HEALTH & WELLBEING BOARD SUPPLEMENTARY AGENDA

20 December 2023

The following reports are attached for consideration and is submitted with the agreement of the Chairman as an urgent matter pursuant to Section 100B (4) of the Local Government Act 1972

10 STARTING WELL JSNA (Pages 3 - 154)

11 SUBSTANCE MISUSE STRATEGY (Pages 155 - 314)

Zena Smith
Head of Committee & Election Services

This page is intentionally left blank

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	BHR JSNA 2023 – Demographics and Starting Well Chapters
Board Lead:	Mark Ansell
Report Author and contact details:	Anthony Wakhisi Anthony.wakhisi@havering.gov.uk Louise Dibsdall Louise.Dibsdall@havering.gov.uk

The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy

☒	The wider determinants of health • Increase employment of people with health problems or disabilities • Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do. • Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.
☒	Lifestyles and behaviours • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☒	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.
☒	Local health and social care services • Development of integrated health, housing and social care services at locality level.

Havering
LONDON BOROUGH

SUMMARY

This report provides a summary of the first two chapters of Havering's Joint Strategic Needs Assessment (JSNA) 2023-2024 – Demographics and Starting Well. These chapters reflect how the Local Authority and Place Based Partnership organises its work to support local residents, focusing on getting the best outcomes for people over their lifetimes. Subsequent chapters will be released for Living Well, Ageing Well and Dying Well. Together, these JSNAs reflect the work we are doing collaboratively across the integrated Health and Social Care system to meet these identified needs and address inequalities.

The data presented in these first two chapters is complemented by an online tool to facilitate both the interrogation and further exploration of useful data, reports, and maps by interested stakeholders (Local Insight (communityinsight.org)).

The work to date on the Demographics chapter has been carried out by the public helath intelligence team and overseen by the Director of Public Health. The Starting Well chapter has been overseen by the Babies, Children and Young People sub-group of the Borough Partnership. As a strategic needs assessment, the indicators chosen and informed by the BCYP Group represent the local intelligence drawn from the wide range of partners, both statutory and voluntary sector who form the membership of this group. Their valuable contribution has offered a unique perspective on what the data means in practice for service providers, allowing us to highlight the assets we have as a borough, but also identifying where the gaps are.

The HWB is requested to note the contents of and recommendations in both the Demographics and Starting Well chapters and approve their publication.

RECOMMENDATIONS

The HWB approve the first two JSNA chapters 2023-2024 and consider how the key recommendations may inform future publication of the board's Health and Wellbeing Strategy.

REPORT DETAIL

1. Statutory Responsibilities for Producing JSNAs

The Health and Social Care Act 2012 supported the principle of local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs. Joint Strategic Needs Assessment (JSNAs) and Joint Health & Wellbeing Strategies (JHWSs) are an important, locally owned process through which to achieve this.

The purpose of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning. The core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, are used to help to determine what actions local authorities, the local NHS and other statutory and voluntary sector partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing

There has been significant change in the past year with the development of Integrated Care Boards (ICBs) and Place Based Partnerships. Alongside radical reforms in the Local Authority in the implementation of the new Target Operating Model, the Council now also aligns its work in the People Directorate under the themes of Starting Well, Living Well, Ageing Well and Dying Well and mirrors the same themes of work in the NHS.

2. Havering's Changing Demography

The Havering demographic profile is the first chapter of the local Joint Strategic Needs Assessment (JSNA). It provides a snapshot of key geographic, demographic and socio-economic facts and figures for the London Borough of Havering, with the intention that this will be the "one version of the truth" or reference document for all local stakeholders. The following are the main topics covered in this chapter:

- Geographic profile
- Population density
- Resident & GP populations
- Deprivation
- Protected characteristics
- Health Outcomes
- Household and economic profiles

The chapter also includes an executive summary consisting of key findings and recommendations that will be vital for decision making around commissioning of services and addressing of highlighted needs and inequalities by partners.

Key recommendations from this chapter are:

- All partners should be encouraged to adopt a Health in All Policies approach that takes into consideration health and wellbeing impacts in decision-making, including on the social determinants of health to maximise the wellbeing of residents and the overall healthy life expectancy.
- The local authority, NHS and partners should consider the implications of the growing population of persons with disability in Havering in their policies and plans in order to meet specific health and wellbeing needs of these groups and protect them from experiencing inequalities related access and experience of essential support and services.
- Strengthen social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options as well as an effective signposting function and bring together NHS, council and CVS stakeholders.
- All partners within the integrated care system must give prevention and treatment equal priority if they are to succeed in improving health, narrow inequalities and provide high quality, affordable health and social care services.
- The local authority and partners need to prioritise addressing the issue of homelessness and overcrowding by including more affordable houses in their housing plans as well as identifying and utilising under-occupied homes.
- The local authority needs to engage with other local partners to address the issue of loneliness and social isolation as these are multi-faceted issues and effective responses should be delivered in cross authority partnerships including the voluntary and community sectors.

- Local authority and partners need to work collectively to improve overall educational attainment, address any inequalities in educational outcomes for young people, support them to develop leadership skills and pursue professional careers.

3. Starting Well JSNA

The experiences we have early in our lives, starting even before conception, through pregnancy and birth and into our early years, are vital in laying the foundations for our future health and well-being[1]. Research consistently shows that even short-term improvements in physical, cognitive, behavioural, social and emotional development can lead to benefits throughout childhood and later life[2].

The experience of poverty in childhood has significant and long-lasting effects and is associated with poorer outcomes in all aspects of life including education, housing, employment and health[3]. Disadvantaged families, who spend a greater proportion of their income on food and heating, are likely to be most affected by the current cost of living crisis. They are also more likely to have Adverse Childhood Experiences (ACEs) – highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence in which a child is harmed directly, or lives in an adverse environment[4]. The Marmot Review, Fair Society, Healthy Lives, identified giving every child the best start as the highest priority in reducing the inequalities gap that exists between different groups of people[5].

This JSNA chapter, Starting Well, describes both the assets that we have locally to promote and support the health and wellbeing of families, and the needs of communities, areas or groups of people where we need to target our limited resources.

The data and insight presented follows a life-course approach covering:

- Maternal and newborn health,
- Early years and families (0-4 years) and covering the first 1001 days
- School age children 4-18 years, including children and young people with special educational needs and disabilities (SEND) up to 25 years.
- Adolescents' health and transition to adulthood

The analyses take into account the social, economic and environmental factors, collectively known as the 'wider determinants of health and wellbeing' as indicators of how Havering as a place supports and enhances the wellbeing of our residents.

