navigate.

At the same event, voluntary organisations also reported concerns regarding a perceived lack of accessible housing and that placing residents in temporary accommodation outside the City can impact community ties, contributing to social isolation and worsening wellbeing.

However, data indicates that only a minimal number of temporary accommodation placements involve statutory housing cases originating directly within the City. Most applicants become homeless from locations outside the Square Mile, going against the perception that out-of-borough housing disadvantages individuals due to a lack of local options.

The City Corporation is working towards mitigating these barriers by progressing its Housing Action Plan with practical solutions to make services easier to navigate. This includes deploying dedicated Resident Services Officers to specific local estates, ensuring vulnerable tenants have consistent, face-to-face support when moving through the system. Alongside this, the Corporation is actively improving accessibility for residents with reading or cognitive impairments to ensure complex housing rules are easier to understand. This approach supports the City's Sufficiency Strategy for care leavers. When young people are ready to leave care, they are provided with practical information to help them secure independent housing.

In addition, the Corporation delivered 66 new affordable homes at Black Raven Court in February 2026. This development features accessible homes and uses a Local Lettings Policy to prioritise existing Golden Lane residents, keeping communities together.

[15] City Advice by Toynbee Hall, 2021-2026

Air Quality and Climate

Air pollution and climate change are significant environmental risks to public health. Exposure to air pollution is associated with premature mortality and contributes to chronic conditions across the life course, including stunted lung development in children, asthma, heart disease, and dementia [27]. Simultaneously, rising temperatures present acute health risks to populations already experiencing disadvantage [28].

Box 5: National and pan-London strategies focused on air quality and climate

National

The Environment Act 2021 and PM2.5 Regulations set statutory targets to reduce population exposure to fine particulate matter (PM2.5). This is supported by national warning system providing real-time health advice to vulnerable groups.

Pan-London

The London Environment Strategy drives regional reductions in vehicle emissions through the Ultra Low Emission Zone (ULEZ) and the Mayor's Air Quality Fund. These interventions aim to mitigate the health impacts of pollution in the capital..

Given its heavily urbanised landscape, the City experiences physical environment challenges, including air pollution and traffic risks, at levels higher than the national average. Recognising the severity of these intersecting risks, climate action and environmental resilience are embedded as a central pillar of the City of London Corporation's Corporate Strategy 2024-29.

The City of London Corporation's Air Quality Strategy 2025-2030 sets ambitious targets aligned with World Health Organisation guidelines. The City Corporation uses various levers to improve the local health environment, including transitioning to a fully electric refuse fleet, tackling engine idling, and restricting motor traffic at major junctions. To tackle non-transport emissions, the City Corporation also enforces strict environmental standards on construction sites and applies new regulations targeting fine particulate matter.

Air Quality

One of the key metrics used to measure air pollution is Particulate Matter (PM), a mixture of microscopic particles suspended in the air. They are categorised by size, which directly determines how dangerous they are to human health (Box 6).

Box 6: How the size of particulate matter determines the health risk

PM10: Inhalable particles, typically from construction dust and road wear, that enter the upper lungs and cause respiratory irritation.

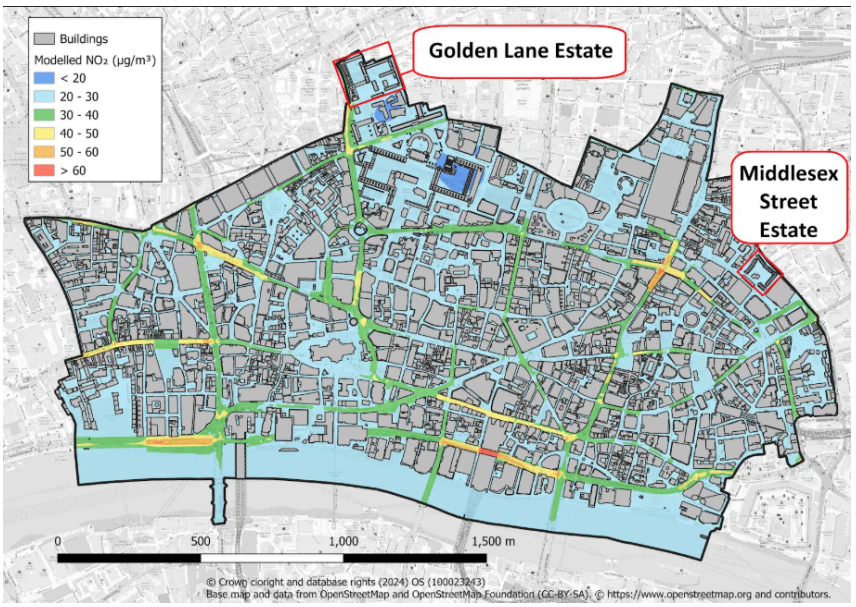
PM2.5: Fine, highly dangerous particles, primarily from vehicle exhausts and commercial heating. They bypass the body's natural defenses to enter the bloodstream, significantly increasing the risk of asthma, heart disease, stroke, and lung cancer.

Mapping pollution helps protect vulnerable residential areas

Air quality in the Square Mile has improved over time. Twenty years ago, local air pollution levels were almost three times higher than they are today. Between 2009 and 2023, the average roadside concentration of nitrogen dioxide dropped by roughly 60% across monitoring sites, and the stricter national standards for fine particulate matter were achieved at both local monitoring locations for the first time in 2023.

Integrating local pollution data with the locations of social housing estates and residential areas allows for a deeper analysis of health equity (Figure 27). While the estates themselves sit outside the most heavily polluted zones, they are bordered by high-traffic corridors. By mapping where residents live in relation to these hotspots, the City Corporation can continuously monitor environmental exposure and better understand how nearby pollution overlaps with existing housing and financial vulnerabilities for these specific communities.

Figure 27: Modelled Annual Mean Nitrogen Dioxide overlaid with major social housing estates, City of London, 2024



Source: Adapted from Air Quality Strategy, The City of London Corporation, 2026

External pollution and urban development present health challenges

Local initiatives are driving significant improvements. However, because three-quarters of air pollution in the Square Mile originates from outside its boundaries, local measures alone cannot fully eliminate the environmental risks to residents. From a public health perspective, this means City populations remain vulnerable to regional pollution flows, making broader pan-London coordination essential.

Alongside imported pollution, the intense nature of local urban development creates additional complexities. At the recent VCS engagement event, health concerns relating to exposure to dust, construction, and tunnel pollution were reported. A concern was also raised that traffic redirection schemes may displace and concentrate pollution into residential corridors, rather than reducing overall emissions. High perceived environmental risk is a public health challenge in itself; it can indirectly impact health by causing stress or deterring active travel and outdoor recreation, even when legal air quality thresholds are technically met.

Urban Heat risk

Climate change and the urban heat island effect[16] pose a growing threat to public health in Central London. Projections suggest the capital may endure 19 heatwave days per year by 2050, putting many London flats at risk of overheating [21].

Because the majority of the City's social housing stock consists of high-density flats, residents in these estates are disproportionately exposed to this built environment risk.

Extreme heat exacerbates existing health inequalities

Heat-related vulnerability is not distributed equally across the population and reflects wider issues of climate justice. Communities most impacted by heat-related harms are those already experiencing disadvantage: this includes families living in crowded or poor-quality housing, or neighbourhoods with limited access to green space and higher levels of urban heat exposure. As a result, extreme heat actively exacerbates existing health inequalities within the City, putting older adults, pregnant women, young children, and individuals with pre-existing health conditions at elevated risk.

Furthermore, people experiencing homelessness or sleeping rough within the Square Mile face extreme exposure due to limited access to sheltered cooling spaces and drinking water.

During periods of extreme heat, the cascading and compounding impacts drive demand and pressure across the local health and care system, resulting in preventable spikes in emergency hospital admissions and mortality [29].

[16] The urban heat island effect is where dense concrete and tall buildings trap heat while a lack of green space reduces natural cooling.

Addressing the impact of air pollution and heat stress

Environmental risks often overlap, compounding their overall impact on public health. There is a well-documented synergistic effect between air pollution and extreme temperatures [30]. Pollutants inhaled during periods of heat stress trigger a stronger inflammatory and oxidative stress response in the body. Consequently, ambient levels of pollution that might normally be tolerated become significantly more harmful during a heatwave.

This compounding effect means that the associated health risks extend beyond traditionally vulnerable groups to affect the wider population, while simultaneously pushing those with pre-existing vulnerabilities into further risk.

To map local vulnerabilities and develop actionable, targeted recommendations, the City and Hackney Public Health team is currently conducting a dedicated Heat Health Needs Assessment. Further adaptation and resilience response efforts are being operationalised through the City of London Climate Action Strategy (2020-2027) and Overheating Working Group.

Community Safety

In most local authorities, high crime rates closely correlate with poverty and deprivation. However, the City of London presents a unique environment. Here, crime incidents are largely driven by the workforce, visitors, the retail sector, and the night-time economy, and occur away from residential areas.

Locally, the Safer City Partnership (SCP) Strategic Plan (2022-2025) and the City of London Policing Plan (2025–2028) recognise the impacts of crime and safety on the health and wellbeing of City residents. The upcoming SCP strategic plan 2025-2029 will highlight four key priority areas:

1. Violence Against Women and Girls
2. Serious Violence
3. Anti-Social Behaviour (ASB)
4. Acquisitive Crime (theft)

While protecting the public is the primary focus, local strategies also recognise that preventing crime requires addressing the underlying health needs of offenders and supporting vulnerable individuals. A key preventative measure is the liaison and diversion programme, which identifies individuals with underlying mental health or substance use needs and refers them directly into treatment. This aims to break the cycle of reoffending by improving individual health prospects.

Local Picture

Overall recorded crime trends are upwards since 2016. In January 2026 alone, 835 crimes were recorded by the City of London Police.

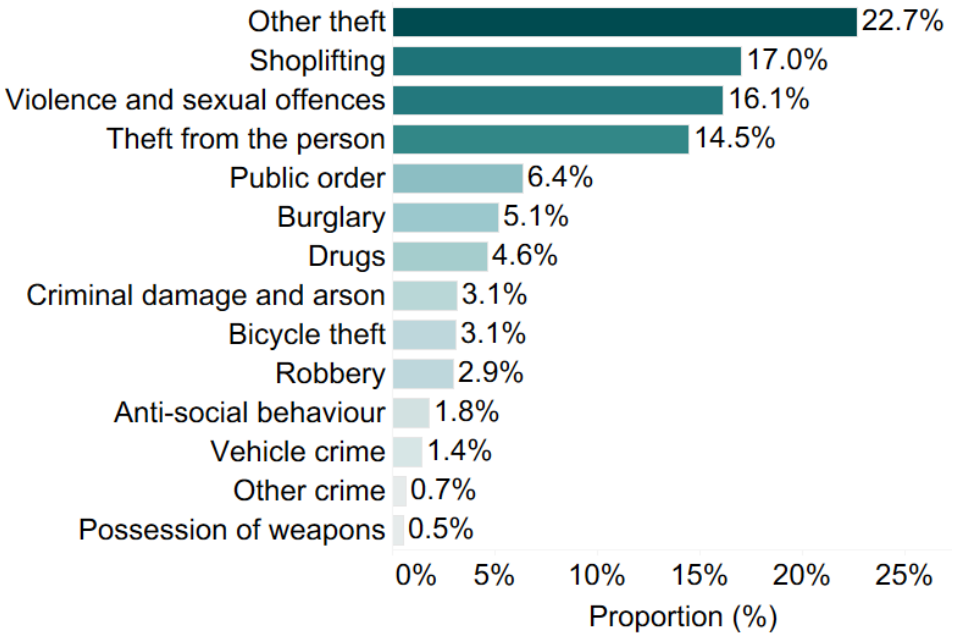
During the JSNA engagement event, VCS representatives provided insight that residents generally feel the City is a very safe place to live. The perception from raw data that the City's crime rates are comparatively high is a statistical artifact: because the resident population is small,

crimes committed by and against the large volume of commuters and visitors inflate the per-capita rate. VCS organisations noted that alcohol-related disruptions around late night venues were an issue for residents.

Fear of theft may restrict mobility for vulnerable groups

Theft is the primary driver of local crime rates, accounting for more than half of all reported offences over the last 12 months. This concentration varies by area. In Bank, theft makes up 62% of all recorded crime, driven heavily by shoplifting. However, it is important to distinguish between commercial and personal theft. Shoplifting at retail hubs like Bishopsgate inflates the overall crime statistics and has little to no direct impact on the day-to-day lives of residents.

Figure 28: Proportion of crimes reported in the City by type, February 2025 to January 2026



Source: Crime Statistics, City of London Police, 2026

While commercial theft impacts the business sector, personal theft creates specific health and mobility barriers for older residents. During local engagement, "phone grabbing" was highlighted as a concern. They highlighted that many older adults and those with visual impairments rely on smartphones for navigation, so the fear of theft creates heightened stress and deters them from walking. Phone snatching is also a recognised issue by the City of London Police, who launched a dedicated initiative in 2024 to target hotspots and their latest annual report suggests some reduction in incidence since it was introduced.

Beyond direct harm, the fear of crime and unsafe streets can result in people exercising less and socialising less frequently. This can inadvertently drive social isolation and poorer physical and mental health outcomes [24].

Targeting violence to support wellbeing

Violent crime carries a higher harm profile. Over a quarter of these are concentrated around Liverpool Street (Figure 29). Local intelligence indicates this is largely driven by assaults related to the night-time economy, alongside domestic or gender-based offences.

Box 7: National and pan-London strategies focused on violence and health

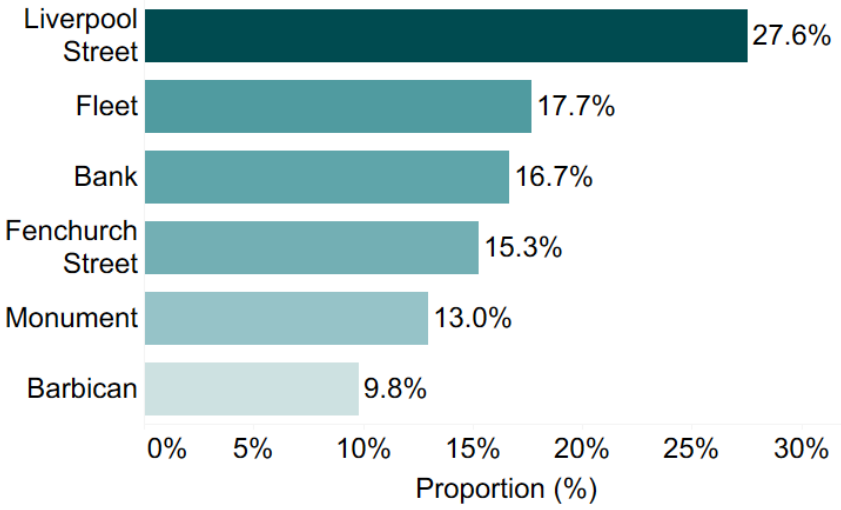
A Public Health Approach to Violence

National and regional strategies, including the Home Office Serious Violence Strategy and the London Violence Reduction Unit (VRU), now treat violence as a preventable health issue. They mandate early intervention and multi-agency collaboration to address structural root causes, such as poverty and adverse childhood experiences.

Violence Against Women and Girls (VAWG)

The national Freedom from Violence and Abuse strategy establishes a 10-year mission to halve VAWG. It requires that tackling abuse becomes an integrated responsibility across all health and social care services, highlighting the overlapping risks of domestic abuse, poor mental health, and homelessness.

Figure 29: Proportion of violent and sexual offences reported in the City by area, February 2025 to January 2026



Source: Crime Statistics, City of London Police, 2026

Managing the impacts of ASB on resident wellbeing

During JSNA engagement, VCS representatives raised resident concerns about Anti-Social Behaviour (ASB), particularly relating to the night-time economy. However, there is often a

disconnect between what residents experience as general community nuisance (such as noisy crowds) and what the police and City services legally define as ASB under the Police and Crime Act. Because of this threshold, the actual volume of ASB formally recorded by the police, and related enforcement power, remains very low. While the City of London Police recognise ASB as a key priority, addressing resident anxiety requires managing this perception gap alongside targeted local management.

Co-designing public spaces could help to improve inclusivity and safety

Finally, safety is also dictated by how public spaces are designed. The recent "Right to the City" initiative by Publica explored how women, girls, and gender-diverse people experience City spaces after dark. The report highlighted an under-provision of basic, accessible facilities, such as well-maintained public toilets, sheltered seating, and adequate lighting. To address this unmet need and ensure urban development does not treat women's safety as an afterthought, the report outlines 18 recommendations, focusing on co-designing spaces and investing in infrastructure that supports the wellbeing of all demographics.

Sexual violence and assault

The banner of sexual violence and assault covers physical sexual assault and domestic violence, but also sexual exploitation, drinks spiking and non-consensual sexualised drug use (often referred to as chemsex).

The City of London's high numbers of daily commuters and visitors as well as hospitality venues and events means safety is of crucial importance.

Box 8: National policy related to sexual violence

Freedom from Violence and Abuse strategy

The UK Government has a core aim to halve VAWG in a decade. This strategy is built on the shared foundation of prevention, perpetrator accountability, and victim/survivor support:

- **Prevention and Early Intervention**: Focused on addressing the root causes of abuse, breaking the intergenerational cycle of harm, and safeguarding young people, particularly from online harms.
- **Pursuit of Perpetrators**: Focused on using every tool available to ensure no perpetrator acts with impunity, driving cultural change in institutions like the police, and deploying cutting-edge enforcement technologies.
- **Support for Victims and Survivors to live free from abuse**: Focused on reforming the fragmented system to ensure victims and survivors can access housing, health, and justice seamlessly, and embedding a trauma-informed approach across the justice system.

Local policy

The Corporation's Preventing Violence Against Women and Girls (VAWG) Strategy 2025-2029 aims to create a safer, inclusive space where women and girls are free from violence, abuse, and exploitation. The strategy focuses on prevention, the unique business environment, multi-agency partnerships and taking a data-led approach [31].

Services and support pathways

Domestic abuse can only be effectively tackled through a multi-agency approach [32]. There is strong collaboration to prevent sexual violence, assault and exploitation between the City of London Police, the Corporation's Community Safety team and other partners.

The health sector also plays a critical role in this system as the NHS sees more domestic abuse victims than any other agency. Nationally, 80% of women experiencing abuse seek support from health services, often disclosing it to their GP first. [33–35]. This evidence informs the design and delivery of support services across the City of London.

Identification and referral to improve safety (IRIS)

IRIS is a specialist, nationally recognised model of early intervention in primary care. Supported by the Department of Health and NICE guidance, and backed by a randomised control trial, IRIS provides targeted training and advocacy to all GP practices across City and Hackney.

It aims to ensure frontline practitioners can recognise the signs of abuse, understand the needs of vulnerable communities, and refer patients to the appropriate channels.

Domestic Abuse Intervention Service (DAIS)

DAIS supports both victims and perpetrators of domestic abuse. The service is available to all City residents aged 16 and over. This includes people experiencing homelessness and those in the City women's project. In 2024/25, GPs made 25 non-MARAC referrals to DAIS.

DAIS also trains City and Hackney partner agencies on domestic abuse and VAWG. Training is delivered via online platforms and direct partnership events. For example, the Neaman Practice has received three dedicated training sessions in the last two years.

Homerton Healthcare Trust and East London Foundation Trust (ELFT)

Healthcare Provider Trusts offer domestic abuse training for their frontline staff. This is usually offered as part of the mandatory safeguarding children and adult safeguarding training. Homerton Healthcare Trust also employs a Primary Care MARAC Liaison Nurse.

Hotel Safety

Under Operation Fortis, the Community Safety Team have worked closely with City of London Police and partners to create a Hotel Safety Toolkit to increase partnership awareness and to develop clear referral pathways and address underreporting.

For Operation Makesafe (CSE in Hotels), The City of London Police are working closely with the Children's Society to get comprehensive training in place for all City Hotels. This also involves improving intelligence and reporting around chemsex, proposing enhanced partnership to develop clear pathways and address underreporting.

City and Hackney Female Genital Mutilation Protocol

This is the only local protocol in the UK that builds on national guidance by explicitly including prompts around anti-racist practice, identifying positive strengths within families, and considering trauma to practitioners.

Iranian Kurdish Women's Rights Organisation (IKWRO)

Targeted support is also vital for those facing severe multiple disadvantages. IKWRO provides a free counselling service specifically for women living, working or sleeping rough in the City who have been affected by domestic abuse and/or harmful practices. Between 2024/25, IKWRO delivered around 100 counselling sessions, demonstrating an ongoing need among the City's most vulnerable female populations.

Other voluntary and community services provide domestic abuse support in the CIty, such as Latin American Women's Aid and Jewish Women's Aid.