As a strategic needs assessment, the indicators chosen represent the local intelligence drawn from a range of partners, both statutory and voluntary sector. Their valuable contribution has offered a unique perspective on what the data means in practice for service providers, allowing us to highlight the assets we have as a borough, but also identifying where the gaps are. This work is overseen by the Babies, Children and Young People (BCYP) sub-group of the Havering Borough Partnership

The recommendations made in this Starting Well JSNA are evidence based and highlight inequalities. They are intended for use by both commissioners and local providers to ensure that both the causes and the consequences of poor health and wellbeing are addressed. Where possible, efforts should be made to intervene early to prevent poor health and wellbeing and/or stop it from worsening through collective activity. However,

[1] The Best Start for Life - The Early Years Healthy Development Review Report (publishing.service.gov.uk)
[2] Social and Emotional Skills in Childhood and their Long-term Effects on Adult Life: A review for the Early Intervention Foundation (publishing.service.gov.uk)
[3] Child health inequalities driven by child poverty in the UK - position statement | RCPCH
[4] Adverse childhood experiences - what support do children need? (nihr.ac.uk)
[5] Fair Society Healthy Lives (The Marmot Review) - IHE (instituteofhealthequity.org)

these recommendations are made without expectation that the issues highlighted will be addressed immediately; all partners will need to take these recommendations into consideration when planning their own work programmes. Key recommendations should be fed into the Health and Wellbeing Board's refreshed Health and Wellbeing Strategy with appropriate timescales for delivery:

- To share data, intelligence and insight across all statutory and voluntary sector partners in Havering to build a better picture of where limited resources should be prioritised.
- Ensure priority services, particularly those who provide early help and support to prevent escalation of need, are adequately resourced at a capacity level to meet demand in our growing children's population.
- Wherever possible, co-locate and/or integrate services to support joint working and create efficiency in identification of need.
- Frontline services to triage people accessing that service, prioritise need and signpost or refer to the most relevant service.
- Ensure children and young people have a voice in what their needs are and how services are delivered, including a voice in the delivery of services for adults to facilitate transition of children to adult services.

IMPLICATIONS AND RISKS

JSNA is a statutory requirement and failing to deliver it would result in breaches in local Public Health authorities' duties, including the respective Health and Wellbeing boards.

BACKGROUND PAPERS

1. Demographics Chapter
2. Starting Well JSNA

This page is intentionally left blank

Havering
LONDON BOROUGH

Starting Well JSNA

Joint Strategic Needs Assessment 2023-2024

Document Version Control

Version	Date	Revision Made	Author/Analysts	Comments
Draft 1.0	04/12/23	First draft	Louise Dibsdall (Lead & Primary Author) Claire Alp Thomas Goldrick Lucy Goodfellow Mark Holder Sedina Lewis Anthony Wakhisi	Approved by BCYP Sub-Group of Borough Partnership on 12/12/2023

Contents

1.0 Background

1.1 Why this JSNA is important

The experiences we have early in our lives, starting even before conception, through pregnancy and birth and into our early years, are vital in laying the foundations for our future health and well-being[1]. Research consistently shows that even short-term improvements in physical, cognitive, behavioural, social and emotional development can lead to benefits throughout childhood and later life[2].

The experience of poverty in childhood has significant and long-lasting effects and is associated with poorer outcomes in all aspects of life including education, housing, employment and health[3]. Disadvantaged families, who spend a greater proportion of their income on food and heating, are likely to be most affected by the current cost of living crisis. They are also more likely to have Adverse Childhood Experiences (ACEs) – highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence in which a child is harmed directly, or lives in an adverse environment[4]. The Marmot Review, Fair Society, Healthy Lives, identified giving every child the best start as the highest priority in reducing the inequalities gap that exists between different groups of people[5].

Improving health and well-being outcomes and reducing health inequalities is a major focus for interventions around pregnancy and maternal health, early years, and children and young people in Havering.

1.2 Purpose and Process

This Starting Well JSNA is part of a series of needs assessments which align with the life-course approach taken in the NHS Long Term Plan for Starting Well, Living Well, Ageing Well and Dying Well. It also reflects how the Local Authority and Place Based Partnership organises their work to support local residents, focusing on getting the best outcomes for people over their lifetimes. Together, and supported by a chapter describing the demographics of the people who live or work in Havering, these JSNAs reflect the work we are doing collaboratively across the integrated Health and Social Care system to meet the identified needs and address inequalities.

This chapter, Starting Well, describes both the assets that we have locally to promote and support the health and wellbeing of families, and the needs of communities, areas or groups of people where we need to target our limited resources.

The data and insight presented here follows a life-course approach covering:

- Maternal and newborn health,
- Early years and families (0-4 years) and covering the first 1001 days
- School age children 4-18 years, including children and young people with special educational needs and disabilities (SEND) up to 25 years.
- Adolescents' health and transition to adulthood

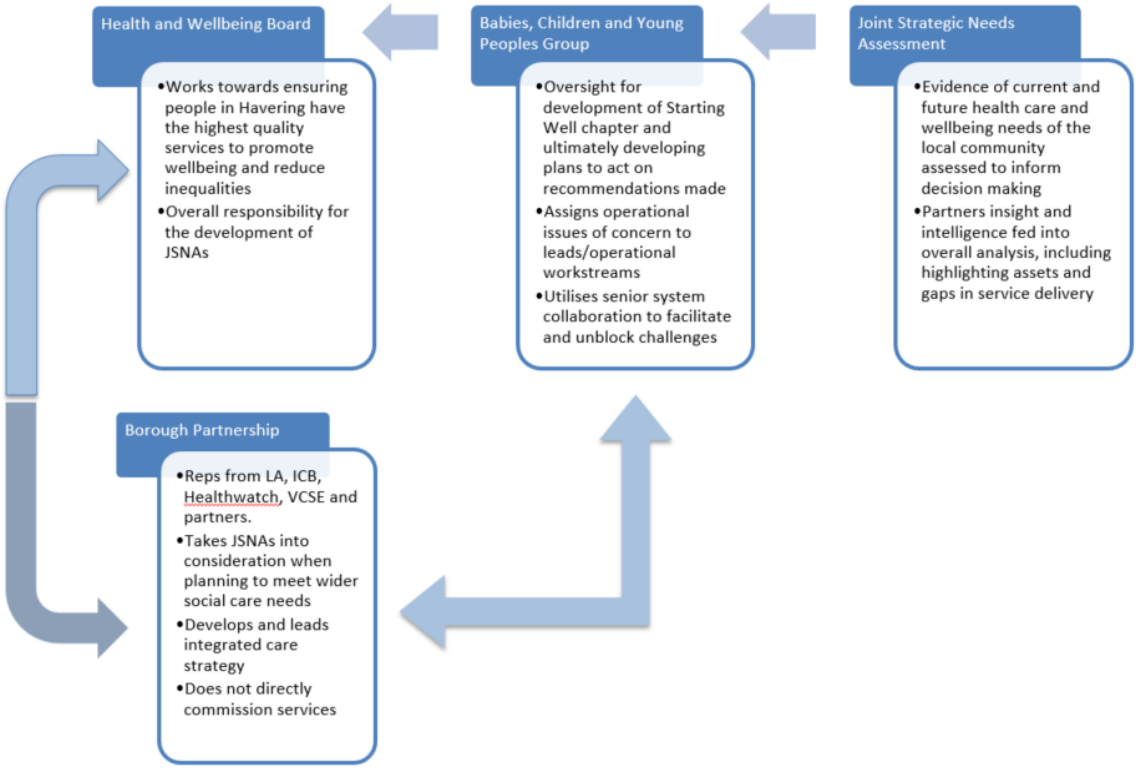
The analyses take into account the social, economic and environmental factors, collectively known as the 'wider determinants of health and wellbeing' as indicators of how Havering as a place supports and enhances the wellbeing of our residents. Key data used in this chapter

[1] The Best Start for Life - The Early Years Healthy Development Review Report (publishing.service.gov.uk)
[2] Social and Emotional Skills in Childhood and their Long-term Effects on Adult Life: A review for the Early Intervention Foundation (publishing.service.gov.uk)
[3] Child health inequalities driven by child poverty in the UK - position statement | RCPCH
[4] Adverse childhood experiences - what support do children need? (nihr.ac.uk)
[5] Fair Society Healthy Lives (The Marmot Review) - IHE (instituteofhealthequity.org)

can also be accessed via Havering's interactive JSNA mapping tool and dashboard available on Local Insight (communityinsight.org).

As a strategic needs assessment, the indicators chosen represent the local intelligence drawn from a range of partners, both statutory and voluntary sector. Their valuable contribution has offered a unique perspective on what the data means in practice for service providers, allowing us to highlight the assets we have as a borough, but also identifying where the gaps are. This work is overseen by the Babies, Children and Young People (BCYP) sub-group of the Havering Borough Partnership, who in turn report to the Havering Health and Wellbeing Board (Fig. i).

Figure i Starting Well JSNA Governance Arrangements



The recommendations made in this Starting Well JSNA are evidence based and highlight inequalities. They are intended for use by both commissioners and local providers to ensure that both the causes and the consequences of poor health and wellbeing are addressed. Where possible, efforts should be made to intervene early to prevent poor health and wellbeing and/or stop it from worsening through collective activity. However, these recommendations are made without expectation that the issues highlighted will be addressed immediately; all partners will need to take these recommendations into consideration when planning their own work programmes. Key recommendations (Section 7) will also be prioritised and fed into the Health and Wellbeing Board's refreshed strategy with appropriate timescales for delivery.

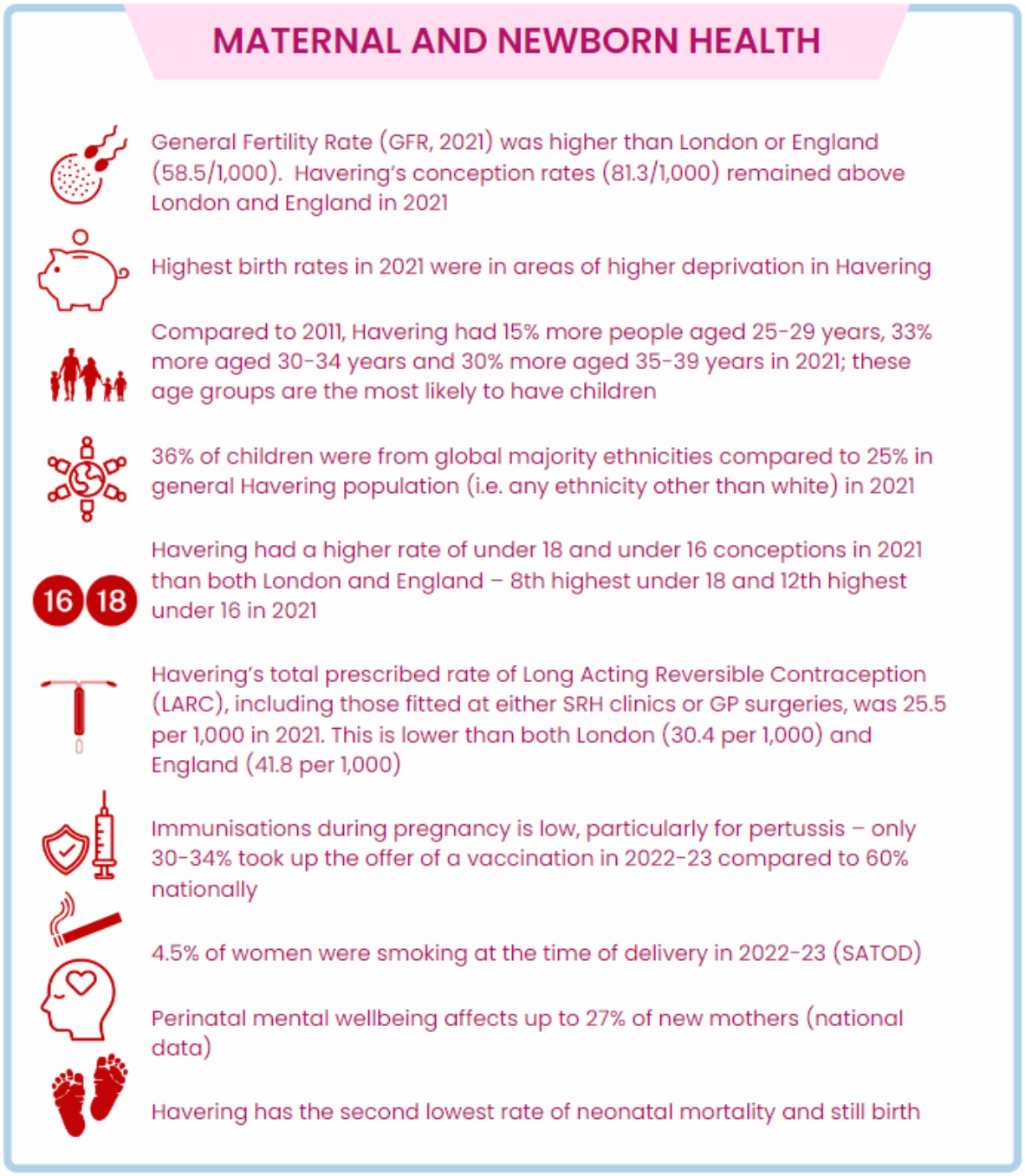
1.3 Contributors to this JSNA

The authors and analysts of this Starting Well JSNA would like to thank everyone who has contributed. This includes all members of the Babies, Children and Young People sub-group of the Borough Partnership and associated colleagues whose oversight and valuable insight was critical in the development of this chapter.

2. Infographic & Executive Summary

2. Infographic & Executive Summary

The number of children aged 0-17 years in Havering is 58,550, compared to 50,827 in 2011 (a 15% increase, compared to increases of 4.8% in London and 3.9% in England). The number of households with dependent children (i.e. families) in Havering has increased in the last decade by 28%. The fertility rate in Havering (58.5/1,000 women) is significantly higher than London and England.