Pan-London support

At a regional level, Victim Support leads a pan-London partnership service consisting of 13 specialist providers. This includes two dedicated hospital Independent Domestic Violence Advocacy teams covering London. However, capacity and the local offer for this specific hospital-based service remain limited.

A pan-London helpline provides clear, confidential, and non-judgmental support. This service assists people of all genders aged 13 and over. It supports individuals facing current or historical domestic or sexual violence. The helpline acts as a gateway to safe accommodation, directly preventing the risk of homelessness among vulnerable populations.

Local picture

Domestic abuse is a widespread and often hidden public health issue. Anyone can be a victim, and locally, the risk is higher among women, young people, individuals from mixed ethnic backgrounds, people with disabilities, and LGBTQ+ individuals [36].

Service access

Between January to December 2025, 16 survivors were referred to DAIS. Notably, quarter 3 of 2025/26 alone generated as many referrals as the previous three quarters combined.

Approximately 10 of the survivors supported had children (involving 15 children in total), and clients represented a range of ethnicities. Referrals also came from a wide variety of sources, with the City Police accounting for 25% of these.

Despite this estimated prevalence, local data indicates a gap between expected and observed cases. This aligns with the reporting in London overall[37]. According to SafeLives', a local authority should expect 40 high-risk cases per 10,000 adult women at the MARAC. Given the City of London's population of approximately 5,000 adult women, the expected MARAC caseload is 20 referrals per year [38].

However, between Feb 2025 to Feb 2026, 10 cases were heard from 7 direct referrals. Additionally, City of London Police sent 15 MARAC referrals to the Community Safety Team, largely representing domestic abuse where the victim resides in another borough.

This gap suggests that domestic abuse remains underreported in the City. The aim is to drive greater reporting through continuous education and awareness-raising. An increase in service

presentations should be viewed positively as an indicator of growing trust in services, rather than necessarily an increase in actual harm.

Domestic abuse and homelessness

Aligning with the national strategy's focus on multiple disadvantages, local homelessness data illustrates the intersection between housing insecurity and domestic abuse. Across the first three quarters of 2025/26, there was a steady stream of individuals approaching the City for homelessness assistance specifically recorded as 'fleeing domestic abuse'.

In total, there were 61 approaches over these nine months where domestic abuse was provided by the applicant as a reason for homelessness. This group was mostly female (82%). While the majority of these cases were resolved and closed (93%), they occasionally triggered statutory duties. This highlights the critical role of housing teams in the early identification and support of domestic abuse survivors.

Social connection

Social infrastructure is a fundamental determinant of population health. Social isolation and loneliness are direct drivers of poor mental and physical health, increasing the risk of cardiovascular disease, cognitive decline, and depression [39].

Box 9: National and pan-London strategies focused on social connection

National strategies

The Protecting What Matters plan is the 2026 national policy paper aimed at rebuilding social cohesion and targeting the root causes of loneliness through investment in local communities. This infrastructure supports the NHS social prescribing model, which allows GPs to direct isolated patients to tailored community activities instead of defaulting to medicine, thereby improving wellbeing and reducing acute clinical demand. [shorten]

Pan-London strategies

The Mayor of London's Health Inequalities Strategy Implementation Plan treats social wellbeing as a measurable health outcome. Through the Thrive LDN mission, it explicitly targets the severe loneliness currently experienced by roughly 1 in 12 Londoners.

The 2025 City and Hackney Annual Director of Public Health report, "Healthy Connections: the role of social capital in City & Hackney", provided recommendations to build social capital. The report emphasised co-designing projects with the community and ensuring interventions support physical places, like parks and community centres, as well as individuals. It also stressed the need to partner with the voluntary sector and local businesses to maximise existing community resources.

Libraries and community hubs offer social and health support to residents

The City Corporation operates three public lending libraries (Barbican, Shoe Lane, and Artizan Street). Adopting a 'Libraries First' approach to social inclusion, these act as vital community hubs offering digital inclusion services, free spaces for self-run networks, and targeted early years support as part of the Best Start Family Hub.

These spaces also integrate wider clinical initiatives. For example, Shoe Lane hosts the Dragon Cafe in collaboration with Mental Fight Club, while Artizan Street includes a dedicated health treatment room. Beyond statutory services, local VCS networks show willingness to partner and support vulnerable residents, such as through Volunteer Centre Hackney's Community Befriending project.

Alongside this, the City of London provides local funding to help charities run activities that bring people together and reduce loneliness. Current projects include the Portsoken Activities Group and the 'We Connect in the City' programme at the Aldgate Centre, which both offer creative and wellbeing activities for families and adults. This local funding also helps groups like Mental Fight Club continue their regular events, ensuring residents have ongoing opportunities to connect and support their mental health.

By addressing some of the root causes of loneliness, these community assets contribute towards preventing depression and cognitive decline.

Removing barriers to existing community assets

The City is home to a wealth of high-quality community assets and public spaces. Ensuring equitable access to these resources for all residents remains a key corporate priority.

Despite these strong assets, feedback from the JSNA engagement event suggests that practical barriers may exist around access. VCS organisations reported a need for more affordable community venues, noting that many buildings are rented out at private, corporate rates, which can price out charities and voluntary groups. Also, operational hours can present a challenge, with many spaces closed on the weekend. Community activities are therefore often held during weekday working hours when attendance may be lower.

Portsoken residents reported having excellent transport links to areas outside of the City. Despite this, VSC representatives shared that geographic and perceptual barriers also limit access. The City's layout and a lack of cross-area bus routes leave some residents feeling restricted by localised boundaries, reducing their confidence or ability to travel to other parts of the Square Mile for services.

Furthermore, representatives shared that some residents believe community centres are exclusively for people living within that specific estate or ward, which can deter them from accessing nearby resources.

Opportunities to strengthen cross-boundary community networks

Local authority boundaries can sometimes create unintended barriers to service access and social connection. The Portsoken area, which includes the Middlesex Street and Mansell Street

estates, benefits from strong community networks, particularly among residents of Bangladeshi heritage.

However, this community spans the border between the City of London and the London Borough of Tower Hamlets. Because the nearby Portsoken Community Centre is commissioned specifically to support City residents, those living on the Tower Hamlets side are generally not eligible to access its core services.

While navigating cross-border funding remits is complex, this geographic overlap presents an opportunity to explore collaborative links with Tower Hamlets. This builds on the Corporation's ongoing commitments to inclusive service provision.

The Family Hub Network offers a strong model for this approach. Its Portsoken site provides a shared, accessible space for joint community and local authority support.

Expanding existing social connections

Portsoken is characterised by a stable residential community with strong social networks and a tradition of neighbours supporting one another. The Health Creation Alliance Project identified that residents who live here trust and rely on community leaders, family networks and trusted local organisations for advice and support.

While these networks are strong, this social connection can be expanded across the City. During the JSNA engagement event, VCS representatives reported that loneliness has increased since the pandemic and its severity varies in different areas. For example, older residents in areas like the Barbican and Golden Lane frequently live alone.

Representatives highlighted that this isolation is often involuntary and compounded by the physical environment. The fear of street crime and fast-moving e-scooters can act as a deterrent, leading to vulnerable adults choosing to remain in their homes.

Embedding services into the community

This engagement also identified opportunities to expand social provision. Current services successfully support older adults and young children. However, VCS representatives reported a need for more dedicated social spaces for middle-aged individuals outside of pubs and commercial venues.

To overcome physical barriers to service access, representatives suggested setting up mobile hubs to bring services directly to where people live. The Portsoken steering group is a successful example, as it uses trusted local spaces to offer health support, such as blood pressure checks.

Chapter 6: Health Behaviours & Lifestyles

Introduction

Our health behaviours and lifestyles are the second most important drivers of health, such as smoking, diet and exercise. These choices or behaviours are heavily shaped by our surroundings, including the local environment and private sector. While past public health efforts improved life expectancy, these new challenges require urgent local action [40].

The City of London's Joint Local Health and Wellbeing Strategy (2024-28) recognises the impact of the environment on our health choices. For example, financial pressures are driving a reliance on lower-cost foods, increasing the risk of obesity [41].

This chapter takes a deeper dive into health behaviours in the City, including:

- Health weight and diet
- Oral Health
- Physical activity
- Sexual and reproductive health
- Smoking

Healthy weight and diet

Being above a healthy weight is a significant driver of poor health, affecting both the body and the mind. People are living too long in ill health, the gap in healthy life expectancy between rich and poor is growing, and nationally nearly 1 in 5 children leave primary school with obesity.

However, weight is a complicated issue. It isn't just about willpower; it is shaped by many things, including the neighbourhoods we live in, our behaviours, the way food is made, and our biology

Because of this, we can't fix the problem with one simple solution. We need a 'whole system' approach. This means everyone, from government and industry to individuals, must work together to change both our environments and our society.

National policy

Published in July 2025, as part of the 10 Year Health Plan, the Government pledged to 'launch a moonshot' to end the obesity epidemic. This included goals to restrict junk food advertising targeted at children and introduce mandatory healthy food sales reporting for all large companies in the food sector.

The Government is also working towards personalised prevention of obesity, applying genomic insights[17] to identify people who are at the highest risk of developing obesity. Finally, they aim to expand access to weight loss medication through the NHS.

Local policy

Healthy weight in the City and Hackney is shaped by five local system priorities to support people to achieve and maintain a healthy weight through collaborative action (Box 10).

Box 10: City and Hackney Healthy Weight Priorities

1. ***Working together***
We will support the development of a social movement for healthy weight in City and Hackney. We will build on the strengths and resources in our local communities and existing partnerships

2. ***Targeted help for those who need it most***
We will strive to ensure that individuals, families and communities at greatest risk of obesity-related harm receive the support they need to live a healthy life

3. ***Easy access to affordable, healthy food***
We will make it easier for people to buy and prepare affordable, healthy food

4. ***A healthy environment that makes it easy for people to be active***
We will continue to work to improve the design of City and Hackney's spaces and places so more people can be active as part of their everyday lives

5. ***Easy access to information***
We will make it easy for everyone in the City and Hackney to find information about what action they can take, and what help they can get, to live a healthy life.

There are a number of broader local strategies and plans across the City and Hackney that make an important contribution towards local action to prevent and/or reduce obesity (in relation to the broader social, economic and environmental influences).

[17]Applying genomic and other insights to identify people who are at the highest risk of developing conditions such as obesity.

Services

Many City of London services that have an impact on healthy weight. City and Hackney have been working towards a 'whole system' approach to preventing and reducing the harms from obesity for a number of years, led by a Healthy Weight Strategic Partnership.

Children's services

Getting a healthy start is a crucial building block. Health visitors and school nurses actively monitor childhood growth. They support infant feeding and deliver the National Child Measurement Programme.

The HENRY programme provides holistic help for families with children under five. They run practical workshops covering portion sizes and fussy eating. Furthermore, local nurseries actively promote good nutrition to achieve Healthy Early Years awards.

For older children, the 'Power Up!' service provides active weight management. They offer tailored support for dietary improvements and behaviour change. For severe cases, NHS clinics provide specialist, holistic therapy to treat obesity complications.

Adults services

City adults can access a 12-week lifestyle programme and residents can also use free NHS digital weight loss plans.

Adults facing diabetes or hypertension can access targeted online support via GP referral. For highly complex needs, specialist clinical services offer advanced interventions.

Adults in North East London can also access weight loss medicines:

- Wegovy® (semaglutide) is available via tier 3 weight management services (either the NEL pilot tier 3 service which currently accepts consultant to consultant referrals or via a right to choose provider).
- Mounjaro® (tirzepatide) is available through primary care. This is in line with the national direction following the release of the obesity indicators in QOF 2026/27.

More information can be found in the NEL obesity management clinical policy.

Food-based community support

Access to affordable, nutritious food is a fundamental health block. The national Healthy Start scheme provides digital food cards to eligible low-income families.

There are 32 supermarkets located in the City boundaries, equating to 268 people per supermarket[18]. Although there is a larger number of supermarkets available to residents compared to other areas in England, 80% of these are convenience shops[19]. Private food provision centres on "on-the-go" meals. This highlights the importance of Corporation-led food services.

[18] Population estimates are based on the Census 2021 estimates.
[19] Categories of shops can be found on geolytix website.

The City Food Club provides affordable groceries in the East and St Lukes offers similar grocery support for Golden Lane residents. In addition, the Aldgate Centre provides free community lunches tailored to cultural diets.

Overcoming practical and cultural barriers

During the JSNA engagement, VCS representatives highlighted that local shops cater to the weekday lunchtime workforce. This can limit the availability of affordable, everyday groceries for residents. Large supermarkets are located outside the City, resulting in residents travelling further for food. For individuals with mobility or transport challenges, this can create a practical barrier to maintaining a healthy diet.

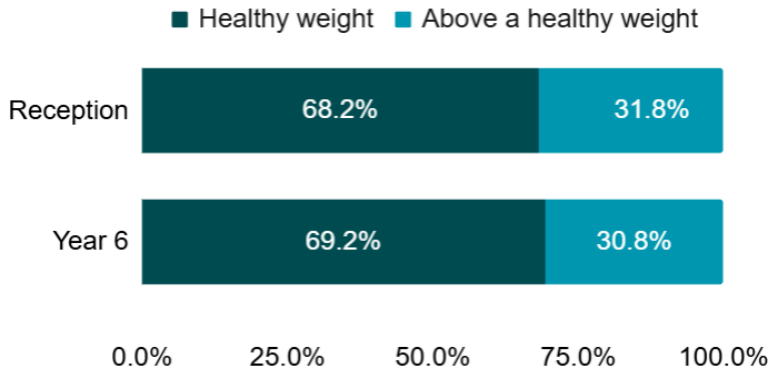
The Health Creation Alliance found that Portsoken residents feel there is a lack of affordable food and struggle to find local vendors who cater to their cultural dietary needs, specifically within the City's boundaries. Vendors meeting these needs do exist in surrounding boroughs.

The Aldgate Centre offers free community lunch every Friday that is culturally attuned to the Bangladeshi population in the Middlesex Street areas. Expanding awareness of this provision will connect residents with existing support and reduce existing or perceived barriers.

Children and young people

Between 2022/23 and 2024/25, the majority of children who lived in the City and attended The Aldgate School were a healthy weight. However, almost a third of these children were classified as overweight, obese, or severely obese. This equates to 7 children in Reception and 8 children in Year 6. Because these figures are based on small numbers, they should be interpreted with caution (Figure 30).

Figure 30: Proportion of City of London residents attending Aldgate School by weight, 2022/23 to 2024/25

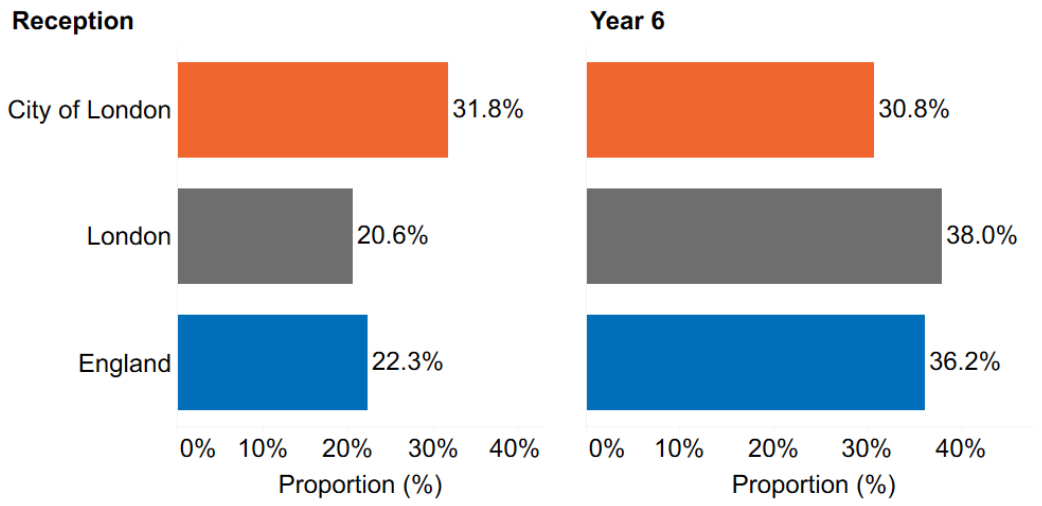


Source: National Child Measurement Programme local data. 2026

Note: Above a healthy weight refers to children who are overweight, obese and severely obese. Data includes children who live in the City and attend The Aldgate School.

In the City, the prevalence of Reception children above a healthy weight exceeds regional and national averages. In contrast, the proportion of Year 6 children above a healthy weight is lower compared with the regional and national average (Figure 31). Caution should be applied to these figures due to small counts as this can lead to fluctuation over time.

Figure 31: Prevalence of children above a healthy weight, City of London, London and England, 2022/23 to 2024/25



Source: Obesity, physical activity and nutrition profile, Fingertips, OHID, 2026. National Child Measurement Programme local data. 2026.

Note: City of London data is for children who reside in the City and attend Aldgate School. Above a healthy weight refers to children who are overweight, obese and severely obese.

Addressing childhood healthy weight

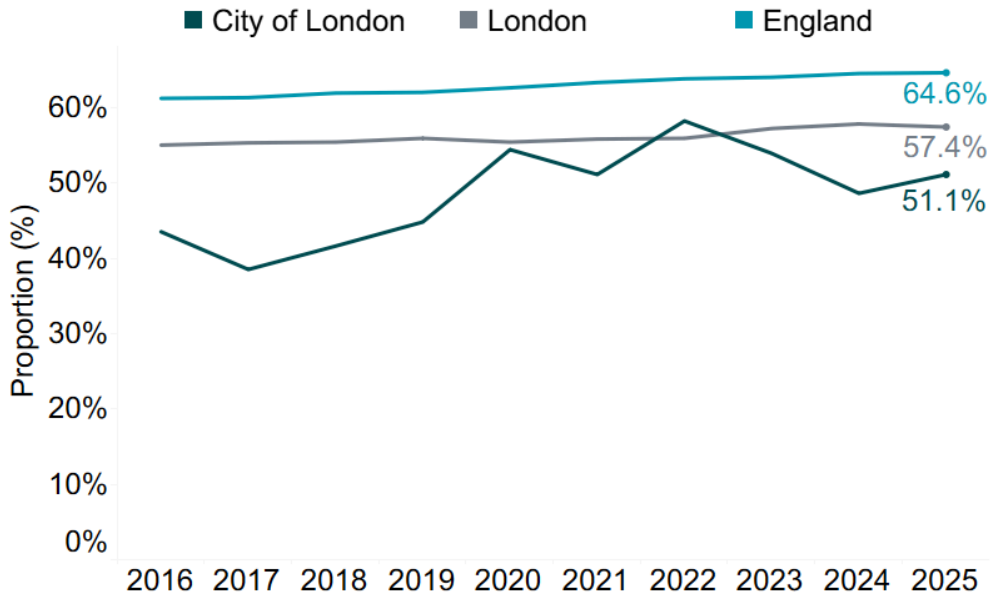
To support local families, the recent Healthy Weight Needs Assessment (2024) outlines several recommendations. One focus is early intervention, including providing nutritional support to new parents and upskilling early years professionals to confidently discuss healthy habits.

The assessment recommends improving how we use NCMP data to better understand and respond to local trends. Finally, it highlights the need to improve care pathways for underserved groups, such as children and young people with SEND [42].

Adults

In the City of London, the prevalence of adults above a healthy weight has remained stable over the last five years. In 2024/25, the local rate was 51%, which is significantly better than the England average (65%) and statistically in line with the London average (57%). Caution should be applied to these figures as information is self-reported and small numbers can account for large fluctuations.

Figure 32: Prevalence of adults above a healthy weight, City of London, London and England, 2016 to 2025



Source: Obesity, physical activity and nutrition profile, Fingertips, OHID, 2026.

Note: Above a healthy weight refers to children who are overweight, obese and severely obese.

Addressing adult healthy weight

The recent Healthy Weight Needs Assessment (2024) outlines key recommendations to support adults, with a priority focused on increasing the uptake of diabetes prevention and remission programmes. The assessment highlights the need to develop clear local pathways for weight management support. This includes improving access to obesity pharmacotherapy.

Local services must improve care pathways for underserved and vulnerable groups. This will ensure that adults with serious mental illness receive the targeted, accessible support they need [42].

Oral Health

Tooth decay is the most common oral health disease affecting children and young people in England, yet it is largely preventable. We have seen a decline in the proportion of 5 year olds in City and Hackney with dental decay from 28% in 2019 to 24% in 2024.

The national guidance includes three main interventions to prevent tooth decay amongst children:

1. Reduced consumption of foods and drinks containing sugar
2. Twice a day brushing of teeth with a fluoride toothpaste
3. Seeing a dentist at different stages of a child's tooth development.

Oral Health Prevention and Promotion Service is offered to children in early years and in primary schools. The key interventions offered are brushing packs, universal fluoride varnish programme to all children in reception and year 1 in primary schools and training of the workforce.

Physical activity

Physical activity is a major determinant of health and wellbeing and is central to prevention across the life course. Regular physical activity helps prevent and manage long term conditions while also improving strength, balance, mobility, mental wellbeing, sleep and quality of life [43–47].

For children and young people it supports healthy growth, motor development and social and emotional wellbeing [48].
Increasing physical activity can improve population health now and reduce future demand on health and care services. Based on this, it is recommended across NICE guidelines, NHS England and Sport England strategies [49,50] [50].

Local picture

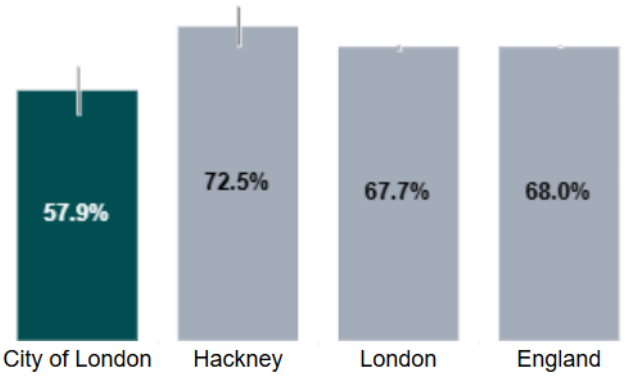
A recommendation from the Healthy Weight Needs Assessment for City and Hackney (2024) includes understanding the physical activity needs across the City of London, ensuring those who experience inequalities are able to become more active.

City residents

In 2024/25, 58% of adults in the City were classified as physically active, which is lower than the London and England average (Figure 33).

Combined City of London and Hackney survey data show lower levels of activity among older adults aged 65 and over compared with London overall. There are also marked inequalities by ethnicity: people from Asian and Black ethnic groups are less physically active. There is also lower activity among lower socioeconomic groups.

Figure 33: Proportion of adults (16+) who are physically active, City of London, Hackney, London and England, 2024/25



Source: Active Lives and Active People Surveys for Adults, Sports England, 2026

Note: Caution should be taken when interpreting City data due to small sample sizes and therefore reduced reliability.

Local services

Physical activity in the City of London is supported through a combination of the local environment, structured leisure provision, community-based support, and health and wellbeing services.

The wider City of London environment

The City of London Walking and Hidden City Map promotes walking through a pedestrian-friendly route around the Square Mile, helping residents and visitors discover local routes and destinations.

The wider street network and transport system are equally important. In the City, over 90% of commuter trips are already made by public transport, walking or cycling [51]. A survey of 250 City employees found that designated cycle and walking routes supported active travel.

In the same survey, City workers cited dangerous motorists and a lack of safe routes as barriers. Furthermore, older residents report feeling unsafe walking due to e-bikes on pavements. This is explored further in the Social Cohesion section of the report.

Green spaces

The City of London has around 180 gardens, estates and green space sites for outdoor recreation.

During the February engagement event, VCS representatives highlighted the Thames, micro-parks (like Fortune Street Park), churches, and City Farm as community strengths. Local gardening initiatives and roof allotments are celebrated as successes that boost mental health, support healthy nutrition, and foster social connections. One representative added 'a lot of people live in the City by choice'.

However, some representatives' perspectives were slightly different. The "uniquely concrete" nature of the City, specifically in Aldgate, limits accessible spaces for exercise and leisure. VCS organisations reflected this impacts residents' mental and physical health.

Facilities

Local infrastructure includes Golden Lane Leisure Centre and online NHS classes. Tailored interventions are also funded, like women-only swimming, to actively overcome cultural barriers.

The City provides tailored physical activity offers for vulnerable young people. This includes dedicated care leaver football sessions and a specific care leaver gym offer. Additionally, children with disabilities can access individualised, tailored leisure and health activities through the Short Breaks programme.

The February engagement session highlighted mixed opinions regarding service provision. Some participants noted the City has physical activity opportunities (e.g., open-air basketball) and a dedicated community sports officer. However, others highlighted a lack of specific facilities for exercise, such as in the Portsoken area, where the community centre lacks the appropriate space for activities. Therefore residents travel out of the City for services.

The City worker survey by ukactive Research Institute showed 58% would use local services, but most remain unaware of them.

Recommendations for physical activity in the City have been captured in the specific health needs assessment, due to be published in Autumn 2026.

Sexual and reproductive health

Local context

Sexual and reproductive health (SRH) form an integral part of people's overall health and wellbeing. The City & Hackney strategy for sexual and reproductive health underscores this through its five themes:

1) Healthy and fulfilling sexual relationships
2) Good reproductive health across the life course
3) STI prevention and treatment
4) Living well with HIV and zero new HIV infections
5) Inclusion communities and those with complex needs

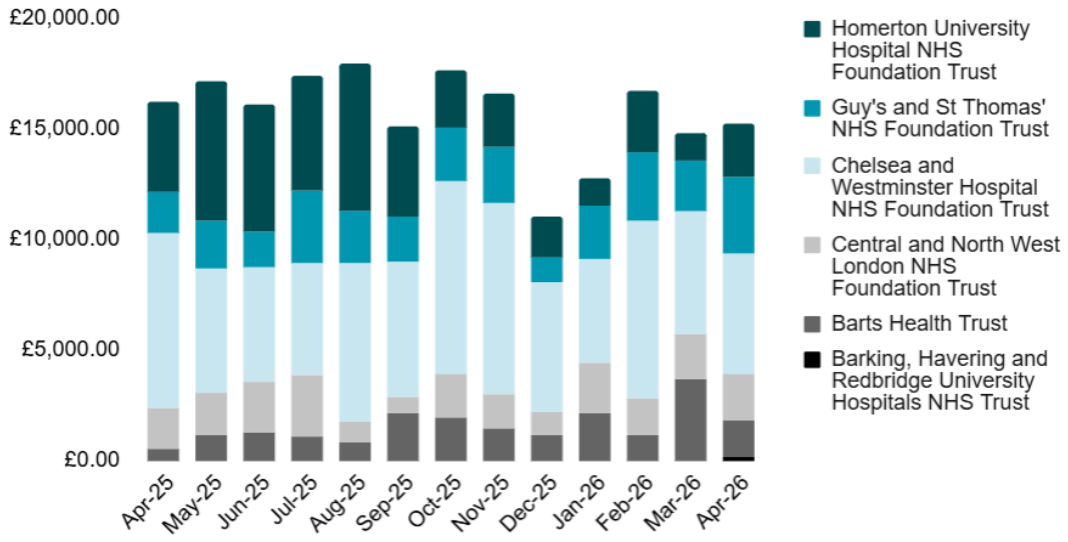
Differential outcomes and ill health in SRH are linked to age, sexual orientation and gender identity, as well as ethnicity and socio-economic deprivation. The City has a relatively high proportion of residents who identify as gay or bisexual (10%), around 40% of its residents are aged 15 to 34, and it has pockets of deprivation which affect certain ethnicities more than others.

Local picture

Clinic activity

Across the 2025/26 financial year, clinic activity for City residents remained fairly stable despite the closure of the satellite sexual health clinic at 80 Leadenhall Street in October 2025. The seasonal dip occurring in December may have been exacerbated by this, and extended into January 2026 (Figure 34), with strong recovery in February 2026.

Figure 34: Sexual and reproductive health clinic activity, City residents, 2025/26



Source: Pathway Analytics, 2026.

In 2025, the majority of City residents accessed sexual health services at Dean Street, which accounted for 378 appointments. This was followed by the Leadenhall Street Clinic with 222 appointments.

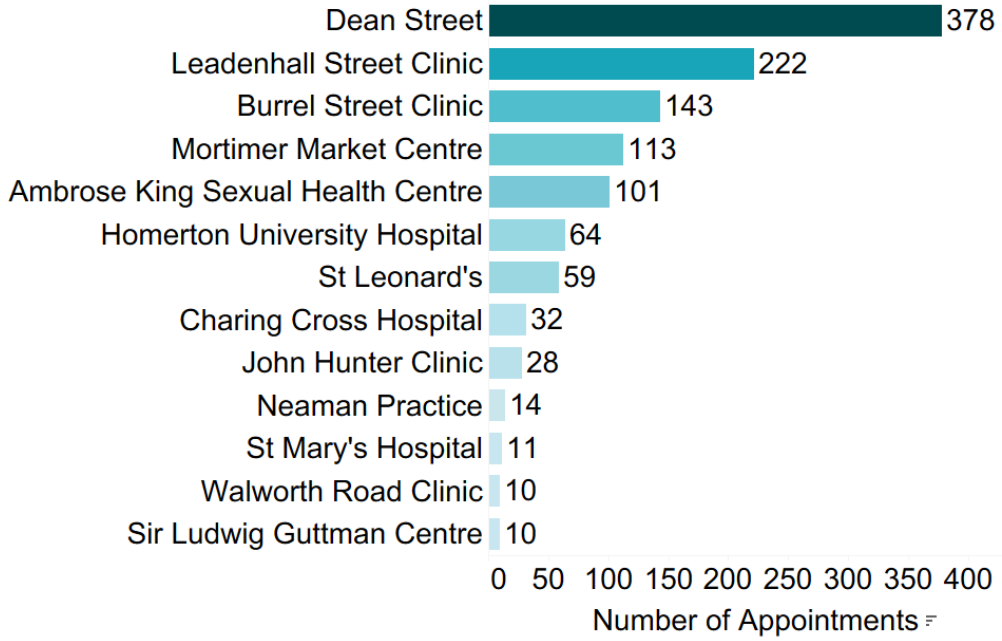
The Leadenhall Street site closure led to an increase in attendances at neighbouring out-of-area clinics such as Chelsea and Westminster, and Guy's and St Thomas. This suggests patients were successfully signposted to other clinics (Figure 35).

The Neaman Practice

In anticipation of the closure of Leadenhall Street, a replacement sexual health clinic opened at the Neaman Practice in September 2025. While it is located within the GP surgery, the clinic is run by Homerton Healthcare rather than the primary care team.

The new clinic currently operates on Fridays. Over a five-month period, the Neaman clinic saw 23 unique patients from the City. This accounted for 51 different clinical interventions. Most of these new appointments were for STI testing (42%) and long-acting reversible contraception (LARC) (20%).

Figure 35: Number of appointments by clinic, City residents, 2025



Source: Pathway Analytics, 2026.
Note: Counts less than 10 have been removed. Data is for sexual health clinics.

Awareness and access challenges

There is a possible lack of awareness of the SRH services within the City. During the February engagement event, VCS representatives shared that no public clinic currently exists following closure of Leadenhall. However, services remain active, highlighting a communication gap.

There are also existing access barriers to the Neaman Practice. Patients cannot book appointments directly through the surgery. Instead, they are required to book via Homerton Healthcare, even though this can be done online.

Feedback included that young people wanting to get tested must travel to Hackney or Tower Hamlets. Some participants also feel that services are primarily focused on and accessed by City workers. This suggests better promotion of the online service SHL is required, as well as the local pharmacy offer.

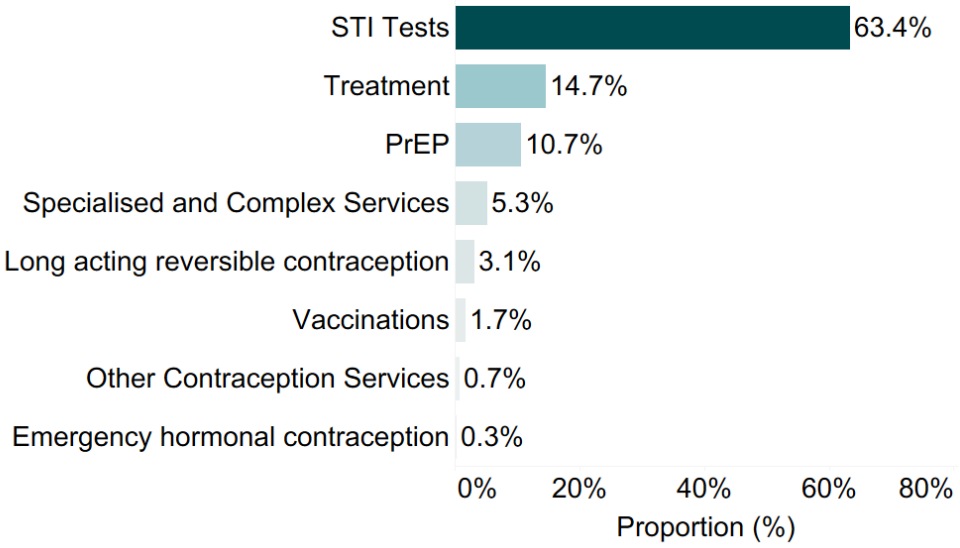
Intervention uptake

Almost two-thirds of clinical interventions for City residents were for STI tests. The most common was a T4 test, which screens for chlamydia, gonorrhoea, syphilis and HIV. Following testing, the most common interventions accessed by residents were STI treatment and Pre-Exposure Prophylaxis (PrEP), which is HIV prevention medication.

In addition to STI tests, City residents also accessed clinical services for vaccinations for preventable sexual health conditions, such as Hepatitis A and B, Human Papilloma Virus, Mpox, and Gonorrhoea.

City & Hackney Public Health is currently undertaking a brief needs assessment to better understand uptake of these interventions amongst priority groups in the City of London and key barriers to access.

Figure 36: Proportion of interventions, City residents, 2025



Source: Pathway Analytics, 2026.
Note: Counts less than 10 have been removed. Treatment includes treatment for STIs such as warts and trichomoniasis. Data is for sexual health clinics.

In 2025/26, there were 132 unique visits to sexual health clinics by children and young people aged 17 to 24 years. Approximately half of these visits were for young people aged 23 to 24 years.

Table 8: Unique visits to sexual health clinics, City residents aged 17 to 24 years, by age group, financial year 2025/26

Age group	Number of people	Proportion of people
17-19	11	8.3%
20	13	9.8%
21	20	15.2%
22	22	16.7%
23	33	25.0%
24	33	25.0%

Source: Pathway Analytics, 2026.

Pharmacies

Pharmacies offer free oral contraception and emergency contraception to all, while one community pharmacy offers additional free sexual health services to residents (chlamydia screening and treatment, free condoms for U25s).

For children and young people there is a good uptake of condoms and STI prevention at local community pharmacy. In the financial year 2025/26, 18 unique young people (aged 15-24 years) collected condoms 41 times.

Pharmacists were highlighted by VCS representatives as an accessible alternative for speaking about SRH matters, with the added benefit that some are now open on Saturdays.

Out of borough services

Many City residents access SRH services in GPs and pharmacies in Tower Hamlets, as well as open access clinics in other nearby or neighbouring local authorities. For young people under 25, a regular sexual health clinic at Health Spot at the Forest Hill Youth Hub offers an additional dedicated service.

DigiPrEP

Since May 2025, City residents who are eligible can access HIV prevention medication (PrEP) online. This has widened access to PrEP for those who do not usually like to access sexual health clinics. It has also made access easier for those already using PrEP by removing the need to go to a clinic. With the closure of the Leadenhall, this has also been a way to mitigate against a potential drop in access to PrEP; in 2025/26, a total of 406 PrEP prescriptions were issued for City residents, in clinic and online combined, versus 409 prescriptions in 2024/25.

Sexual Health London

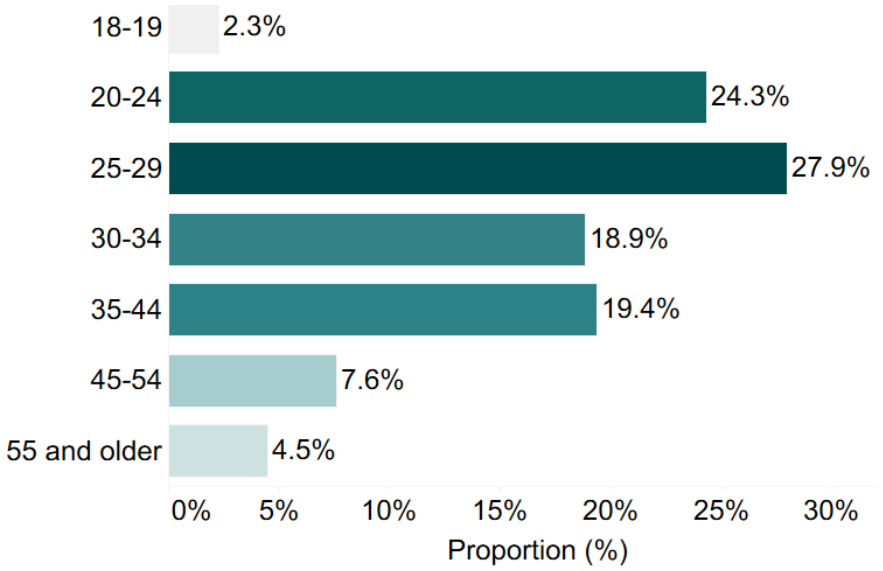
The online service SHL.uk gives access to residents aged 16 and over for STI testing and contraception, and HIV prevention medication, PrEP. As SHL is used by 32 other London local authorities, this is a service accessible by the majority of City workers, as, based on ONS estimates, 74% of City workers reside in London.

Uptake

The number of online STI tests ordered by City residents from SHL.UK has remained stable over the last two years. In January 2026, 131 tests were ordered and 70% of these were returned and completed.

Men ordered the majority of testing kits (60%). Young people aged 19 and under ordered the fewest kits (2.3%).

Figure 37: Proportion of online STI tests ordered by age group, 2024 to 2025



Source: SHL.uk, 2026.
Note: The age group 16 to 17 has been excluded due to small counts.

Positivity rates

Across 2023 to 2025, male City residents had higher positivity rates compared to females for both chlamydia and gonorrhoea.

Those aged 25-34 years ordered the most tests, followed by 35-44 years. Both groups had a chlamydia positivity rate of 4%. The highest chlamydia positivity rate was for younger residents, aged 20-24 years, at 7%. This group ordered 15% of all tests, aligning with anecdotal evidence that younger individuals are more likely to test when presenting with symptoms

Gonorrhoea positivity rate showed a different pattern. Those aged 45-64 years had the highest positivity rate of 6%.

White residents ordered the majority of tests (72%). Chlamydia positivity rate was highest among Asian residents (6%) and gonorrhoea positivity rate was highest among residents in the Other ethnic group (6%)[20]. This group includes the City's Latin American residents.

Outreach and engagement

Several commissioned providers offer in-person outreach, engagement and prevention work within the City, including:

- condom distribution for young people
- SRH engagement and PrEP promotion for global majority communities
- HIV prevention and testing
- counselling, group engagement and advice for people living with or affected by HIV

[20] 1% of STI tests did not have ethnicity recorded.

In the City of London, there are two regular outreach spaces: the Guildhall School of Music and Drama (GSMD), and the Fashion Retail Academy.

Since March 2024, the outreach team has spoken to 388 young people (202 women and 186 men) at the GSMD. Three sessions have been held at the Fashion Retail Academy. The team successfully engaged 66 young people and distributed a total of 56 condom packs. Outreach will continue at both schools in September 2026.

HIV

National context

DHSC HIV Action Plan for England in 2025 aims to eliminate new HIV transmissions by the end of the decade. The initiative focuses on five core pillars: prevention, testing, treatment, quality of life, and system-wide collaboration.

The plan also identifies five populations that are disproportionately affected by HIV and require targeted focus.

Local picture

The City of London has higher proportions of populations disproportionately affected by HIV compared to the national average [21] (Table 9). This shows the importance of supporting City residents with HIV prevention, care and treatment.

[21] Due to local data limitations, the population data cannot be simultaneously disaggregated by sex, sexual orientation, and ethnicity. While we are able to identify the overall proportion of gay, bisexual, and other men who have sex with men (GBMSM), the ethnic breakdowns for gay/bisexual residents are based on all adults. Consequently, the local 'ethnic minority gay/bisexual adults' and 'White gay/bisexual adults' categories include women, whereas the national high-risk focus is specifically on GBMSM. The 'ethnic minority heterosexual adults' category encompasses three distinct national target groups combined: Black African heterosexual men, Black African heterosexual women, and other ethnic minority heterosexual adults.

Table 9: Proportion of residents, population groups disproportionately affected by HIV* in City of London compared to England

Population group	City of London Proportion of residents (%)	England Proportion of residents (%)	HIV action plan rationale
Gay, bisexual, and other men who have sex with men (GBMSM)	8.0%	1.3%	This group has the highest rates of new diagnoses, specifically for men from the Global Majority.
Global majority gay/bisexual adults	2.1%	0.4%	GBMSM from the Global Majority experience the highest rates of HIV diagnoses.
White gay/bisexual adults	7.7%	2.5%	While new diagnoses have fallen for White GBMSM due to PrEP and regular testing, this group still accounts for a high proportion of new diagnoses.
Global majority heterosexual adults	23.6%	14.4%	Diagnosis for Black African men and women have increased from 2020 to 2024. Increased risk for this group is shaped by structural inequalities and barriers to access.