EARLY YEARS AND FAMILIES (0-4 YEARS)

Infant mortality rate in 2021 was lower (2.9/1,000) than London or England

Havering had a lower rate of A&E attendance for children aged 0-5 years in 2021/22; lowest of all London boroughs

For children aged 0-9, Havering had a higher rate of admissions for asthma and diabetes in 2021-22

Uptake of primary childhood immunisations has dropped below 95% target (90.9% DTaP/IPV/Hib)

1 in 4 children had obvious dental decay in 2021/22 – better than London but worse than England

As at 31st March 2023, Havering had 241 children in care (CIC).

Havering's Children in Need (CIN) rate as at 31st March 2023 was higher, at 402.1 per 10,000, than London (369.8 per 10,000) and England (342.7 per 10,000)

During 2022/23 there were 3,167 referrals to Children's Social Care in Havering; referrals were 3% lower than the previous year but 15% higher than in 2018/19

Only 2/3 of eligible families took up the offer of free early education

64% of children in Havering had a good level of development by end of Reception year in 2021-22 – similar to London and England but requires improvement through identification and intervention at an earlier stage

SCHOOL AGE CHILDREN (4-18 YEARS)

22% of children in Reception were overweight or obese in 2021-22; rising to 39% in Year 6

9.3% of pupils in school in Havering had Special Educational Needs (SEN). This is lower than the rate for both London (14.4%) and England (14.4%)

19.5% of primary school pupils in Havering are known to be eligible for freeschool meals (FSM) in 2022/23. Uptake of FSM, amongst primary school pupils is less than the percentage of pupils eligible

Those receiving FSM had a similar percentage achieving a good level of development at end of reception as those without FSM status

Among children 0-15 years, 4.34% are on an Education Health and Care plans (EHCP) in Havering. The number of children with EHCPs in Havering has increased from 1,534 in 2019 to 2,182 by 2023

In 2022, Havering's rate of emergency hospital admissions caused by unintentional and deliberate injuries to children was lower (54.7 per 10,000) than England (84.3 per 10,000)

Havering's rate of hospital admissions for asthma for all children under 19 years was 146.5 per 100,000 .This was, was higher than London (142.3 per 100,000 and England (131.5 per 100,000)

Havering had fewer (1.5%) unauthorised absences in schools than both London (1.9%) and England (1.8%) in 2022

National data shows that 11 to 15 year old's represented the group (in 5-year age bands) with the highest number of contacts with mental health services

ADOLESCENTS' HEALTH AND TRANSITION TO ADULTHOOD (15-24 YEARS)

The percentage of 15 year olds in 2015/15 Havering with 3 or more risky behaviours (15.8%) was similar to England (15.9%) but higher than London (10.1%)

For children under 18 years, there were more attended visits with community and outpatient mental health services in Havering in 2019/20 (30,196 per 100,000) than London (25,930 per 100,000) and England (28,395 per 100,000)

There were 200.3 per 100,000 hospital admissions as a result of self-harm amongst 10-24 year olds in Havering. This was better than England (427.3 per 100,000) and similar to London (229.7 per 100,000)

Amongst 15-24 year olds specifically in the period 2018/18 to 2021/22, the rate of hospital admissions due to substance misuse in Havering is significantly worse (117.4 per 100,000) than both London (56.5 per 100,000) and England (81.2 per 100,000). Havering had the highest (worst) rate out of all the London boroughs over this period

In 2023, the average Attainment 8 score per pupil was 47.3 for Havering children, better than England (44.6), but lower than the average score for pupils across the whole of Outer London (51.0)

69.2% of Havering pupils in Key Stage 4 in 2023 achieved a 9-4 pass in English and Maths. This is better than England (60.5%) and boroughs with similar populations (65.3%).

The rate of first time entrants to the youth justice system aged 10 to 17 years in Havering in 2022 (106.5 per 100,000) was similar to England (148.9 per 100,000) and better than London (166.3 per 100,000)

Executive Summary & Key Points for Decision Makers

- Havering has traditionally been seen as an ageing borough; however, it is clear from the 2021 Census data in the above analysis that our local population is rapidly changing.
- Not only do we have more children and young people (the increase in which is greater than both London and England rates), but Havering is also likely to have a growing child population in the future with higher numbers of people of ages likely to start families.
- Those additional children are also more likely to live in areas of deprivation, which will place an increasing demand for children's social care, maternity and health visiting services, child care, and early education (funded pre-school places).

- The mid-year population estimates for 2022, just one year after the 2021 Census suggest a growth of a further 1,500 children – this is equivalent to an entire secondary school. Future planning will be required for these children as they grow, including school provision, opportunities for active travel to school and play and leisure facilities.
- Children in need or children in care have more complex needs. Early Help services are designed to reduce problems and improve outcomes for children and families.
- Demand for services continues to increase and capacity is an issue faced by all services, especially in the current cost of living crisis.
- Resources are limited, and we cannot continue to add more service provision; instead, we will have to ultimately prioritise where our funds can be spent to achieve the best possible outcomes, for those whose needs are greatest.
- Havering already has a wide range of assets, and the people who run these services should be celebrated for the good work they do; focusing on addressing the gaps should not detract from these existing assets.
- Prevention is better than cure, but it is challenging to divert resources to early help and prevention from those who are already needing more complex care.
- Better partnership working will allow us to ensure we have clearer lines of accountability and reporting and to take action following early identification of a problem.
- There are a number of assets already in place to contribute to earlier intervention, including all frontline service staff, the diverse range of voluntary and community sector (VCS) organisations, Health Champions, Community Connectors and Local Area Co-ordinators.
- The recommendations made in each section of this Starting Well JSNA are evidence based and highlight inequalities. However, these are made without expectation that the issues highlighted will be addressed immediately; all partners will need to take these into consideration when planning their own work programmes. Key recommendations will also be prioritised and fed into the Health and Wellbeing Board's refreshed strategy
- Key overall recommendations are:
    - To share data, intelligence and insight across all statutory and voluntary sector partners in Havering to build a better picture of where limited resources should be prioritised.
    - Ensure priority services, particularly those who provide early help and support to prevent escalation of need, are adequately resourced at a capacity level to meet growing demand.
    - Wherever possible, co-locate and/or integrate services to support joint working and create efficiency in identification of need.
    - Frontline services to triage people accessing that service, prioritise need and signpost or refer to the most relevant service.
    - Ensure children and young people have a voice in what their needs are and how services are delivered, including a voice in the delivery of services for adults to facilitate transition of children to adult services.