Source: Census 2021, Office for National Statistics, 2021

***Note: Data could not be disaggregated by sex (female or male) and by ethnic groups. Data could not be disaggregated by detailed ethnicity such as Black African. Population groups may not fully align with those mentioned in the HIV Action Plan.**

The C&H Sexual and Reproductive Health Strategy (2024-2029) and action plan serve as the direct local delivery mechanism for these national ambitions. Recognising City & Hackney as an area of high HIV prevalence, the strategy outlines a whole-system partnership approach.

HIV prevalence and prevention

In 2024, in the City of London, the HIV diagnosis rate was 4.4 per 1,000 (individuals aged 15 to 59 years). This rate has been decreasing and improving since 2021 and is now in line with the national average. However, this rate is classified as high, according to national benchmarks[22].

A key outcome of the C&H Sexual and Reproductive Health Strategy is 'all communities who would benefit from HIV prevention interventions including condoms and PrEP are easily able to access services '[52]. As mentioned above, PrEP accounted for 11% of interventions accessed by City residents in 2025 with the majority of this being for continued PrEP (9%) rather than new treatment (2%).

[22] A high rate of HIV diagnosis prevalence is defined as 2 - 5 diagnoses per 1,000 people.

Further exploration is required to identify which communities in the City are experiencing new diagnosis and where there is variation in prevention and treatment access.

Chemsex

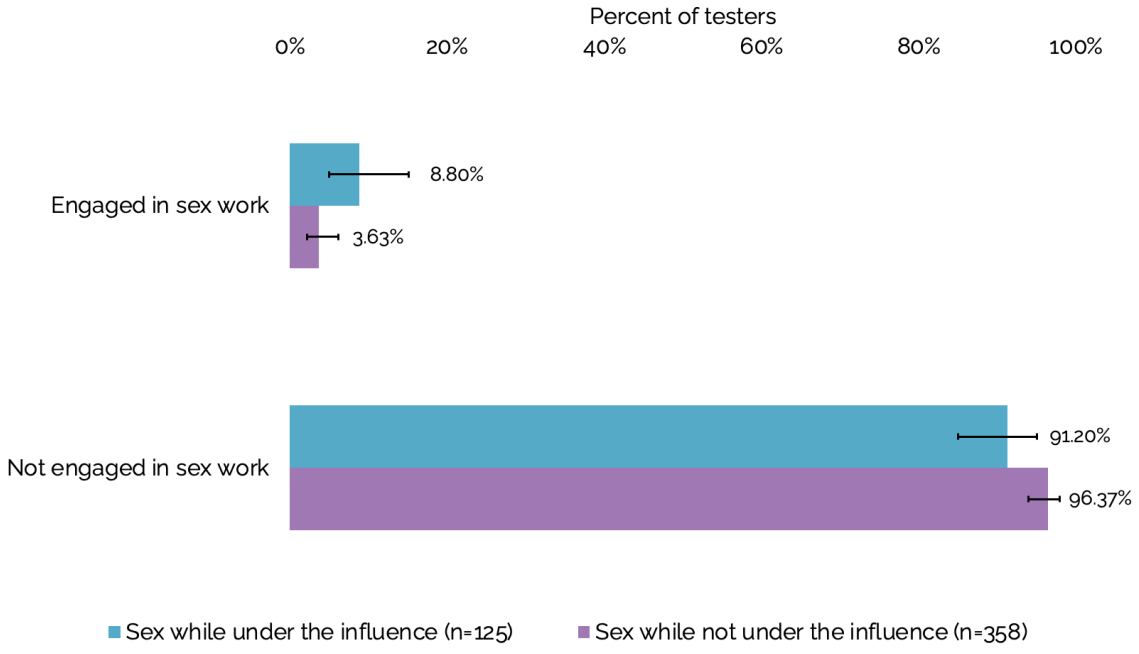
Current intelligence on chemsex is insufficient, with underreporting suspected. A Substance Use Health Needs Assessment for City and Hackney focusing on chemsex has been published. Initial findings suggest that 10-20% of GBMSM engage in chemsex [53,54]. Locally, this translates to an estimated 44 to 88 individuals in the City.

The needs assessment also actively explores participation among individuals from Black and Global Majority ethnic groups, who remain underrepresented in local service data alongside other highly vulnerable groups, such as sex workers.

In the City, GBMSM and transgender or gender non-conforming (TGNC) individuals who reported having sex under the influence were more than twice as likely (2.56, CI: 1.12-5.87) to also report engagement in sex work in the same year, compared to those who did not (Figure 38).

Further details on sex work are discussed in the Needs & Inclusion section of this report.

Figure 38: GBMSM+TGNC SHL service users from the City by reported engagement in sex work and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Source: Preventx. SHL users from the City of London, 2022-2024. 2025.

Data limitations

Reporting mechanisms are being broadened to cover all crimes, including sexual violence, allowing victims to report safely outside of traditional policing routes.

However, discrepancies exist between official crime data and the reports from frontline estate teams, particularly regarding disability and hate crimes. This underscores the need to improve local intelligence-gathering and community reporting mechanisms.

Smoking

National policy

Action on tobacco is key to supporting City residents to live healthier lives, as well as meeting the national ambition for a "smoke-free" generation by 2030. However, nationally, more than 1 in ten adults smoke and the Action on Smoking and Health has called for new action to ensure England meets its smoke-free goal.

To achieve this, the government's Stopping the Start policy has established increased funding for stop smoking services, granted new powers to Trading Standards, and introduced the pioneering 'Swap to Stop' vaping scheme (consolidated as of 2026/27 into the public health grant). This is strengthened by the Tobacco and Vapes Act, which bans the sale of tobacco to anyone born on or after 1 January 2009. The Act also introduces strict controls on the advertising and promotion of vapes, and establishes smoke-free, vape-free, and heated tobacco-free environments.

Local policy

The Joint Local Health and Wellbeing Strategy 2024-2028 identifies tobacco control and smoking cessation as a key enabler for all three of its core priority areas. Helping residents to quit smoking is recognised as a direct driver for increasing financial resilience, strengthening social connection, and improving mental wellbeing.

Strategic leadership for tobacco control across the local area is provided by the City and Hackney Tobacco Control Alliance (TCA). TCA members collaborate to oversee delivery against eight key partnership priority areas. These priorities are agreed upon in four-year cycles, ensuring the local approach remains responsive, with the next strategic refresh scheduled for 2026.

Local services

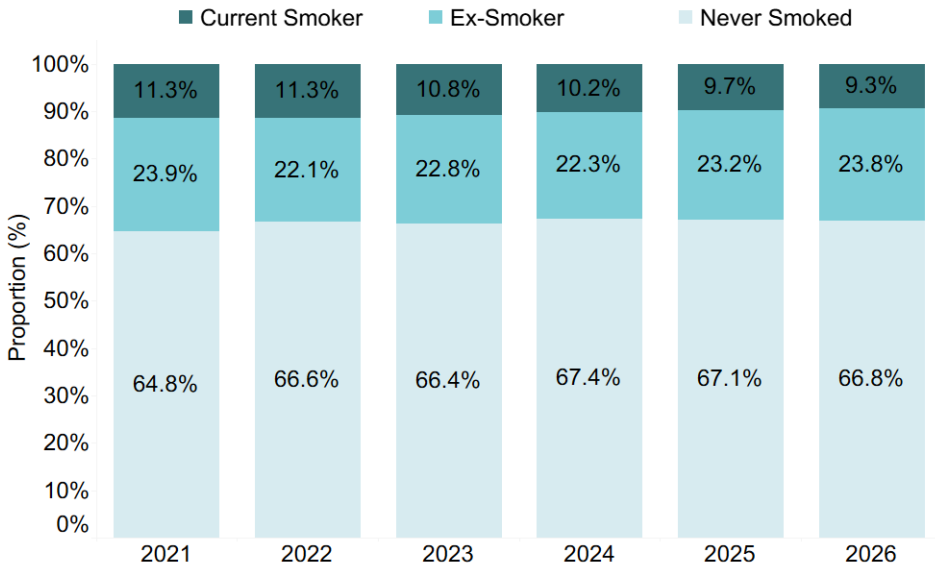
Since July 2024, Gloji Smokefree City and Hackney is the local Stop Smoking Service (SSS) for adults and children (12+ years) who live, work, study or have a GP in the City of London or Hackney. SSS delivers a model designed to reduce barriers to access and ensure equity of provision across the City of London. The current offer consists of fixed-site provision, outreach and engagement, including workplace engagement, and digital support.

Local picture

Smoking prevalence in London and England has continued to decrease each year, reaching a record low in 2024[23]. More adults aged 18 and over are current smokers in the City of London compared to England for the years 2021 to 2024 [55].

Over time there has been a slight decrease in the prevalence of current smokers in the City of London and an increase in ex-smokers and never smokers. However, these trends have remained fairly stable over the last 5 years (Figure 39).

Figure 39: Smoking prevalence by smoking status, City of London residents, 2021 to 2026



Source: Primary care records, North East London ICB

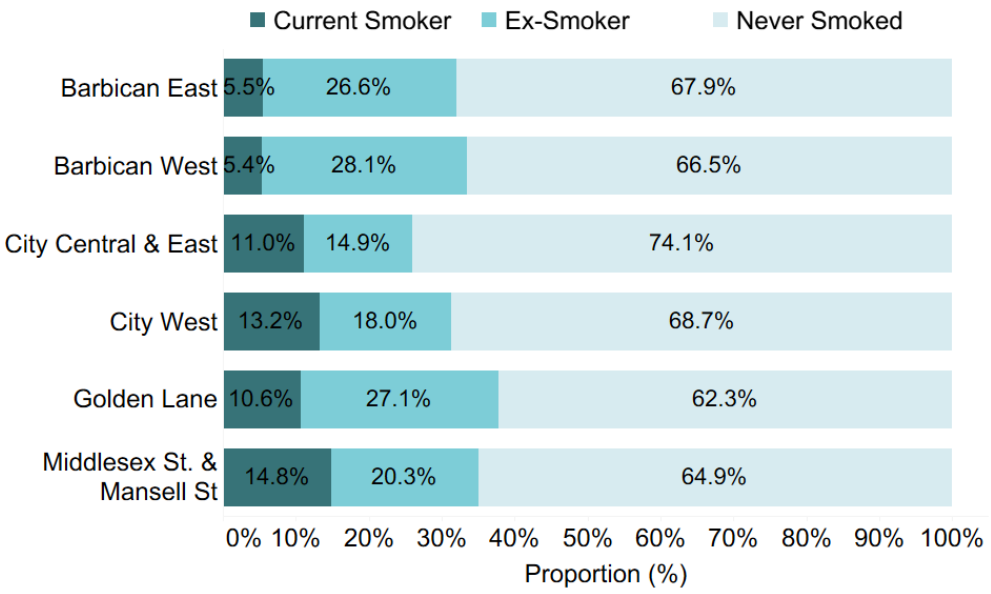
Note: Data covers City of London residents registered at North East London GPs, excluding records with missing or outdated (>5 years) smoking statuses

In 2025, there were 425 current smokers in the City. Almost half of these individuals live in just two areas: Middlesex Street and Mansell Street and Golden Lane (105 and 95 residents, respectively).

[23] National and regional data is produced based on the Annual Population Survey. City of London data is from GP records. Caution should be applied when making comparison.

Middlesex Street and Mansell Street, the most deprived area in the City, also records the highest local smoking rate. By contrast, Barbican East is the least deprived area and has the lowest proportion of current smokers and the highest proportion of people who have never smoked (Figure 40).

Figure 40: Smoking prevalence by smoking status and small-area, City of London residents, 2025



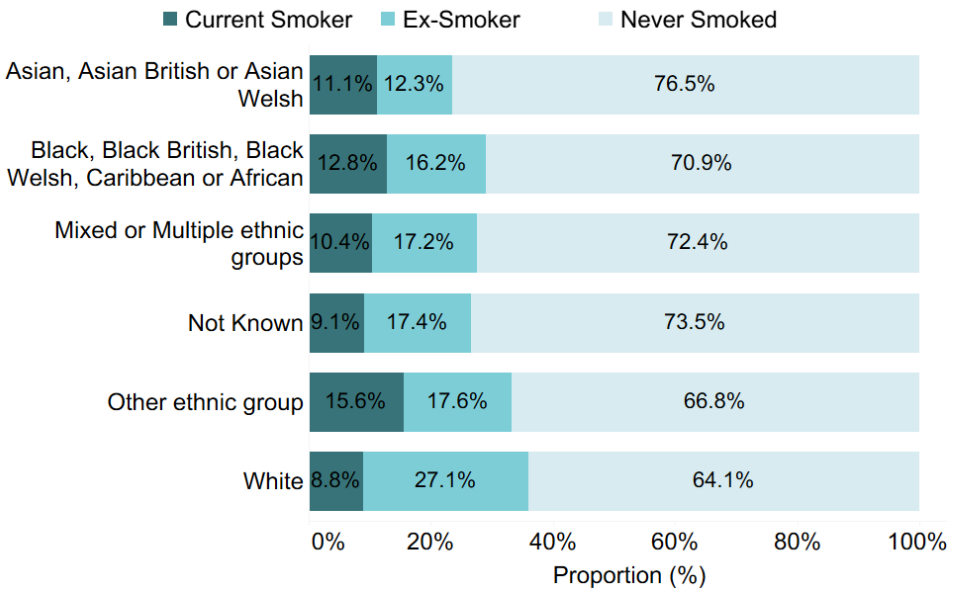
Source: Primary care records, North East London ICB

Note: Data covers City of London residents registered at North East London GPs, excluding records with missing or outdated (>5 years) smoking statuses.

In 2025, 12% of local men and 8% of local women were current smokers, aligning with national trends [88].

Smoking trends also vary across different ethnic groups. The Other ethnic group had the highest proportion of current smokers at 16%. The White ethnic group had the lowest proportion at 9%. The White group also recorded the highest proportion of ex-smokers. Bangladeshi residents recorded the highest overall rate. Within this specific group, 20% reported being current smokers.

Figure 41: Smoking prevalence by smoking status and ethnicity, City of London residents, 2025



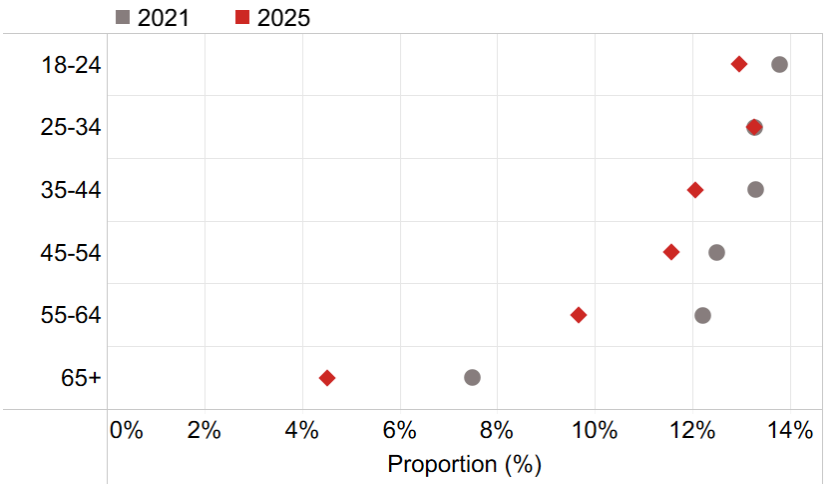
Source: Primary care records, North East London ICB

Note: Data covers City of London residents registered at North East London GPs, excluding records with missing or outdated (>5 years) smoking statuses.

In the City, people aged 25 to 34 are the most likely to smoke. In 2025, 13% of this demographic were current smokers. This is the only age group where smoking prevalence has not decreased over time (Figure 42).

Smoking prevalence among people aged 18 to 24 in the City in 2025 was 13%, a decrease from 14% in 2021. This is higher than the national estimates (Figure 42). During the JSNA engagement event VCS representatives reported an increase in children vaping in the City for all ages.

Figure 42: Proportion of current smokers by age group, City of London residents, 2021 to 2025



Source: Primary care records, North East London ICB

Note: Data covers City of London residents registered at North East London GPs, excluding records with missing or outdated (>5 years) smoking statuses.

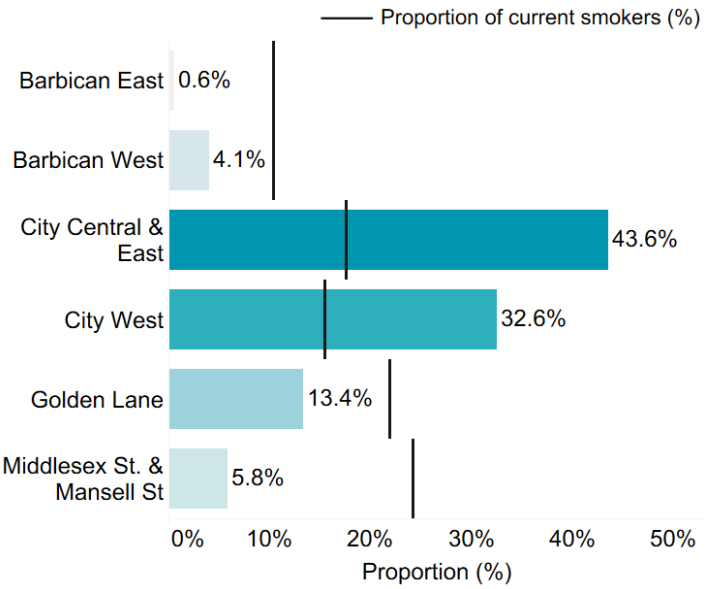
Smoking cessation support

Around 170 City residents[24] accessed the SSS between July 2024 and March 2026. Two-thirds of these residents went on to set a quit date. Around 50% of those who set a quit date were successful at 4 weeks, dropping to 40% at 12 weeks.

Smoking prevalence is highest in Middlesex Street and Mansell Street. This area contains nearly a quarter of the City's smokers. However, these residents make up just 6% of people using the service. By contrast, City Central and East and City West account for 75% of service users. Yet, these areas make up only 35% of current smokers (Figure 43).

It is important to note that residents in Middlesex Street and Mansell Street may be accessing SSS in Tower Hamlets as they are likely registered with a Tower Hamlets GP. This could account for the difference in current smokers and access.

Figure 43: Proportion of individuals accessing the stop smoking service compared to proportion of current smokers by small area, City of London residents, July 2024 to March 2026



Source: Stop Smoking Service, Gloji, 2026. Primary care data, North East London ICB, 2026.

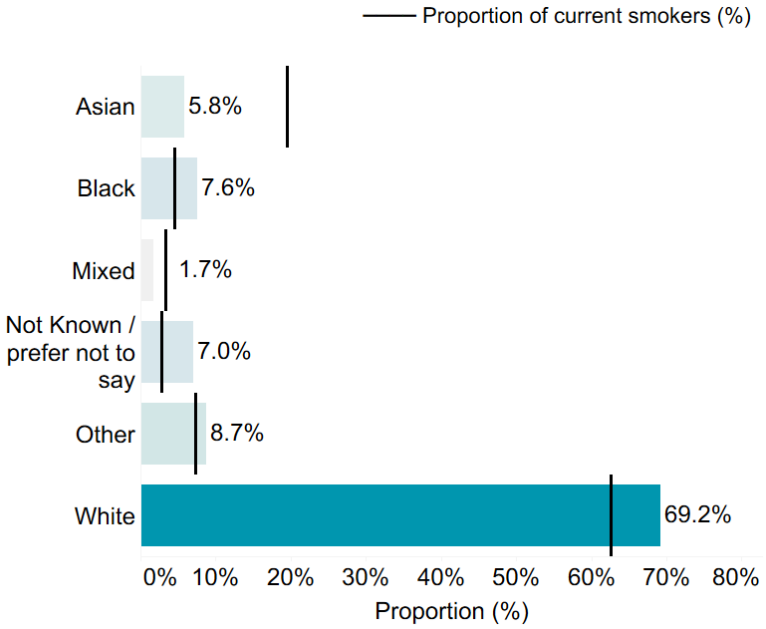
Note: 8% of Gloji Stop Smoking Service records did not have LSOA recorded.

[24] While the service is available to City workers, it is not possible to currently identify these individuals. Service data only records a user's home address, meaning the figures below only reflect people who live in the City.

The City's Asian community is also underrepresented in the service, accounting for 6% of users but 20% of current smokers. In contrast, White residents are overrepresented making up 69% of service users and 63% of current smokers.

The discrepancies between service uptake and smoking prevalence by ethnicity highlight a health inequality. Service outreach should target communities underrepresented in the City.

Figure 44: Proportion of individuals accessing the stop smoking service compared to proportion of current smokers by ethnicity, City of London residents, July 2024 to March 2026



Source: Stop Smoking Service, Gloji, 2026. Primary care data, North East London ICB, 2026.

Note: Detailed ethnic groups did not match across data sources. Gloji ethnic reporting has been grouped to align with the Census 2021 classifications. Please note, 7% of records were missing ethnicity information.

Occupation evidence only reflects people who live in the City. Routine and manual occupations make up over a third of service users (40%) which aligns with national prevalence estimates of smoking [55].

Chapter 7: The Health and Care System

Introduction

In addition to social and behavioural factors, communities' health is also shaped by their access to good quality health and social care services [40,56].

The Government's 10-year health plan, Fit for the future, sets a clear national goal. The health system must shift its focus from treating sickness to preventing it and creating equal access to health services.

In recent years, there has been a shift toward integrated health and care systems where partnerships are created between Local Authorities, the NHS, social care and VCS organisations. This joined-up approach encourages teams to work together, addressing the growing number of people living with complex, long-term conditions [57].

By fostering collaboration, local care systems can focus on long-term prevention and patient independence instead of reactive acute care [40].

This section will cover the following topics related to integrated health and care in the City:

- Primary care services
- Long term conditions and multimorbidity
- Dementia
- Mental health conditions

Primary care services

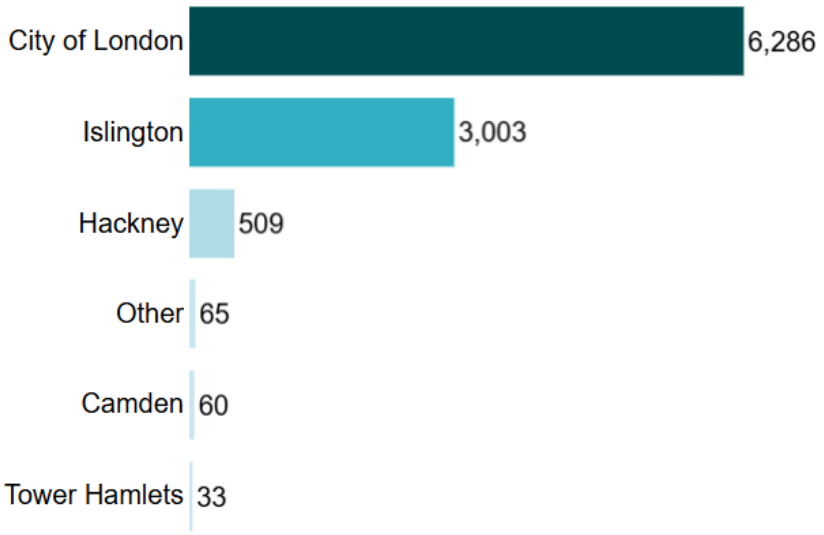
Primary care services act as the front door to health services. Ensuring individuals have fair access to good quality health care services, including GPs, supports people to live healthier and longer lives [58].

The Neaman Practice

The Neaman Practice is in the north-west of the City. It is the only GP practice inside the city boundaries, serving over half of the City's registered patients (Figure 45). This GP has been rated as Good by the Care Quality Commission and has received positive feedback from users and VCS representatives.

The Neaman Practice's catchment area includes areas outside of the City as well as excluding the Portsoken ward, located in Middlesex Street & Mansell Street. Therefore, access to care depends heavily on where City residents live.

Figure 45: Number of patients registered at The Neaman Practice by local authority, 2026



Source: Patients Registered at a GP Practice, NHS England, January 2026

Note: 'Other' refers to patients residing in Scotland, Wales, Northern Ireland or where the registered postcode is invalid. Local authorities are only displayed if there are more than 30 patients from that area.

Variations in access

Many City residents register with GP practices in surrounding boroughs. For example, Goodman's Field Health Centre in Tower Hamlets is the second most popular for all City residents and the most popular service for Middlesex Street & Mansell Street residents.

King's College Health Centre, a GP service for university staff and students, is also popular among residents (Appendix 13 & Appendix 14). This highlights a large student population living in the City.

Currently, there is a lack of evidence on health service access beyond primary care. However, new population data helps clarify these wider health needs. Students typically use services for mental health, sexual health, and substance use [51].

These students will likely become a part of the future residents or worker population. Understanding their health needs now, offers an opportunity for prevention.

Access for children and young people

GP access differs for children living in Middlesex Street & Mansell Street compared to the City's overall child population. In January 2026, almost two thirds of those aged under 14 who live in the City were registered at The Neaman Practice (Appendix 15).

However, this proportion drops to almost zero for children living in Middlesex Street & Mansell Street. Similar to the adults, these children mostly use GPs located in Tower Hamlets (Goodman's Field Health Centre and The Spitalfields Practice) (Appendix 14) This is because the Neaman Practice's catchment area does not include the most eastern area in the City.

Barriers to accessing services

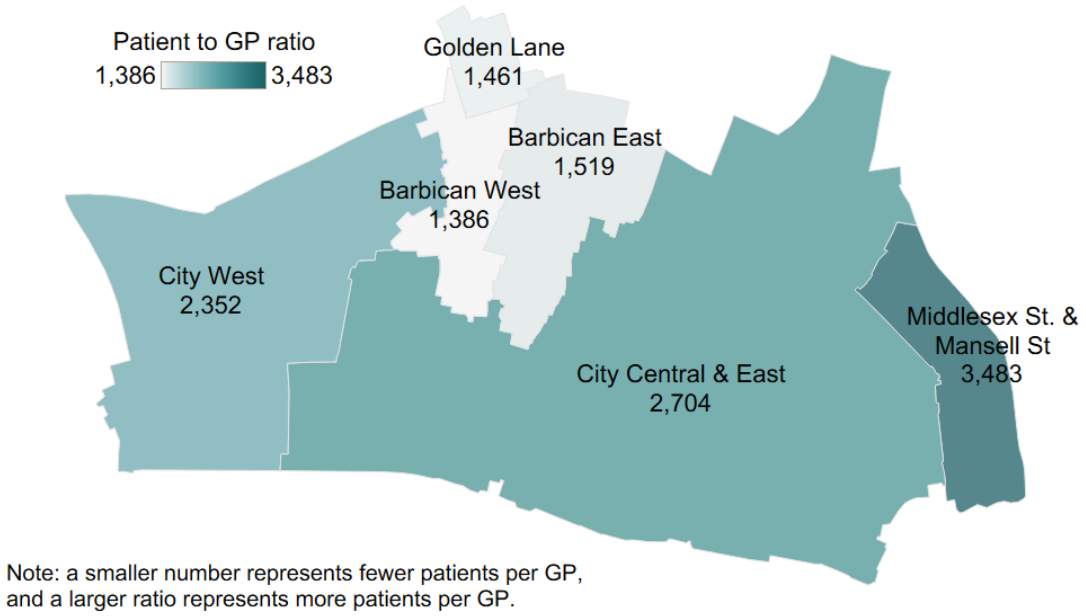
Cross border health services

Evidence from practitioners and VCS representatives suggests that City residents who are not registered with a GP in the City of London or Hackney are either not eligible for specific care pathways or find pathways confusing and complex.

Given the GP access patterns mentioned above, this presents a possible geographical inequality to service access. This inequality may be worsened by a variation in primary care capacity across the City, with there being more patients per GP[25] in the East compared to the North (Figure 46).

To ensure equitable access to healthcare for all resident children, cross-boundary collaboration must be prioritised and City services should be actively linked with these neighbouring Tower Hamlets surgeries.

Figure 46: Patient to GP ratio by small-area, City of London, November 2024



Source: Index of Multiple Deprivation (IMD) 2025, Ministry of Housing, Communities & Local Government, 2025

Logistical barriers

At the engagement event held in February 2026, VCS representatives shared that there is a reluctance amongst residents to travel to Hackney for specific routine appointments.

This is often compounded by practical logistical barriers; for example, early morning hospital appointments (such as 9am slots at Homerton Healthcare) conflict with the validity times of residents' Freedom Passes, impacting attendance for older or lower-income adults.

[25] GP to patient ratio is an indicator used in the Barriers to Housing and Services IMD 2025. A smaller ratio means there are less patients per GP. These ratios are calculated based on the location of an individual's GP, reflecting the cross-border healthcare usage which is common for some residents living in the City.

To mitigate these geographical barriers, community feedback favoured mobile outreach, suggesting that routine vision, hearing, and health checks be brought directly to residential estates via health buses.

Digital exclusion and service awareness

The systemic shift towards "digital-by-default" communication—such as app-based booking systems, online hospital letters, and complex local authority websites—has widened health inequalities for residents without IT access or lower digital literacy.

Even when physical provisions (like food pantries or cooking courses) exist, there seems to be a lack of community awareness. Feedback from the February VCS engagement event suggests residents are unsure of what support is available, or believe local community centres are restricted to residents of specific housing estates.

Trust and consultation fatigue

Systemic access issues, such as long wait times for GP call-backs and difficulty securing appointments, have steadily reduced community trust in local services. From the February engagement event, VCS representatives shared that residents feel they are frequently consulted by statutory bodies but rarely see conversations turn into action or improvements. This differs from the Health Creation Alliance project where Portsoken residents are keen to engage with council officials.

As mentioned in the report, VCS organisations mentioned that for some residents with lower English proficiency, language can act as a barrier to navigating complex housing and mental health systems. This has further led to a reduction in trust in services.

Long term conditions

In England, long-term conditions[26] are a major cause of poor quality of life [59]. Around 15 million people live with at least one of these illnesses. This number is growing, and more people are now being diagnosed with multiple conditions [47,60]. Box 11 outlines national strategies to tackle this growing pressure.

[26] Long-term conditions or chronic diseases are conditions for which there is currently no cure, and are managed with drugs and other treatments. Examples include diabetes, cancer, cardiovascular disease and musculoskeletal disease [59].

Box 11: National strategies focused on long term conditions

The NHS Long Term Plan

The NHS Long Term Plan marks a shift in how chronic illnesses are managed. The strategy purposefully moves away from reactive hospital treatments, focusing heavily instead on prevention, community-based care, and patient empowerment [57].

The Major Conditions Strategy

The government's Major Conditions Strategy shifts away from single-disease action plans. Instead, it creates one combined framework for the six condition groups that drive the most ill health (including cancers, cardiovascular disease, and mental ill health) [60].

Local picture

In 2025, over a quarter (28%) of City residents had been diagnosed with at least 1 LTC[27]. This aligns with the NEL average and trends have remained stable over the past five years. Overall, condition rates are lower in the City of London compared to the NEL average. However, the City records a higher prevalence of cancer and osteoporosis (Table 10).

Table 10: Long term conditions, age standardised rates per 1,000, City of London compared to North East London, 2025

Condition	City of London (per 1,000 population)	North East London (per 1,000 population)	City comparison to NEL
Hypertension	144	190.6	Lower
Depression	75.9	93.3	Lower
Obesity	53	106.9	Lower
Type 2 Diabetes	36.2	104.6	Lower
Cancer	38.8	34	Higher
Coronary Heart Disease	25.6	33	Lower
Chronic kidney disease	40.1	48.5	Lower
Stroke/TIA	15.1	18.7	Lower
Osteoporosis	20.1	16.3	Higher

[27] This figure differs slightly from the NEL segmentation model and this proportion includes hypertension, obesity, depression and common mental health conditions. The NEL segmentation model excludes these conditions.

Source: Primary Care data, North East London ICB. 2026.
Note: City residents are those registered with a GP in North East London with a City of London home postcode. Rates are age standardised based on the European Standard Population.

Prevalence also varies between population groups and across different areas within the City. The highest rates for most conditions are in Golden Lane and Middlesex Street & Mansell Street. For example, in 2025, Middlesex Street & Mansell Street had the highest rates of hypertension, obesity, depression and type 2 diabetes (Table 11).

Table 11: Rates per 1,000, Long term conditions by small-area, City of London, 2025

Condition	Barbican East	Barbican West	City Central & East	City West	Golden Lane	Middlesex St & Mansell St	City of London
Cancer	36	41	27	46	38	41	39
Chronic kidney disease	35	31	44	27	36	87	40
Coronary heart disease	22	21	25	37	28	31	26
Depression	61	79	49	49	98	114	76
Hypertension	122	127	121	125	145	232	144
Obesity	33	39	52	40	56	122	53
Osteoporosis	25	21			22	16	20
Stroke/TIA	10	16			15	27	15
Type 2 Diabetes	20	22	32	16	39	108	36

Source: Primary Care data, North East London ICB. 2026.
Note: City residents are those registered with a GP in North East London with a City of London home postcode. Rates are age standardised based on the European Standard Population. Data with counts less than 10 have been removed to comply with disclosure controls.

These rates are age-standardised and therefore this higher prevalence cannot be solely attributed to the age profile of these areas; Golden Lane has an older population, while Middlesex Street & Mansell Street is younger in comparison.

Because these rates are age-standardised, the higher prevalence cannot be solely attributed to the area's age profile. Instead, it demonstrates a disproportionate disease burden within this specific community. This elevated risk is likely compounded by wider health determinants, such as housing quality, financial pressures, and localized barriers to healthcare access.

The Health Creation Alliance and City Healthwatch are exploring what might be driving these worse outcomes and they are investigating the health of residents within the Portsoken area. These findings are expected to be available in 2027.

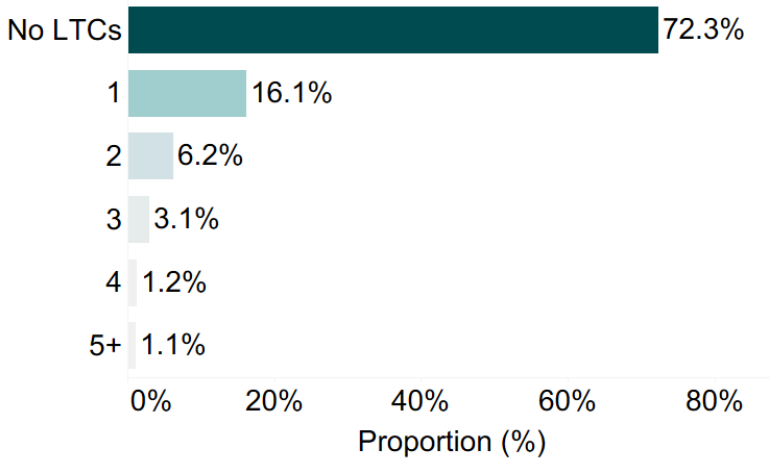
Multimorbidity

Multimorbidity is defined as the co-occurrence of two or more chronic conditions, for example an individual being diagnosed with both dementia and obesity [61].

In 2025, 12% of all City of London residents were recorded as multimorbid. Supporting this group requires local healthcare services to be integrated, as treating one condition can often complicate the management or medication of another.

At the severe end, 85 local residents (1% of the City's population) are currently diagnosed with five or more long-term conditions. This is currently half the NEL average of 2%.

Figure 47: Proportion of patients diagnosed with long term conditions, City of London, 2026



Source: Primary care data, North East London ICB, 2026

Note: City residents are those registered with a GP in NEL who have their home postcode in the City.

While anyone can develop multiple long-term conditions, the risk is not shared equally. National evidence highlights an intersection between health inequalities, discrimination, and the likelihood of developing complex health issues [62].

Socioeconomic factors

Socioeconomic disadvantage is a driver of chronic illness. National Institute for Health and Care Research suggests, people with the lowest incomes are up to four times more likely to have multiple conditions compared to those with the highest incomes [62]. Furthermore, those living in the most deprived areas acquire multimorbidity 10 to 15 years earlier than those in the most affluent areas [62].

In the City, prevalence of multimorbidity is similar across deprivation deciles. This is likely linked to all areas in the City being ranked in line or above the average national deprivation.

Ethnicity

People from Indian, Pakistani, Bangladeshi, Black African, and Black Caribbean backgrounds are at an increased risk [62].

Locally, the multimorbidity rate is higher for specific minority ethnic groups. GP records show almost a quarter of the Bangladeshi community have multiple chronic illnesses, which is double the City average. Outcomes are worse for Black Caribbean residents as this figure rises to nearly a third (Table 12).

Table 12: Proportion of residents by number of long term conditions, City residents, 2025

Number of LTCs	Bangladeshi	Black African	Black Caribbean	All City residents
No LTC	60.9%	54.9%	48.4%	72.3%
1 LTC	15.7%	20.8%	19.4%	16.1%
2 or more LTCs	23.5%	24.3%	32.3%	11.6%

Source: Primary care data, North East London ICB, 2026

Note: Caution should be applied due to small counts. City residents are those registered with a GP in NEL who have their home postcode in the City. Indian and Pakistani residents were excluded due to small counts.

Other vulnerable residents

National data shows adults from sexual minority groups, especially young women, are more likely than others to have long-term mental and physical conditions [63].

As mentioned above, people experiencing homelessness are also more likely to suffer from multiple physical and mental health conditions at once [64].

Mental Health Conditions

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community [65].

When people have difficulties coping because of challenges with mood, thinking and/or behaviour, they may be diagnosed with a mental illness or mental health condition. People living with mental health conditions are another key priority area in the new national Neighbourhood Health Framework.

Prevalence of mental health conditions

Common mental health conditions

Nationally, about 1 in 5 adults in England report living with a common mental health condition (CMHC) like depression or anxiety. Levels of reported CMHCs have increased in the past 10 years, especially among women.

The rate of recorded depression amongst City of London residents has increased, from 71 per 1,000 residents in 2024 to 76 in 2025, but this rate is lower than London and England.

In 2025, depression rates vary by ethnicity and sex. White residents have the highest rate, followed by Black residents and depression is higher for females compared to the general population (Table 13). Small numbers of residents with diagnosis can cause large changes to rates and caution should be taken when comparing across years and ethnicity groups.

Table 13: depression diagnoses by ethnicity, age standardised rates per 1,000, City of London, 2025

Ethnicity	2022	2023	2024	2025
Asian	67	58	50	51
Black	74	80	75	82
Mixed	71	65	73	68
Other and not stated	52	54	51	60
White	81	80	80	83
Total population	71	71	71	76

Source: Primary Care data, North East London ICB. 2026.
Note: City residents are those registered with a GP in North East London with a City of London home postcode. Rates are age standardised based on the European Standard Population. Data with counts less than 10 have been removed to comply with disclosure controls. Small numbers of residents with diagnosis can cause large changes to rates and caution should be taken when comparing across years and ethnicity groups.

Severe mental illness

Severe mental illness (SMI) includes mental health conditions which can significantly impact a person's ability to manage daily living such as schizophrenia, bipolar affective disorder and other psychotic illnesses.

The rate of diagnosed SMI among City of London residents (0.9%) is similar to North East London (1.1%) and England (1.0%) overall. However, the rate in the City has increased slightly since 2022 (0.7%).

Rates of diagnoses are similar for men and women, but highest amongst White residents.