3. Demographics of Babies, Children and Young People in Havering

3. Demographics of BCYP in Havering

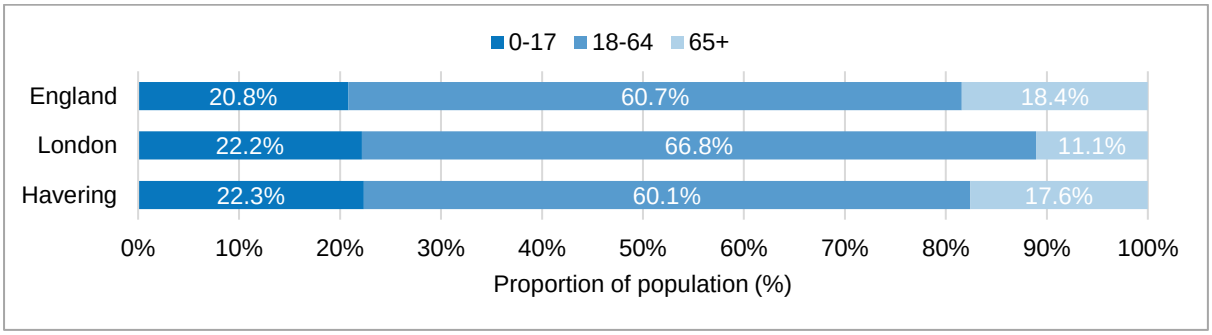
Demographic data helps provide an understanding of communities as they are now, where they've been and where they're headed. It is important to know this in order to plan for what a community needs to live, work and thrive. Knowing about our community can tell us whether we have enough houses, and what type of housing is needed and to plan for potential demand on healthcare, education, employment and transport. This section summarises and expands on key data in the JSNA Demographics chapter, focused on babies, children and young people and should be read in conjunction with that chapter[6]. Additional mapping of demographics can be found on: Local Insight (communityinsight.org).

3.1 Population Profile and Growth

The Census, collected every 10 years, is the most accurate data for how many people live in England and Wales. In 2021, 22.3% of all people living in Havering were children aged 0-17 years (Fig. 1). Between 2011 and 2021, Havering saw significant growth in population, at a higher rate of growth than the average across London or England. The growth in children living in Havering has been predominantly in the 0 to 4 years and 5 to 9 years populations (Fig. 2).

- The total estimated unrounded population count in Havering at the time of the Census 2021 was 262,052, compared to 237,232 in 2011; at 10.4% this is a **higher increase** than London (7.7%) and England (6.6%)[7].
- The number of children aged 0-17 (under 18 population) in Havering in 2021 was 58,550, compared to 50,827 in 2011 (a 15.2% increase, compared to increases of 4.8% in London and 3.9% in England)[8].
- Whereas England saw a 7% **fall** in the number of 0-4 year olds between the 2011 and 2021 Census, Havering had a 21% **increase** in the same period (Fig.2)[7].
- Between 2011 and 2021 England had a 13% rise in 5 to 9 year olds compared to a 28% rise in Havering[7].
- Havering had a **higher proportion** of younger children, aged 0-5 years than England (Fig.3) in 2021.

Figure 1. Comparing Havering populations aged 0-17, 18-64 & 65+ to London and England in 2021



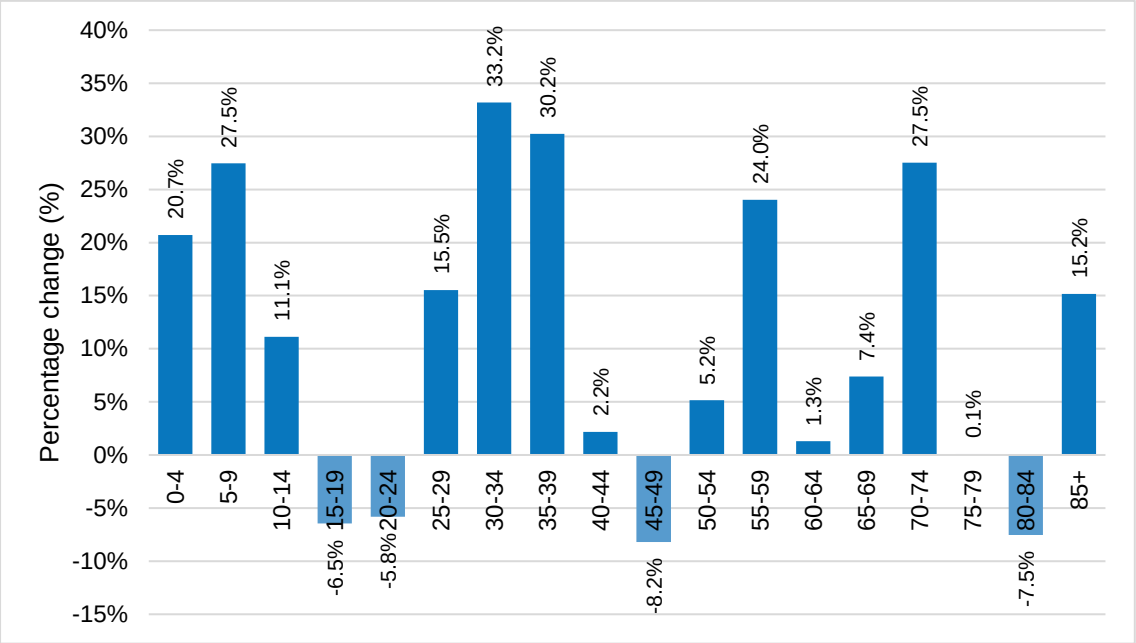
Source: Census 2021, Produced by: LBH PHI 2023

[6] See also JSNA Demographics Chapter

[7] Havering population change, Census 2021 – ONS

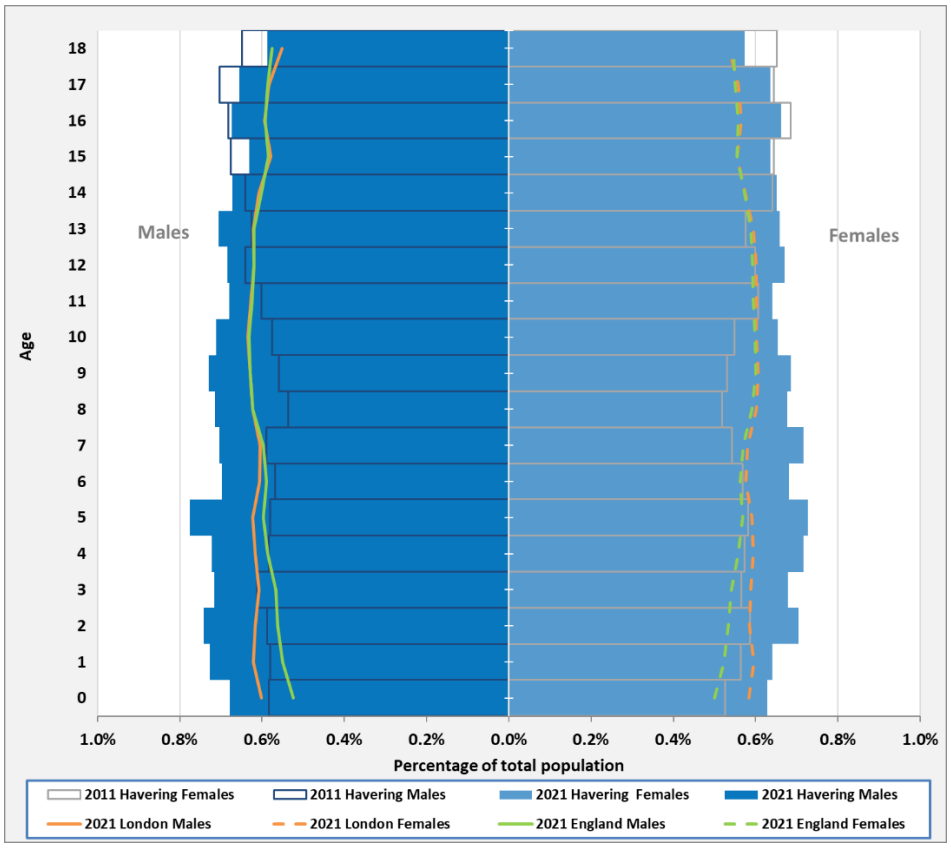
[8] Census-2021-Topic-Summary-Demography-and-Migration.pdf (haveringdata.net)

Figure 2. Percentage change in population by 5-year age bands in Havering 2011 to 2021[9].