Table 14: Proportion of residents with mental health conditions, comparison by area and data source 2025

Metric	City of London (GP records only)	North East London	England*
Depression	8.2%	10.1%	14.3%
Anxiety	4.0%	11.9%	Not available
Severe mental illness	0.9%	1.1%	1.0%
Eating disorders	67 per 100,000	47 per 100,000*	-

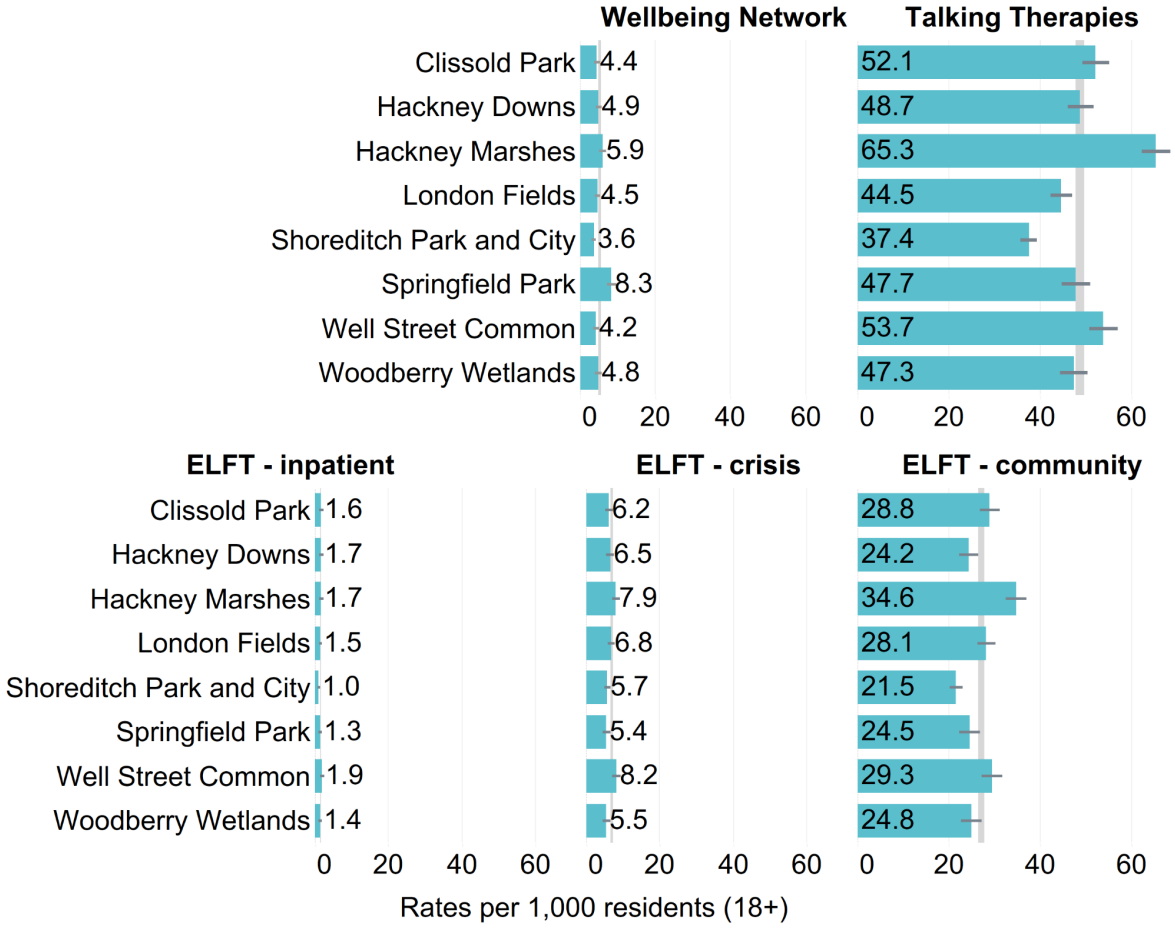
Source: Fingertips https://fingertips.phe.org.uk/profile/adult-mental-health-wellbeing. Population Metrics Viewer, North East London ICB.

Note: North East London rate for eating disorders is age standardised.

There are a range of sources of support for people experiencing mental health conditions in the City of London:

- **General practitioners** provide consultation and referrals for mental health concerns and can prescribe medications.
- **Talking Therapies** are provided by Homerton Healthcare as well as a number of VCS organisations. This service is designed for people experiencing symptoms of CMHCs including anxiety, depression and post-traumatic stress disorder.
- **East London NHS Foundation Trust (ELFT)** provides support for residents with severe mental illness in the community as well as inpatient services. ELFT also provides care for people experiencing mental health crises.
- **The Wellbeing Network** is a service provided by a group of VCS organisations and can support residents with mental health problems as well as more complex social factors like domestic abuse, insecure migration status, and culturally-specific needs.
- **The Systemic Family Therapy Clinic** is open to anyone accessing children's social care and early help, offering all tiers of support.

Figure 48: Service users assessed by/referred to the WBN, TTAD and ELFT inpatient, crisis, and community services, by primary care network, rate per 1,000, 2024



Most mental health services see the lowest rate of people from the Shoreditch Park and City Primary Care Network, apart from ELFT crisis services where the rate is still below average. This PCN also has a lower than average prevalence of mental health conditions locally and the lowest prevalence of SMI. Services such as the Wellbeing Network and Talking Therapies have conducted intermittent outreach and engagement work to increase uptake of their support among City residents such as delivering events in partnership with local community organisations. This can be limited due to resource constraints.

Eating disorders

In the City of London, there is a growing need for eating disorder support. Between 2020 and 2024, the primary care diagnosis rate for City residents was 67 per 100,000, while the hospital admission rate was 22 per 100,000 [66].

Suicide

Rates of death by suicide are very low amongst City of London residents. However, the Square Mile remains a location of concern due to the number of people from other areas of the country who attempt or die by suicide. There are a range of initiatives in the City of London to prevent and reduce the impact of suicide including a street triage service, workplace wellbeing programmes, and efforts to improve safety of public spaces and the built environment.

System gaps

The challenges identified in the City and Hackney Adult Mental Health system are structured around four main themes, with governance and accountability issues seen as underlying the others:

- **Navigating and Accessing Services:** Residents and referring professionals can find it difficult to know which services are most suited to meet needs. This confusion can lead to mis-referrals, repetitive information sharing, and long waiting times. Furthermore, these challenges can be even greater for residents with complex co-occurring needs, sometimes excluding them entirely due to issues like substance use.
- **Knowledge, Insight, and Decision-Making:** Decision-making is constrained by fragmented data and insufficient insight. Key data on service utilisation, outcomes, and demographics (such as sexuality) are often incomplete or not routinely shared by providers, preventing a consistent, whole-system overview.
- **Inequalities and Inclusivity:** Certain groups (including residents living in more deprived areas, men, LGBTQIA+ communities, and some global majority ethnicity groups) are underrepresented in services. Accessibility is further challenged by practical barriers and limited funding for VCS organisations who could offer more culturally sensitive support.
- **Governance and Accountability:** Overarching governance and accountability is held across multiple organisations and can sometimes function in a siloed manner.. This results in service gaps, unclear funding streams for holistic interventions, and targets that can discourage service integration and partnership working.

Rough Sleepers and Mental Health

People sleeping rough are a vulnerable group. They experience severe mental health conditions at higher rates than the general population. However, their needs are often hidden because they are frequently missing from routine GP data. This is explored further in the homelessness chapter.

To address this gap, it is recommended to conduct further exploratory analysis. This should include reviewing specific service-level data from targeted outreach teams, such as the Rough Sleepers Adult Mental Health Project (RAMHP).

Neurodiversity

Neurodiversity refers to the diversity of human minds meaning it is expected for brains to be different and unique. Our brain development is influenced by a range of genetic and environmental factors and while all brains have commonalities, they can also differ. Autism, attention deficit hyperactivity disorder (ADHD) and dyslexia are examples of brain differences [67,68].

Historically these differences have been viewed through a deficit lens. This means that in some settings those individuals who are neurodivergent[28] are considered less than because they do not fit into ideas of what it is to be 'typical' [68].

Prevalence

Recent national data from the Adult Psychiatric Morbidity Survey (APMS 2023/24) illustrates that prevalence of neurodivergent conditions has likely remained stable over time, but the clinical and social need for support services has risen. This increased demand may be driven by a growing public awareness, better diagnostic criteria, and adults seeking diagnoses for conditions that were missed during their childhood.

National levels of autism have remained consistent over the past decade. The prevalence of autism in adults in England has been stable since 2007, remaining at approximately 0.8% (roughly 1 in 100 adults) [69].

While prevalence may be stable, the proportion of adults screening positive for possible ADHD symptoms has increased sharply. In 2023/24, 13.9% of adults screened positive for ADHD, up from 9.7% in 2014 and 8.2% in 2007 [70].

The local picture

In June 2025, autism was formally diagnosed at a rate[29] of 11.6 per 1,000 residents in the City. This is slightly lower than the broader North East London average of 12.1 per 1,000 residents.

Currently, historical trend data and demographic data for the City of London are not available, which presents a data gap in monitoring changes over time and health inequalities.

Services

Local authorities have duties under the Autism Act 2009 and the Care Act 2014 to assess local needs and develop appropriate autism strategies. While an autism diagnosis does not confer automatic entitlement to services, adults with eligible care and support needs may access provision under the Care Act. Separately, local authorities hold distinct statutory duties to assess eligibility for housing assistance, independent advocacy, and Special Educational Needs and Disabilities (SEND) support for young people up to age 25.

The City and Hackney Adult Autism Service

The Adult Autism Service in City and Hackney is run by ELFT. This service provides diagnostic assessments, brief interventions, and advisory support for adults without a prior autism diagnosis.

The service is accessible to individuals aged 18 and over who are registered with a City and Hackney GP.

[28] Neurodivergent refers to those children whose development diverges from typical developmental expectations. This is often a lifelong difference, such as being autistic. Neurodivergence is its own way of being and should be respected.[68]

[29] Rates are age standardised.

Child and Adolescent Mental Health Service (CAMHS).

The CAMHS Disability service provides targeted mental health, emotional, and behavioural support for children and young people (aged 0 to 18) with neurodevelopmental conditions. The team provides a comprehensive offer, including diagnostic assessments, therapeutic and pharmacological interventions, and dedicated group work for parents and siblings. It also runs a specific Autism Assessment Pathway for children aged 5 to 18.

Similar to the Adult Autism Service, access to both the core disability service and the autism pathway requires the patient to be registered with a GP in the City of London or Hackney.

This GP registration requirement presents a barrier to access for City residents. As highlighted in the primary care data, almost all children aged 14 and under living in Middlesex Street & Mansell Street are registered with neighbouring GP practices located in Tower Hamlets. This highlights a gap in cross-border care pathways, leaving families of children with complex disabilities at risk of falling through the gaps between different health systems.

A comprehensive review of the specific health, care, and educational needs for this younger demographic is available in the recently published City and Hackney Health Needs Assessment for Children and Young People with Special Educational Needs and Disabilities (2024).

Chapter 8. Needs & Inclusion

Introduction

Good health relies on strong building blocks. When everyone has what they need, our community thrives. However, some individuals face significant barriers when accessing healthcare and support. These are often people who are socially excluded, who experience overlapping risk factors for poor health, stigma and discrimination. Without adequate support, this leads to worsening health and increasing disparities.

This chapter takes a deeper dive into the inclusion health groups in the City:

- Homelessness
- Substance use
- Sex workers

It is important to acknowledge this chapter is not exhaustive and does not include all inclusion health groups. For example, migrants are not included due to a lack of available data. In addition, due to limited resources, the chapter does not include voices of people with lived and living experiences.

Homelessness

Box 12: National Context

In December 2025, the UK government released A National Plan to End Homelessness, outlining plans to end homelessness and rough sleeping, ensuring that everyone has access to a safe, decent and secure home. It sets out aims to build 1.5 million new homes and invest 3.5 billion in homelessness and rough sleeping services [65].

Nationally, the scale of this challenge is reaching unprecedented levels. In autumn 2025, there was a record high of 4,793 people sleeping rough, surpassing the previous 2017 peak. This is the fourth annual increase in a row, increasing 3% since 2024, and 171% higher than 2010 when the snapshot data was introduced [26].

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data was introduced [72] .

Local context

The North East London Homeless Health strategy 2025-2030 outlines that homelessness is not static, takes many forms and individual experience of homelessness often changes over time [73].

In 2025/26, 757 individuals were recorded rough sleeping in the Square Mile, which is a decrease from 873 in 2024/25. This is following a year on year rise from 350 in 2020/21 [74].

Outreach services are active 7 days a week, conducting a minimum of seven weekly shifts alongside non-verification shifts. During the 2025/26 period, 48% (nearly half) of the individuals sleeping rough in the City of London were seen just once, and 13% were seen twice. These statistics underline the high level of transiency among the rough sleeping population within the Square Mile [74].

Demographic information

In the latest year, 89% of people sleeping rough in the City of London were male and 10% were female.

The figure does not represent the true extent of rough sleeping women. Undercounting female rough sleeping remains a recognised issue nationally. Women's rough sleeping is hidden, transient and intermittent. Women are sleeping rough in locations and ways which are not recognised within the existing definition of rough sleeping[75].

To address this, the City launched a pilot programme with two weekly non-verification outreach shifts to identify and support hidden homeless women. It provides tailored assistance and referrals to substance use, mental health, and physical health services, and reconnects individuals with existing support.

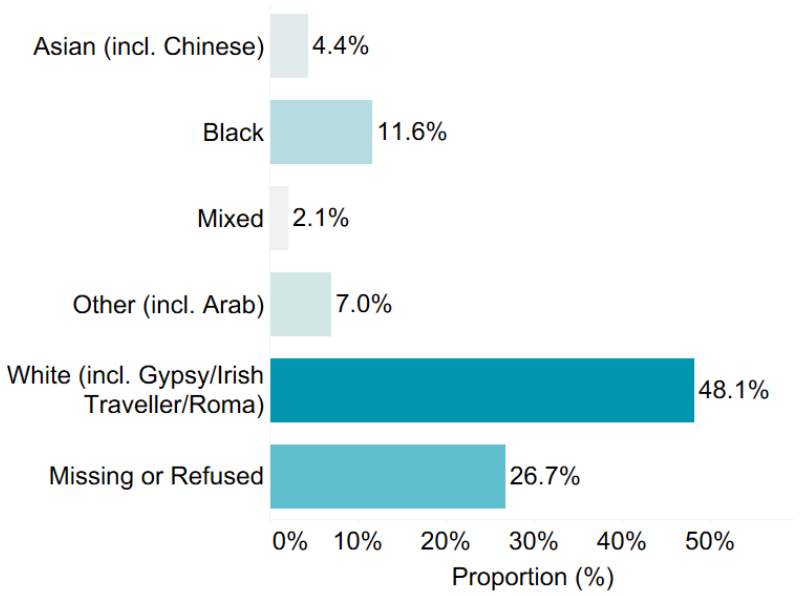
This year, the pilot has identified 14 women and is working with four, one of which has returned to another borough and is working with their outreach team.

The pilot goes some way to address the hidden homelessness, however the likelihood remains that there is still unmet need. A full evaluation of the gender-informed outreach approach and a review of the evidence should be explored after the pilot.

Overall, the majority of verified rough sleepers are in the young to middle-aged adult brackets, with individuals aged 26 to 35 forming the largest group at 38% (288 people), followed closely by those aged 36 to 45 at 31% (238 people).

Among those whose nationality was recorded, nearly two-thirds were UK nationals (66%), followed by European Economic Area nationals at (14%) and African nationals at (11%). In terms of ethnicity, 48% were identified as White (including British, Irish, Roma, and Gypsy/Irish Traveller backgrounds), (11%) as Black, (7%) as Arab or Other, and (4%) as Asian [76].

Figure 49: Proportion of people rough sleeping by ethnicity, City of London, 2025/26



Source: CHAIN, 2026.

Note: it is not possible to disaggregate data for White and Gypsy Roma Traveller

Multiple disadvantage

Rather than an individual failing, multiple disadvantages is a systemic issue where people are frequently let down by services that treat problems in isolation. Long-term exposure to deprivation, poverty, trauma, neglect, and abuse typically shapes these circumstances.

Such structural inequalities express themselves through overlapping challenges, including domestic abuse, substance use, homelessness, criminal justice contact, and mental ill health [77]. Within the City of London, this is reflected by the fact that 69% of the 257 assessed individuals had a recorded mental health condition [74].

Furthermore, 46% of those assessed in the City had a history of imprisonment, and 17% had experience in care. Homelessness can be compounded by the criminal justice system, individuals leaving prison frequently face obstacles such as a lack of employment, difficulty securing settled accommodation, and capacity limitations within mental health services and adult social care [78][79].

Accurately identifying data on these overlapping vulnerabilities remains difficult. There is a need for further development of a system that can properly monitor and capture the level of need within this cohort [80].

Asylum seekers

In 2025/2026, of 98 newly rough sleeping individuals for whom prior accommodation history was recorded, 11% (11 people) had spent their last settled base in asylum support accommodation (NASS/other). Further 10% (10) had not had a settled base since arriving in the UK.

For those returning to rough sleeping in 180 days since their previous contact, 4% (10) had no settled base since arriving in the UK.

These figures show that a large proportion of rough sleepers in the City of London have been navigating the asylum system prior to experiencing homelessness.

Once an asylum seeker is granted refugee status, they face an abrupt transition out of asylum accommodation, with only a short period to secure housing and financial stability. This rapid transition frequently leads to destitution, as newly recognised refugees struggle to find employment, register for benefits and secure housing within an unreasonably tight timeframe [81].

Many asylum seekers will have been housed in asylum accommodation in different local authorities but rough sleep in the City of London, adding pressure to the rough sleeping support services.

Health and care needs

National research indicates that individuals experiencing homelessness face significant health inequalities, with much higher prevalence of both physical and mental health conditions compared to the general population, and experience frailty, and geriatric conditions, at an earlier age[82].

A national report by Homeless Link found that 81% (587) of respondents reported having at least one physical health condition but that comes down to 58% (423) when it comes to a physical health diagnosis with the most common being asthma (21%) [83].

Locally, there is limited data held on the health and care needs of people experiencing homelessness. However, among individuals who underwent support assessments, 69% exhibited mental health needs, 47% required drug-related support, and 37% needed alcohol support. 49% of individuals had more than one support need.

Also, 38% of the people supported by ASC in residential care have experienced rough sleeping. These individuals have more complex overlapping needs and earlier onset on long term conditions which can have an impact on ASC resources.

There is a need for system wide improvement in data collection to better understand individuals needs. Without a clear picture of need, discharge planning is often delayed or ineffective, increasing the risk of discharge to the street. Lack of registration with a local and/or specialist accessible GP can also leave post-discharge care unmanaged, contributing to deterioration in health and missed follow-up appointments.

Long term conditions

Long-term conditions (LTC) or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatments, for example: diabetes, cancer or cardiovascular disease. LTC are also a criteria for palliative care pathways, which could increase pressure on adult social care services in the City. However, the pathway is likely underutilised for people who are rough sleeping, not least because of difficulties in accessing formal diagnoses.

Of those experiencing homelessness, around 40% had been diagnosed with a long term condition, with mental health conditions being the most common diagnosis. Depression was the most common LTC with a third of the homeless population registered with a GP. This is a higher proportion compared to the total population (9%).

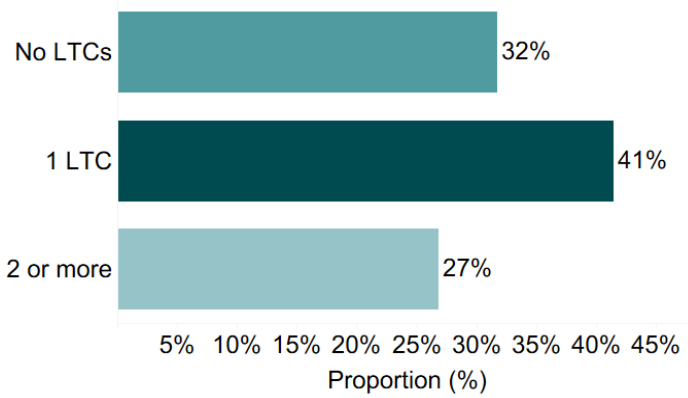
Cardiovascular and metabolic conditions were the next frequent conditions after mental health. This includes conditions such as hypertension, stroke, and obesity. Obesity in rough sleepers is often linked to poor nutrition, poor access to cooking facilities and healthier options, as well as substance use.

Multimorbidity

People who experience homelessness face higher rates of complex health issues compared to the general population. Globally, 45% of people who have experienced homelessness live with more than one long term condition[64].

While 12% of City of London residents live with multiple long-term conditions. This figure doubles to 27% among people experiencing homelessness who are registered with a NEL GP. This figure is likely to be an underestimation because many people experiencing homelessness are not registered with GPs and therefore will not be included in evidence. For this group, their complex-health needs remain hidden.

Figure 50: Multimorbidity among people experiencing homelessness, by disease group, City of London, 2025



Source: East London Database, Clinical Effectiveness Group, Queen Mary University of London, 2025.

There is also a high rate of trimorbidity within this vulnerable group. Globally, a third of people experiencing homelessness live with three interacting health complexities simultaneously: a physical condition, a mental health condition, and a substance or alcohol use dependency [64]. Of the studies, 30% were from UK settings.

Because of this, siloed healthcare is often ineffective. Integration, collaboration, and co-ordination between local housing, social care, and NHS services are needed to properly support the extreme health needs of this population [64].

Admitted patient care

Nationally, people experiencing homelessness attend A&E six times as often as people with a home, are admitted to hospital four times as often, stay three times as long, and are less likely to be registered with an appropriate GP [73].

Locally, the data is limited and does not reflect the true story. Over a five year period of 2020/21 to 2024/25, there were 25 admissions to patient care where homelessness was recorded as a diagnosis and the patient's residence was recorded as the City of London. This is a failure in reporting systems that do not properly capture people experiencing homelessness.

The lack of accurate data means their care needs are not fully known and therefore cannot be supported fully.

Local services

Greenhouse Practice

The Greenhouse is a specialist GP for people experiencing homelessness in City and Hackney. It is located in Hackney, approximately 3 miles from St Paul's or 2 miles from Liverpool Street. Therefore, there is a potential barrier to access, especially for those with mobility issues.

The Greenhouse team collaborates with the Thames Reach City outreach team and various partners to deliver street outreach. A significant constraint, however, is the service's operating hours of 8:00 am to 6:30 pm. This hinders the team's ability to engage with the most transient rough sleepers, who are frequently located outside the Square Mile during these specific times.

The Community Wellbeing Team

The Community Wellbeing Team (CWT) uses mobile outreach vehicles to support people in the City and Hackney. The CWT clinical van is used by Turning Point, SWERVE, and Greenhouse staff.

While the mobile outreach model makes progress in addressing the unmet needs of the rough sleeping population, it cannot fully substitute for a physical site within the City. CWT faces specific difficulties, including heavy traffic, navigating narrow streets, and the challenge of finding appropriate times when people are neither actively begging or bedded down. There is also the fact some individuals do not want to seek clinical support in a vehicle, which has space limitations and can't substitute for a clinical space.

Health Inclusion Team

The City Homelessness and Rough Sleeping team commissions Guy's and St Thomas' Health Inclusion Team to mitigate the lack of local clinical services at two City accommodation settings. The 14-bed Rough Sleeper Assessment Centre at Snow Hill Court and the 21-bed supported accommodation at Grange Road in Bermondsey.

The service runs one day a week in collaboration with the CWT using the van and trailer as Snow Hill Court assessment centre does not have a suitable clinical space.

Substance use

National Context

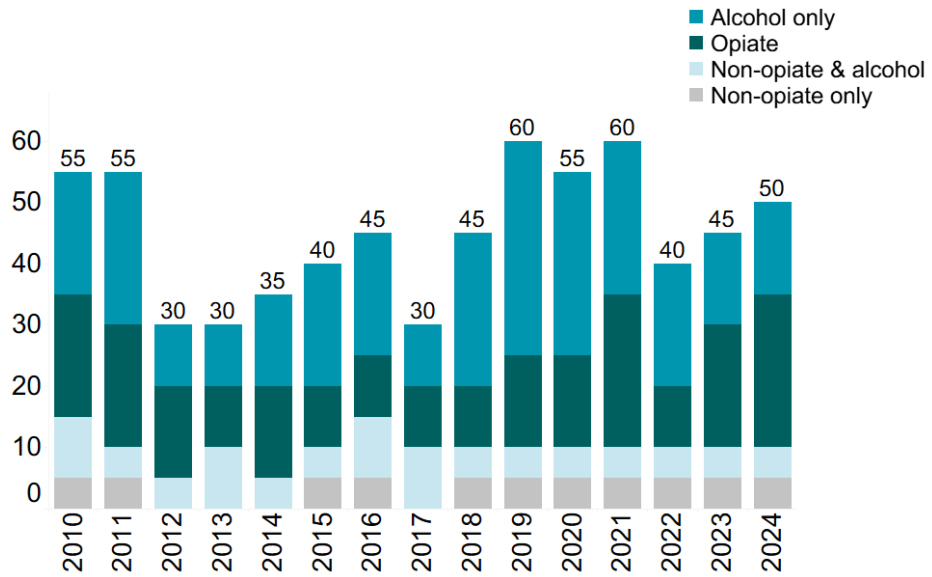
Nationally, there were 329,646 adults aged 18 and over in contact with drug and alcohol treatment services between April 2024 and March 2025 [84]. This is a 6% rise compared to the previous year (310,863) and the highest number of adults in treatment since reporting began.

The majority of those in treatment (42%) were there for problems with opiates. The proportion of adults in treatment for non-opiates (non-opiates and alcohol and non-opiates alone) has grown from 21% in 2020 to 2021 to 28% this year [84].

Local picture

The number of City adults in treatment has fluctuated over time. Recently, totals have increased from 40 to 50 in the last three years. Opiate cases represent the largest category recently (50%) aligning with national insight. Historically alcohol only represents a large proportion.

Figure 51: Number of people in treatment by substance category, City of London residents, 2010 to 2024



Source: NDTMS, 2024.

Substance use and homelessness

The need for highly accessible substance use services for rough sleepers is underscored by data. In 2024/25, outreach teams found 47% of rough sleepers required support for drug use[30]. This highlights the importance of ensuring substance use interventions are reachable for the homeless population.

Although the City of London does not hold a statutory housing duty for every individual sleeping rough (such as those without a local connection under homelessness legislation), the local authority maintains primary responsibilities for Care Act assessments, adult safeguarding, and providing drug and alcohol treatment to anyone bedded down within its boundaries, regardless of where their homelessness originated.

To combat this, joint funding partnerships with neighbouring boroughs could be explored for homelessness specific services.

Local services

Turning Point

Turning Point serves as the local drug and alcohol service for the City of London and Hackney. Similarly to the Greenhouse, its building is in Hackney. Asking residents to travel can create service access barriers, especially for those with long-term conditions or limited mobility.

In 2024/25, out of 910 new referrals to Turning Point, just 12 were confirmed as City residents (though 137 referrals lacked address information). This figure is very low and shows the service struggles to engage with residents, or they are using alternative private means for support.

Currently, the Turning Point Rough Sleepers Team maintain a regular presence in the City throughout the week. They work collaboratively with the outreach team, Greenhouse and CWT at Liverpool Street. The team also has a drop in clinic at Snow Hill Court assessment centre.

Expanding these local drop-in clinics in the City in a building designated space for people experiencing homelessness may reduce existing access barriers.

SWERVE harm reduction hub

SWERVE, City and Hackney Harm Reduction Hub, are a peer-led service that provides flexible needle and syringe provision (NSP). The service is run by volunteers and staff with lived and living experience of drug use, to provide a safe and judgement-free community space where people can collect safer drug-using kits, get harm reduction advice, and receive other support with accessing the services they need.

Young Hackney

The Young Hackney Substance Misuse Service (YHSMS) responds to the support needs of children and young people aged 6 to 19 and up to 25 with additional needs. They aim to help all

[30] 878 rough sleepers were engaged with. Assessments of 367 of these people revealed that 178 required support for drug use.

of Hackney's young people to enjoy their youth and become independent and successful adults. YHSMS responds to these needs by providing:

- Harm reduction interventions
- Education and prevention work (such as 'Dealing Intervention' and 'Prevention School and Professional Workshops')
- Identification of, and support for, families with parental substance use
- A Youth Justice function. Currently 56% of referrals into Young Hackney SMS are from the youth justice system

Pharmacies

As of 2026, no pharmacies in the City that dispense methadone for opioid substitution treatment (OST) or NSP.. This is a barrier for people needing to access daily prescriptions having to travel long distances. There are other pharmacies in neighbouring boroughs that are used by Turning Point to deliver prescriptions, including one in Camden, one in Islington and two in Tower Hamlets.

Alternative support provision

There are other service provisions not commissioned by the Corporation to support people with problematic drug and alcohol use. There are daily Alcoholics Anonymous groups running throughout the City and online. The meetings take place in the EC1, EC2, EC3 and EC4 postcodes and sessions start as early as 6am and run through lunchtimes in the evening.

Narcotic Anonymous meetings also run from Monday to Saturday in or within a mile radius of the City of London. There is no data held on these services and further work is required to understand if residents are accessing these services..

Sex Workers

National context

Sex workers face significant risks to their sexual and physical health, including disproportionately high rates of violence, sexual assault, and homicide [85][86]. These vulnerabilities are often worsened by co-occurring challenges such as homelessness and substance use, which create substantial barriers to accessing mainstream services [85]. Reluctance of individuals to disclose their circumstances to healthcare professionals stems from fear of stigma, judgment, and legal prosecution. Combined with inflexible services that lack trauma-informed approaches, it results in low engagement and significant unmet health needs[87].

Local

Open Doors, running since April 2019, supports sex workers in the City, both on-street and off-street. In 2025/26, there were 28 contacts with Open Doors with individuals who identified themselves as City of London residents, however, this could include the same individuals accessing the service more than once across the year. The service conducts welfare checks, takes them to appointments and provides support accessing housing and benefit services. They also offer pregnancy tests, condoms, naloxone, and NSP.

The link between substance use and sex work is well documented nationally [87,88]. In 2025/2026, 244 individuals who engaged with Open Doors reported drug use and dependency

across City and Hackney. This number cannot be disaggregated for City specific data.. 91 individuals were engaging in substance use support.

To better understand the health and wider needs of sex workers and inform targeted outreach and support, Open Doors employs a multi-agency approach. This involves collaboration with key local organisations such as the City of London Police, Turning Point, and SWERVE.

Abbreviations and Acronyms

ADHD - Attention Deficit Hyperactivity Disorder
APMS - Adult Psychiatric Morbidity Survey
APS - Annual Population Survey
ASC - Adult Social Care
ASH - Action on Smoking and Health
BBV - Blood-Borne Viruses
CEW - Complications in Excess Weight
CHD - Coronary Heart Disease
CIL - Community Infrastructure Levy
CMHC - Common Mental Health Condition
COLTALE - City of London Talks and Listens Enthusiastically
CSDS - Community Services Dataset
CSE - Child Sexual Exploitation
CWT - Community Wellbeing Team
CYP - Children and Young People
DAIS - Domestic Abuse Intervention Service
DHSC - Department of Health and Social Care
DsPH - Directors of Public Health
EEDI - Equity, Equality, Diversity and Inclusion
EHCP - Education, Health and Care Plan
ELFT - East London Foundation Trust
FPSBT - Financial Services, Professional Services, Business, and Technology
GBMSM - Gay, Bisexual and other Men who have Sex with Men
GLA - Greater London Authority
GP - General Practitioner
HCA - Health Care Assistant
HES - Hospital Episode Statistics
HHSRS - Housing Health and Safety Rating System
HIV - Human Immunodeficiency Virus
HWSP - Healthy Weight Strategic Partnership
ICB - Integrated Care Board
IDVA - Independent Domestic Violence Advocacy
IKWRO - Iranian Kurdish Women's Rights Organisation
IMD - Index of Multiple Deprivation
IRIS - Identification and Referral to Improve Safety
JSNA - Joint Strategic Needs Assessment
LARC - Long Acting Reversible Contraception
LOF - Local Outcomes Framework
LSOA - Lower Super Output Area

LTC - Long-Term Condition
MARAC - Multi-Agency Risk Assessment Conference
NCMP - National Child Measurement Programme
NEET - Not in Education, Employment or Training
NEL - North East London
NICE - National Institute for Health and Care Excellence
NIESR - National Institute of Economic and Social Research
NRT - Nicotine Replacement Therapy
NSP - Needle and Syringe Provision
OHID - Office for Health Improvement and Disparities
ONS - Office for National Statistics
OST - Opioid Substitution Treatment
PAYE - Pay As You Earn
PCN - Primary Care Network
PDS - Personal Demographics Service
PGSI - Problem Gambling Severity Index
PM - Particulate Matter
PrEP - Pre-Exposure Prophylaxis
QDS - Quit Dates Set
SCP - Safer City Partnership
SEN - Special Educational Needs
SEND - Special Educational Needs and Disabilities
SHL - Sexual Health London
SMI - Severe Mental Illness
SORT - Street Outreach Recovery Team
SRH - Sexual and Reproductive Health
SSS - Stop Smoking Service
STI - Sexually Transmitted Infection
TCA - Tobacco Control Alliance
TGNC - Transgender or Gender Non-Conforming
TIA - Transient Ischaemic Attack
UHI - Urban Heat Island
ULEZ - Ultra Low Emission Zone
VAT - Value Added Tax
VAWG - Violence Against Women and Girls
VCS - Voluntary and Community Sector
VRU - Violence Reduction Unit
WHO - World Health Organisation

Glossary of Terms

Term	Definition
Active travel	Active travel describes everyday journeys made by walking, wheeling, or cycling. It includes trips that are made by foot, pedal-cycles, e-cycles, adapted cycles, wheelchairs, mobility scooters and push-scooters.
Chemsex	Sexualised drug use.
Deprivation	The official measure of relative deprivation in England, linked to an increased risk of illness, lower access to care, and worse health outcomes.
Ethnic group	Ethnic groups are based on those used in the 2021 Census. This report includes the five broad categories (Asian, Black, Mixed, Other and White) and the 19 specific categories.
Genomic insights	Applying genomic and other insights to identify people who are at the highest risk of developing conditions such as obesity.
Essential workers	Essential workers—such as cleaners, security, and catering staff—keep the Square Mile operating. They are often employed by third-party contractors and face distinct health inequalities.
Houselessness	People who have temporary places to sleep, including people living in local authority temporary accommodation or in institutions, shelters or provided accommodation.
Inclusion health	A term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health, experience stigma and discrimination, and are not consistently accounted for in electronic records.
Long-term conditions	Conditions for which there is currently no cure, and which are managed with drugs and other treatments.
Metabolic condition	Health conditions such as hypertension, stroke, and obesity.

Multimorbidity	The co-occurrence of two or more chronic conditions.
Multiple Disadvantage	The systemic exclusion faced by individuals who experience two or more overlapping social and health challenges, most commonly homelessness, substance use, mental health issues, domestic abuse, and contact with the criminal justice system.
Neurodiversity	The different ways in which people's brains function, learn and process information.
Particulate Matter (PM)	A mixture of microscopic solid particles and liquid droplets suspended in the air, categorised by size (e.g., PM10 and PM2.5).
Rooflessness	People living without shelter and sleeping rough on the streets.
Severe Mental Illness (SMI)	Mental health conditions which can significantly impact a person's ability to manage daily living such as schizophrenia, bipolar affective disorder and other psychotic illnesses.
Small area	Small areas (also called lower super output areas or LSOAs) are statistical geographies set by the Office for National Statistics. They comprise between 400 and 1,200 households and have a usually resident population between 1,000 and 3,000 persons (based on the 2021 Census)
Social capital	Social capital is a term used to describe the extent and nature of our connections with others and the collective attitudes and behaviours between people that support a well-functioning, close-knit society (Office for National Statistics).
Total fertility rate	This measures the number of children born per woman of childbearing age (ONS).
Trimorbidity	The experience of three interacting health complexities simultaneously.
Whole system approach	An approach replacing fragmented interventions with a holistic model that addresses clinical needs alongside wider social determinants, requiring everyone from individuals to government and industry to work together to change environments and society.

Appendices

Appendix 1: Quantitative data used in analysis

Population and Demographics

- Office for National Statistics (ONS): Census 2021, Annual Population Survey, and Business Register and Employment Survey are used to map the resident and worker populations.
- NHS England: Patients Registered at a GP Practice is used to track the local GP-registered population. This is sourced from Patient Demographic Service and Hospital Episode Statistics.

Health and Social Care Outcomes

- NHS England / NHS Digital: Hospital Episode Statistics (HES) and NHS Digital Births data provide data on hospital admissions and local birth rates.
- North East London Integrated Care Board (NEL ICB): Primary care records and Client Level Data provide insight into the prevalence of long-term conditions, dementia, and smoking.
- Clinical Effectiveness Group (CEG), Queen Mary University of London: The East London Database offers local data on multimorbidity and specific health conditions.

Wider Determinants of Health

- Ministry of Housing, Communities & Local Government: Index of Multiple Deprivation (IMD) 2025 is used to assess local deprivation across multiple domains.
- City of London Corporation & Police: Local data including the Air Quality Strategy, and City of London Police Crime Statistics.
- Homelessness Data: The Combined Homelessness and Information Network (CHAIN) tracks rough sleeping trends.
- Department of Education: Data on young people Not in Education, Employment, or Training (NEET).
- Office for National Statistics (ONS): Crime Survey for England and Wales.

Health Behaviours and Lifestyles

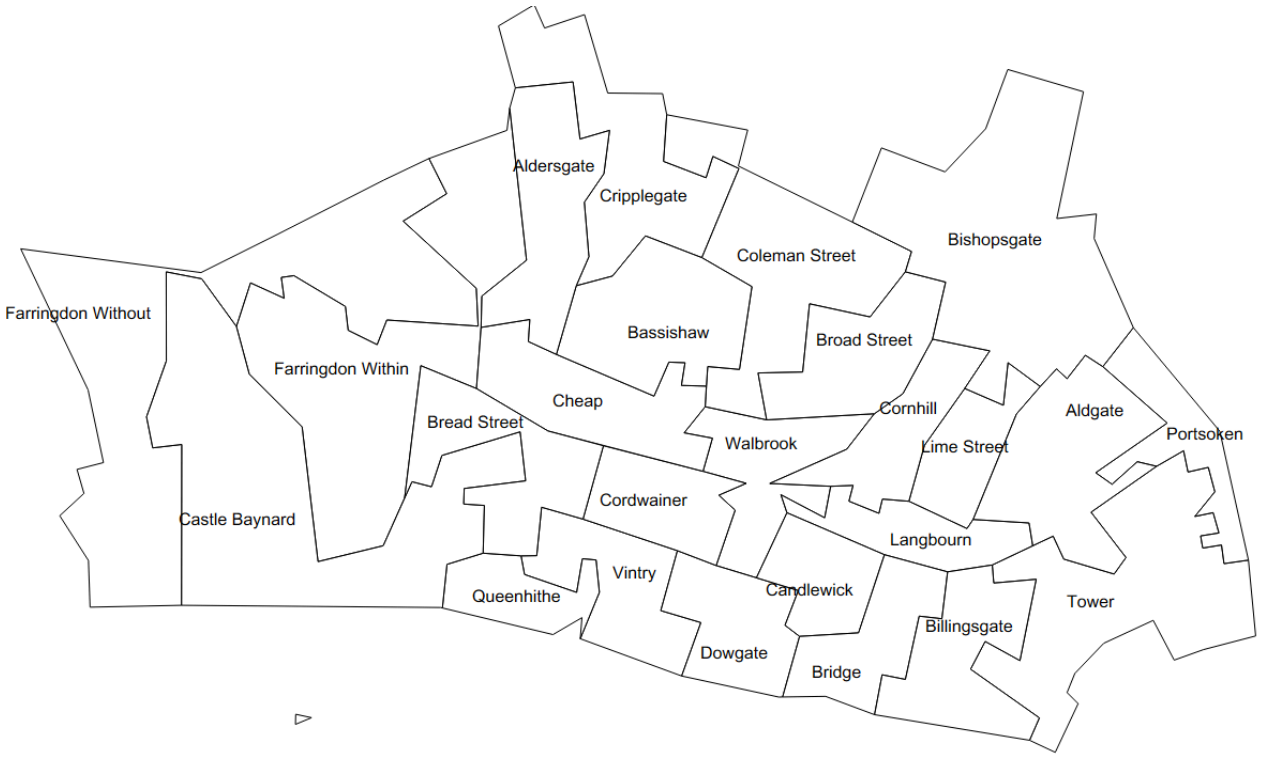
- Department of Health and Social Care: Fingertips public health profiles supply benchmarked data on obesity, physical activity, nutrition, and adult mental health.
- Sports England: The Active Lives and Active People Surveys provide data on adult physical activity levels.
- Sexual Health Services: Pathway Analytics , SHL.uk , and Preventx track the usage of sexual and reproductive health clinics and online STI testing.
- Local Services: Data from the Gloji Stop Smoking Service

Appendix 2: Map of small areas and their wards

City of London lower super output areas (small-areas) and ward boundaries.



City of London ward boundaries.



Appendix 3: Information on data sources used to estimate population size

The GP registration list

These estimates are derived from the number of individuals registered with a GP in England whose home postcode falls within the City of London. The data uses the NHS Personal Demographics Service (PDS) to confirm patient identity and link care records.

Includes: City residents who are registered with an NHS, and people experiencing homelessness if they are registered with the GP.

Excludes: Patients registered with a private GP are not included and inclusion health groups (such as irregular migrants or people experiencing homelessness) are less likely to be included.

While it is considered an accurate dataset, research conducted by the ONS shows the PDS can lead to some overcoverage for urban areas with high population churn, like the City.

Possible reasons for over counting

- ↑ Individuals moving without deregistering with their GP
- ↑ Shared custody of children with split residence is not flagged in the medical record
- ↑ Instances where a single patient has multiple records (e.g., due to unlinked surname changes)
- ↑ Records remaining at a previous address after a patient moves to nursing/residential care
- ↑ Delays in removing records for individuals who have recently died

Possible reasons for under counting

- ↓ Individuals de-registering and moving without registering again
- ↓ Babies born but not registered in a timely manner
- ↓ Individuals moving into the area and delaying registration
- ↓ Individuals inappropriately removed from a GP list due to "no-contact"

Census 2021 estimates

For the 2021 Census, a usual resident of the City of London is defined as anyone who, on 21 March 2021, was in the City of London and had stayed, or intended to stay, for 12 months or more. This includes people with a permanent City of London address who were outside the UK for less than 12 months.

Includes: People who have lived, or intend to live, in the City of London for 12 months or more, such as students and long-term residents.

Excludes: The weekday resident workforce, tourists, and short-term visitors.

The Census is the national standard for measuring the size and characteristics of the population. However, errors in estimates can occur.

Possible reasons for over counting

↑ People with multiple residences (e.g a City residence for work and a country home for weekends) may be counted twice.
↑ Shared custody of children with split residence is being recorded in both households.