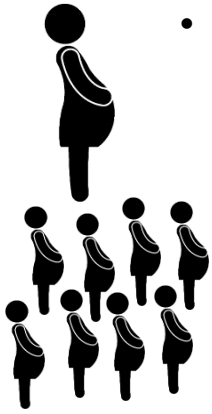
Source: Census 2021, Produced by: LBH PHI 2023

Figure 3. Havering aged 0-18 population change from 2011 to 2021 compared to 2021 London and England population



Source: Census 2011 & 2021, Produced by: LBH PHI 2023

[9] Havering population change, Census 2021 – ONS



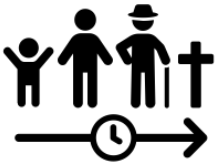
- In England, 2021, women aged 30 to 34 years were the group most likely to concieve a baby, with the highest rate of conceptions (116.2 per 1,000 women)[10]. Havering also saw a large growth in the percentage of people of ages most likely to have children, which is likely to result in an even bigger 0-4 year old population in the coming years[11].

% Increase from 2011 to 2021 in ages:	Havering	England
25-29 years	15%	2%
30-34 years	33%	13%
35 to 39 years	30%	7%

- Mid-year population estimates by the Office of National Statistics (ONS) for 2022 (released November 2023) indicate that the population of Havering has increased by a further 1% to 264,703[12].
- For the 2022 mid-year estimates, 22.7% of the population were children aged 0-17 years, or a total of 60,088. This is a further estimated 1,538 children living in the borough, or 2.6% increase in one year alone.

3.2 Life Expectancy for Children in Havering

Life expectancy is the number of years an average person is expected to live[13]. This means that for a person born in Havering today they could expect to live around 80 years. Healthy life expectancy is the average number of years people can expect to live in 'good' or 'very good' health according to a self-assessment of what good and very good health means to them. By age 65, people are more likely to develop a health condition, or limiting long term illness that affects their ability to go about their daily lives, including problems related to old age, such as mobility issues, diabetes, cancer, coronary heart disease etc.. However, it is possible to estimate how many years people might live without developing a condition – this is called disability-free life expectancy at age 65[14]. People living in poorer areas tend to have shorter lives and fewer years spent in good health[15].



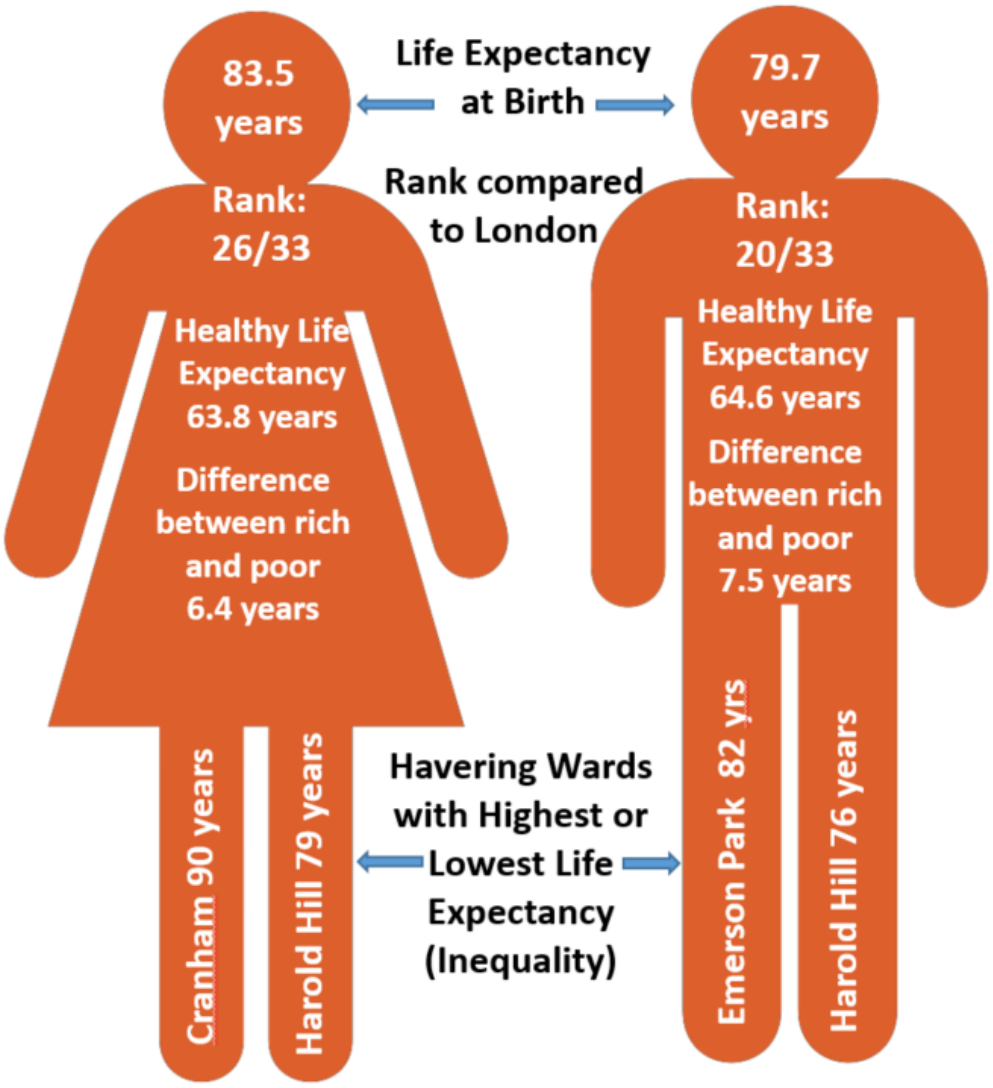
- Life expectancy at birth pooled for the period 2018 to 2020 (as this is more reliable than a single year estimate of life expectancy) in Havering was 83.5 years for women and 79.7 years for men. This was **similar** to England (83.1 and 79.4 years respectively) and London (84.3 and 80.3 years respectively)[16].
- Women in Havering are expected to live on average longer than men but live for fewer years in good health than men overall. Healthy life expectancy for women in Havering (pooled for 2018-2020) is 63.8 years whilst for men it is 64.9 years.
- By age 65, both men and women are more likely to develop a limiting long term illness or disability. However, it usually takes more years for these conditions to develop in women. As a result, women in Havering