Possible reasons for under counting

↓ The Census captures a snapshot of the population on a single date therefore residents who were temporarily away or moving home on that day may have been counted elsewhere. This limitation was likely exacerbated by the COVID-19 pandemic.
↓ Despite ONS adjustments, the Census can miss specific groups, particularly recent immigrants or those in irregular housing.
↓ The Census uses a strict definition of where someone spends the majority of their time. This excludes the transient City population who, despite not being counted as residents, may still access local services.

Annual Population Survey

The insights on the demographics of the worker population were compiled by the Office for National Statistics (ONS) following a series of requests submitted in June to August 2025. The data provided for all characteristics is derived from the Annual Population Survey (APS).

The APS is a continuous household survey covering the UK, with the aim of providing estimates of variables such as the number of people in employment. The APS is one of the recommended data sources for employment related estimates.

Includes: Workers aged 16 and over who identify their place of work in the "City of London".

Excludes: Workers aged under 16 years, those living in communal establishments or students in boarding schools.

Limitations that may impact data quality

- Some respondents give 'City of London' as a generic response when their workplace may not strictly be within that area.
- Variable response rates for certain questions (e.g. religion, sexual identity).
- Small sample sizes for certain characteristics result in less reliable estimates.

Appendix 4: Voluntary and Community Sector (VCS) Engagement Workshop

As part of the qualitative data gathering for the City of London JSNA, a community engagement workshop was held on 11th February 2026 at the Golden Lane Community Centre. The primary aim of this workshop was to gather a range of lived experiences for people living and working in the City.

The session was designed to:

- Capture qualitative evidence explaining the specific barriers residents face when navigating health and social care.
- Identify key health challenges and inequalities from a community perspective.
- Highlight what is currently working well in the City so existing strengths can be built upon.

Methodology

The workshop utilised a 'World Café' methodology to encourage dynamic, collaborative discussions. Participants were divided across three tables, each focusing on a core pillar of the population health system:

- Wider Determinants of Health
- Health Behaviours and Outcomes
- Service Access (including primary, secondary care, and adult social care)

Each table was supported by a lead facilitator and a note-taker from the City & Hackney Public Health team. Participants reviewed local data infographics and rotated through all three tables, discussing the biggest challenges, identifying which demographic groups are most impacted, and sharing local success stories.

Participating Organisations

To ensure a wide range of professional and community views were captured, representatives from various grant-funded organisations, commissioned services, and local community groups were invited.

Representatives and volunteers from the following 13 organisations and community groups attended the workshop:

- Age UK City of London
- Care to Dance
- City Advice
- City Carers Community
- Family Action
- Family Emotional Wellbeing Project C.I.C.
- Hackney CVS / VCS Neighbourhoods
- Healthwatch City of London
- Homerton Healthcare NHS Trust Charitable Funds
- Mental Fight Club
- Royal National Institute for Deaf People
- The Jewish Square Mile foundation
- Volunteer Centre Hackney (including the Together Better project)

Appendix 5: Residents by ethnicity and lower super output area, 2021

Proportion of residents by ethnic group and small-area, 2021

Ethnic group (broad)	Ethnic group (narrow)	Barbican East	Barbican West	City Central & East	City West	Golden Lane	Middlesex St & Mansell St
Asian	Bangladeshi	0.6%	0.3%	0.2%	0.0%	0.7%	23.8%
Asian	Chinese	7.4%	4.5%	7.5%	12.1%	3.3%	3.1%
Asian	Indian	2.6%	3.3%	7.7%	3.5%	2.5%	2.1%
Asian	Other Asian	2.2%	2.6%	3.6%	3.8%	3.1%	2.8%
Asian	Pakistani	0.1%	0.1%	0.7%	0.9%	0.1%	0.1%
Black	African	0.5%	0.5%	0.9%	0.9%	2.2%	7.1%
Black	Caribbean	0.2%	0.2%	0.2%	0.3%	0.9%	2.4%
Black	Other Black	0.0%	0.0%	0.1%	0.1%	0.5%	1.4%
Mixed	Other Mixed or Multiple ethnic groups	1.9%	1.2%	3.0%	1.4%	2.8%	2.4%
Mixed	White and Asian	2.1%	2.0%	2.4%	2.4%	2.2%	1.5%
Mixed	White and Black African	0.4%	0.5%	0.5%	0.3%	0.6%	1.1%
Mixed	White and Black Caribbean	0.3%	0.2%	0.9%	0.5%	0.4%	1.7%
Other	Any other ethnic group	2.8%	3.1%	3.3%	2.9%	5.6%	9.2%
Other	Arab	0.9%	1.5%	1.4%	0.9%	1.1%	2.2%
White	English, Welsh, Scottish, Northern Irish or British	52.9%	55.5%	35.0%	32.9%	50.4%	23.5%
White	Gypsy or Irish Traveller	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
White	Irish	3.0%	2.3%	1.6%	2.5%	2.3%	1.5%
White	Other White	21.6%	21.4%	29.6%	33.7%	21.2%	13.6%
White	Roma	0.3%	0.7%	1.3%	0.9%	0.2%	0.5%

Source: Census 2021, Office for National Statistics, 2021

Appendix 6: Residents by English proficiency, 2021

Number and proportion of residents by English proficiency and small-area, City of London, 2021

Small-area name	Total residents	Residents whose main language is not English		Residents who do not speak English or who do not English well	
		Number	Proportion (%)	Number	Proportion (%)
Barbican East	1,363	239	17.5%	5	0.4%
Barbican West	1,449	203	14.0%	5	0.3%
City Central & East	1,606	413	25.7%	24	1.5%
City West	1,376	407	29.6%	16	1.2%
Golden Lane	1,586	250	15.8%	13	0.8%
Middlesex St & Mansell St	1,071	315	29.4%	72	6.7%

Source: Census 2021, Office for National Statistics, 2021

Proportion of residents in the City of London who reported they do not speak English or do not speak English well, by age group, 2021

Age group	City of London			Middlesex St & Mansell St		
	Total residents	Number	Proportion (%)	Total residents	Number	Proportion (%)
Aged 15 and under	442	4	0.9%	107	3	2.8%
Aged 16 to 24 years	1,149	6	0.5%	199	3	1.5%
Aged 25 to 34 years	2,210	23	1.0%	215	7	3.3%
Aged 35 to 49 years	1,819	28	1.5%	208	9	4.3%
Aged 50 to 64 years	1,615	53	3.3%	235	31	13.2%
Aged 65 years and over	1,206	26	2.2%	105	19	18.1%

Source: Census 2021, Office for National Statistics, 2021

Appendix 7: National deprivation deciles (IMD 2025)

National deprivation deciles of small-areas by domain, City of London (IMD 2025)

Deprivation domain	Barbican East	Barbican West	City Central & East	City West	Golden Lane	Middlesex St. & Mansell St
Index of Multiple Deprivation (IMD) Decile	10	8	8	8	8	5
Barriers to Housing and Services Decile	10	9	6	9	10	4
Crime Decile	10	10	10	10	9	8
Education, Skills and Training Decile	10	10	9	10	9	5
Employment Decile	10	10	9	10	8	6
Health Deprivation and Disability Decile	10	10	6	5	7	4
Income Decile	10	10	10	10	8	5
Living Environment Decile	2	1	1	1	2	2

Source: Index of Multiple Deprivation (IMD) 2025, Ministry of Housing, Communities & Local Government, 2025

Appendix 8: Occupations of workers in the City

Number and proportion of workers by occupation, City of London, 2023 and 2024

Sector	Employment in 2023		Employment in 2024	
	Number	Proportion	Number	Proportion
Financial Services	220,975	32.70%	225,550	33.35%
Professional Services	182,260	26.97%	181,005	26.76%
Technology	98,300	14.55%	97,175	14.37%
Business Services	70,600	10.45%	63,400	9.37%
Retail and Hospitality	26,000	3.85%	27,000	3.99%
Other Sectors	17,245	2.55%	15,280	2.26%
Health and Social Care	15,500	2.29%	15,000	2.22%
Real Estate	11,000	1.63%	14,450	2.14%
Construction	9,000	1.33%	11,250	1.66%
Wholesale Trade	7,100	1.05%	9,125	1.35%
Education	7,000	1.04%	7,000	1.03%

Note: Sector groupings have been customized to better reflect the makeup of employment in the City, rather than strictly following the SIC07 codes used by the ONS.

Appendix 9: Demographic breakdowns of City workers

Number of workers employed in the City of London by sex and age, financial year 2024/25

	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 and over
Female	22,149	91,198	68,285	41,747	23,696	4,608
Male	38,316	127,996	121,424	89,956	46,881	7,815
Total	60,465	219,194	189,709	131,703	70,577	12,423

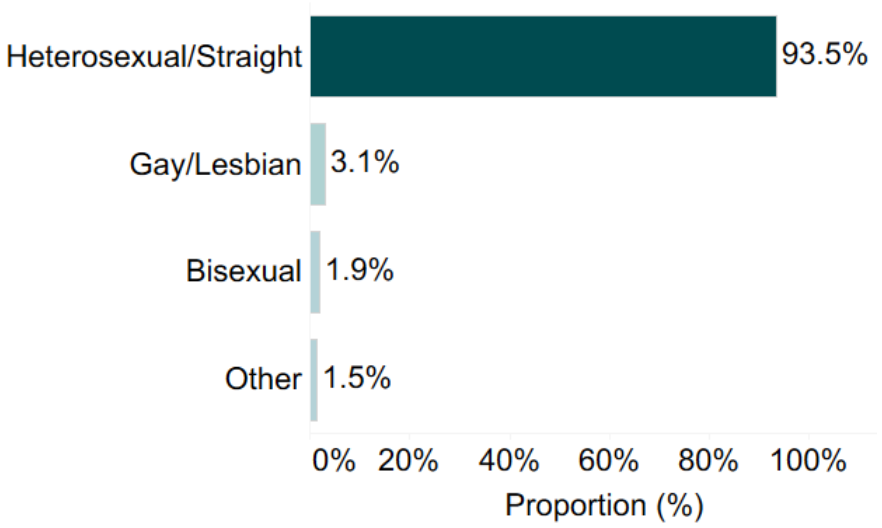
Number of workers employed in the City of London by sex and disability, financial year 2024/25

	Equality Act Disabled	Not Equality Act Disabled
Female	38,361	212,965
Male	28,078	399,835
Total	66,439	612,800

Number of workers employed in the City of London by ethnicity and sex, financial year 2024/25

	Asian	Black	Mixed	Other ethnic group	White
Female	40,224	28,949	14,596	18,436	148,869
Male	82,253	33,225	8,792	27,106	279,651
Total	122,477	62,174	23,388	45,542	428,520

Proportion of workers employed in the City of London by sexual orientation, January 2023 to December 2023



Source: Annual Population Survey, January 2023 to December 2023 (weighted 2022), Office for National Statistics, 2026

Note: For ethnicity, disability and sexuality estimates are based on a small sample size. This may result in less precise estimates, which should be used with caution. Under the 2010 Equality Act, you are defined as disabled if you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities.

Appendix 10: Estimating the population of children and young people in the City

Primary care registers consistently record a higher number of children and young people compared to the 2021 Census.

Number of children living in the City, by age group, Census compared to GP records

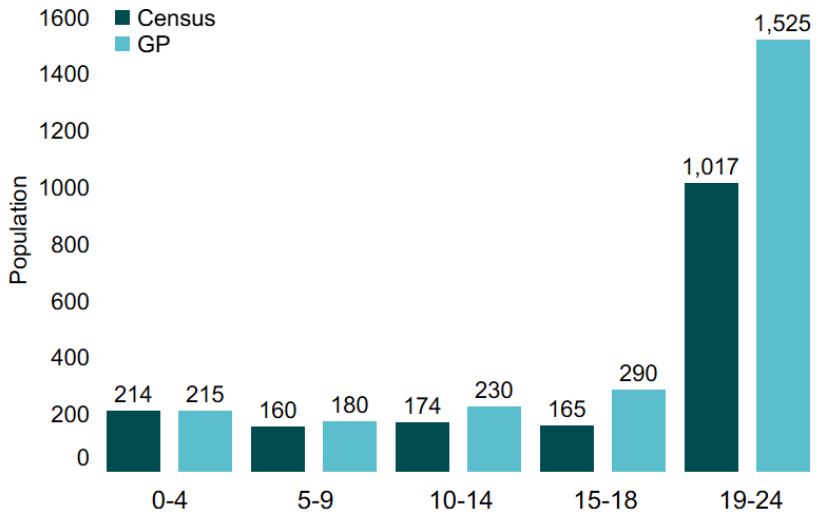
Age group	Census 2021		GP records	
	Number	Proportion of total population	Number	Proportion of total population
Aged 0 to 18 years	713	8.3%	920	7.5%
Aged 0 to 24 years	1,730	20.2%	2,445	19.9%

Source: Census 2021, Office for National Statistics. GP registration via Hospital Episode Statistics (HES), NHS England, 2026.

Note: GP records have been rounded to the nearest 5 to comply with disclosure controls.

For younger cohorts (those aged 0 to 9 years), this discrepancy is minimal. The difference between the two data sources increases progressively with age, with the greatest gap of 508 individuals within the 19 to 24 age group. This may be linked to the transient student population; young adults studying in the area registering with a local City GP using their university term-time address.

Number of children living in the City by age group, aged 24 and under, Census compared to GP records, by age



Source: Census 2021, Office for National Statistics. GP registration via Hospital Episode Statistics (HES), NHS England, 2026.

Note: GP records have been rounded to the nearest 5 to comply with disclosure controls. As a result, the sum of individual age groups or small area breakdowns may not match the aggregate totals.

Appendix 11: Comparison of data sources for dementia diagnosis in City of London, 2025

Residents in the City of London who have been diagnosed with dementia, by age group and data sources, 2025

Dataset	Age Group	Prevalence (%)	Recorded Dementia Diagnoses (Numerator)	Population Denominator
GP Records Only	All Ages	0.3%	25	7,725
	Aged 65+	1.9%	25	1,296
Combined GP & ASC Records	All Ages	0.5%	36	7,841
	Aged 65+	2.6%	35	1,361

Source: Primary care records, Client Level Data, North East London ICB, 2026

Note: Population denominators are based on recorded individuals. For GP records, the denominator includes only City residents registered with a North East London GP. The combined data source denominator expands this by adding records for individuals known to Adult Social Care who are not captured in the GP data.

Appendix 12: Long term conditions by small areas

Long term conditions related to poor housing conditions and air quality by small area (LSOA), City of London, 2025

	Barbican East	Barbican West	City Central & East	City West	Golden Lane	Middlesex Street & Mansell Street	City of London
Asthma	4.7%	4.2%	1.8%	2.2%	4.3%	3.4%	3.5%
Depression	7.1%	9.9%	5.6%	6.3%	13.1%	11.5%	9.1%
Severe Mental Illness	0.4%	0.7%	0.4%	0.5%	2.1%	1.0%	0.9%

Source: East London Database, Clinical Effectiveness Group, Queen Mary University of London, 2025

Appendix 13: GP registrations of all City residents

GP Practices with more than 100 City of London residents as registered patients, 2026

GP Practice (Code)	Practice Location	Number of Residents
The Neaman Practice (F84640)	City of London	6,286
Goodman's Field Health Centre (F84039)	Tower Hamlets	990
King's College Health Centre (E87768)	Westminster	926
Clerkenwell Medical Practice (F83624)	Islington	737
St Philips Medical Centre (F83672)[31]	Westminster	635
The Spitalfields Practice (F84081)	Tower Hamlets	525
GP At Hand (E85124)	Hammersmith & Fulham*	345
Gray's Inn Medical Group Chancery Lane (F83042)	Camden	326
GP Pathfinder Clinics (E84066)	Brent*	234

Source: Patients Registered at a GP Practice, NHS England, January 2026

Note*: Main registered address

[31] The St Philips Medical Centre, located in Westminster, has a catchment area outside of the City of London to the west of Farringdon and Fleet Street. However, out of area registrations are open to patients who "wish to access services closer to their workplace, study, or other regular activities" [78].

Appendix 14: GP registrations of Middlesex Street & Mansell Street residents

GP Practices with more than 40 Middlesex Street and Mansell Street area residents as registered patients, 2026

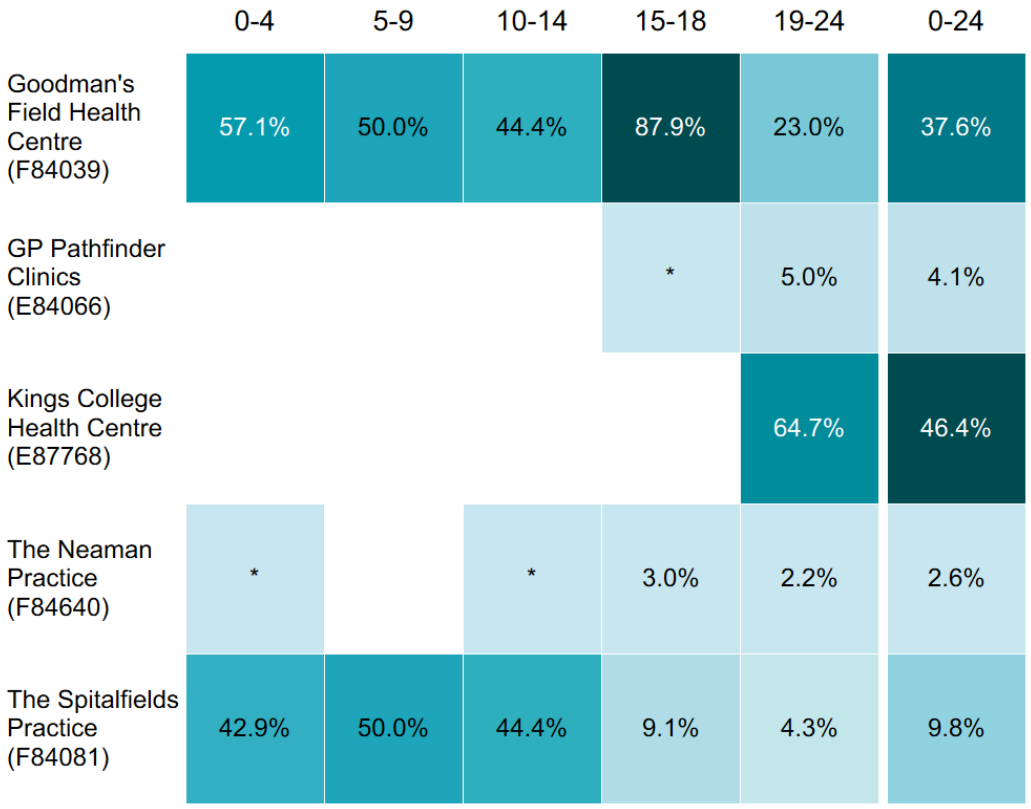
GP Practice (Code)	Practice Location	Number of Residents
Goodman's Field Health Centre (F84039)	Tower Hamlets	828
King's College Health Centre (E87768)	Westminster	776
The Spitalfields Practice (F84081)	Tower Hamlets	458
The Neaman Practice (F84640)	City of London	109
GP Pathfinder Clinics (E84066)[9]	Brent*	75
GP At Hand (E85124)[32]	Hammersmith & Fulham*	43
City Square Medical Group (F84114)	Tower Hamlets	41

Source: Patients Registered at a GP Practice, NHS England, January 2026

Note*: Main registered address

[32] Both GP Pathfinder Clinics and GP At Hand offer online consultations in addition to in-person appointments. GP Pathfinder Clinics surgeries are located in North West London while GP At Hand have surgeries in Euston, Canary Wharf, Victoria, Wimbledon and Fulham.

Proportion of children registered by GP practice, aged 24 and under, Middlesex Street and Mansell Street area of the City of London, 2026



Source: GP registration via Hospital Episode Statistics (HES), NHS England, 2026

Note: Number of residents has been rounded to the nearest 5. Percentages may total to more than 100% due to this. * denotes where the number of residents was less than 8.

Appendix 15: GP registrations of all City children

Proportion of children registered by GP practice, aged 24 and under, in the City of London, 2026

	0-4	5-9	10-14	15-18	19-24	0-24
Clerkenwell Medical Practice (F83624)	7.9%	6.3%	4.8%	*	4.9%	4.6%
Goodman's Field Health Centre (F84039)	13.2%	9.4%	11.9%	52.7%	15.9%	19.9%
Kings College Health Centre (E87768)				*	47.3%	27.6%
The Neaman Practice (F84640)	71.1%	71.9%	73.8%	41.8%	28.8%	43.1%
The Spitalfields Practice (F84081)	7.9%	9.4%	9.5%	5.5%	3.1%	4.8%

Source: GP registration via Hospital Episode Statistics (HES), NHS England, 2026

Note: Number of residents has been rounded to the nearest 5. Percentages may total to more than 100% due to this. * denotes where the number of residents was less than 8.

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