[10] Conceptions in England and Wales - Office for National Statistics
[11] Havering population change, Census 2021 – ONS
[12] Estimates of the population for England and Wales - Office for National Statistics (ons.gov.uk)
[13] Life Expectancy releases and their different uses - Office for National Statistics (ons.gov.uk)
[14] Health state life expectancies, UK - Office for National Statistics (ons.gov.uk)
[15] Health state life expectancies by national deprivation deciles, England (ons.gov.uk)
[16] Life Expectancy and Mortality - OHID (phe.org.uk)

were expected to live more years free of disability (10.8 years) than men (9.8 years) (Fig. 4).[17].

- There are large differences in life expectancy at birth between people living in more or less disadvantaged areas. Women living in the top 10% of most deprived areas of Havering live around 6.4 years less than those living in the least deprived areas[18].
- For men, the difference in overall number of years lived between the most and least deprived areas is even greater: 7.5 years less.

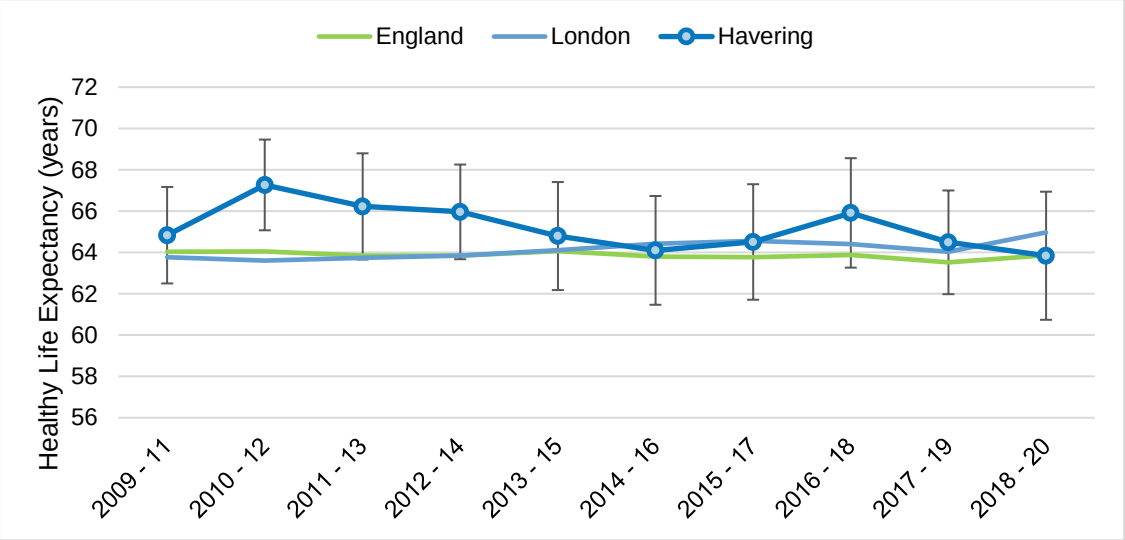
Figure 4. Life Expectancy and Healthy Life Expectancy for men and women living in Havering ranked against London.



Although men and women are both living longer, since 2010 the number of years women are living in good health in Havering has been reducing; whereas in 2010-2012 women could expect to live 67.3 years in good or very good health, by 2018-2020 this has reduced to 63.8 years (Fig.5)[19].

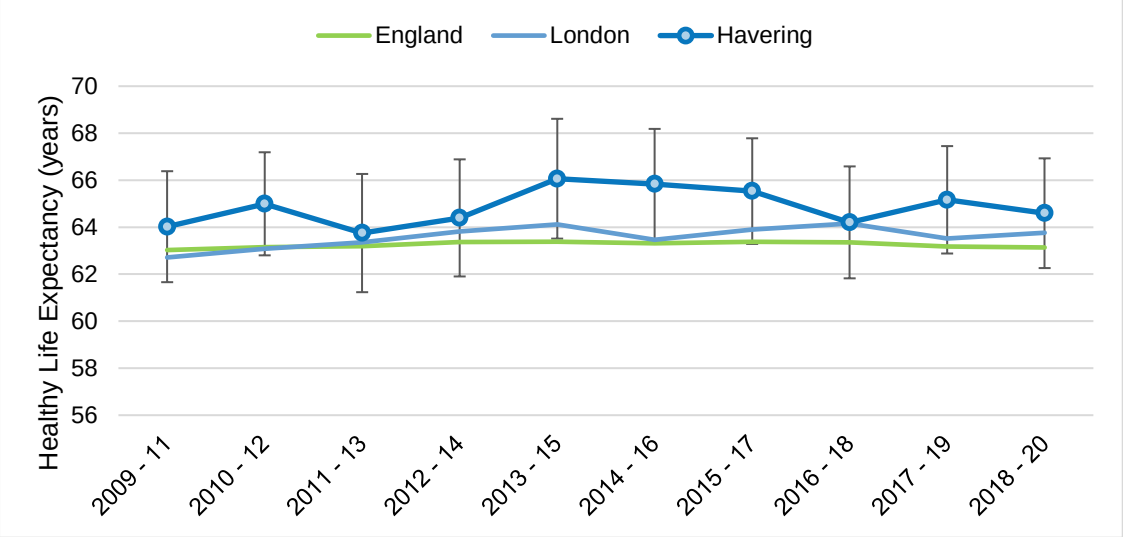
[17] Public health profiles - OHID (phe.org.uk)
[18] Public health profiles - OHID (phe.org.uk)
[19] Life Expectancy by Local Authority - Office for National Statistics (ons.gov.uk)

Figure 5a. Female healthy life expectancy at birth in Havering compared to London and England 2009-2020



Source: OHID Fingertips, Produced by: LBH PHI 2023

Figure 5b. Male healthy life expectancy at birth in Havering compared to London and England 2009-2020



Source: OHID Fingertips, Produced by: LBH PHI 2023

3.3 Ethnic Diversity

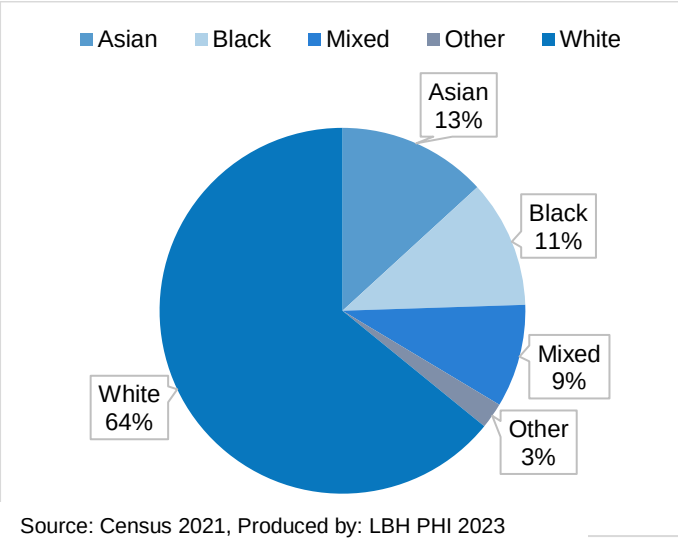
Nearly 85% of the global population are people from African, Asian, Latin American and Arab ethnicities, and as such represent the global majority. To reflect this in the UK population where 'white' as an ethnic identifier is the majority, this JSNA will refer to people from ethnic backgrounds other than white as the Global Majority (GM)/

- Census 2021 data showed that 64% of the children aged 0-17 years in Havering were White (English, Welsh, Scottish, Northern Irish or British) (Census 2021) (Fig. 6 and Fig. 7) [20].

[20] Population - UTLA | Havering | Report Builder for ArcGIS (haveringdata.net)

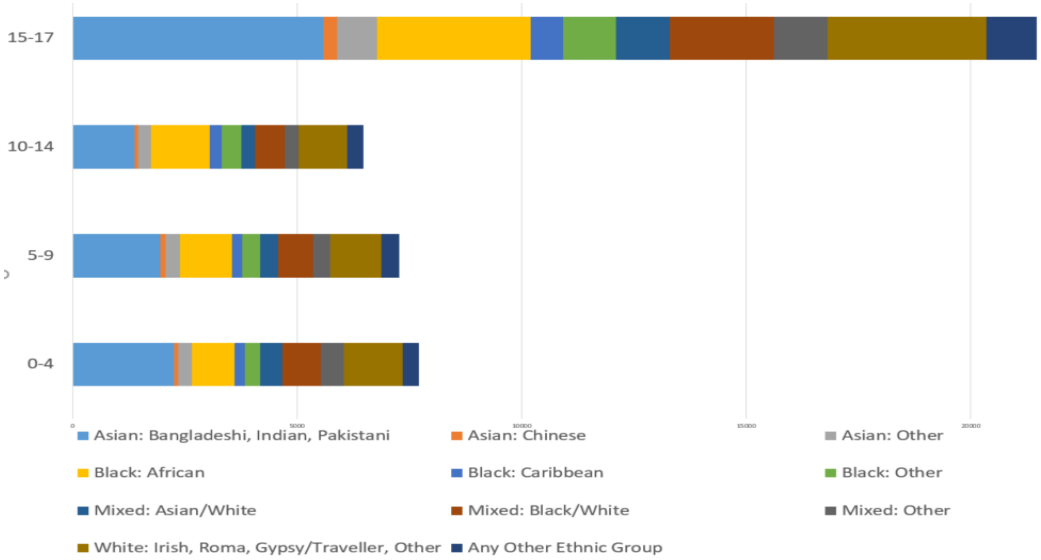
- Overall, there are more children from Global Majority ethnicities (36%) than amongst the general population in Havering in 2021[21]; 75% of the entire Havering population were White British/White Other compared to 25% GM/Other.
- 13.3% of children were Asian, 11.4% Black (African/Caribbean) and 9.1% mixed; these proportions were higher than observed amongst the population as a whole in Havering in 2021 (10.7% Asian; 8.2% Black and 3.7% Mixed) [22].

Figure 6. Proportion of the Havering population aged 0-17 by ethnic group



Source: Census 2021, Produced by: LBH PHI 2023

Figure 7. Relative Proportions of Global Majority Group by Age (Census 2021) for Children in Havering aged 0-17 years in 5-year age bands (excluding White/White British)



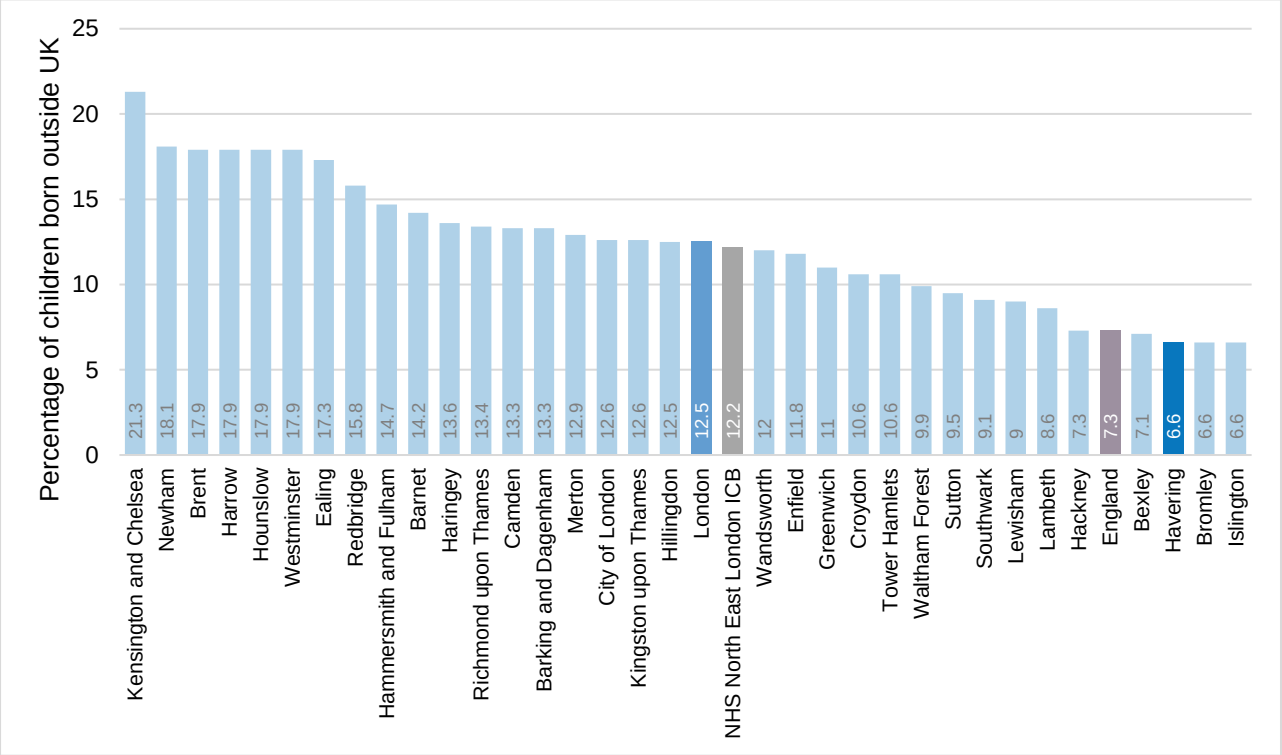
Source: Census 2021

[21] See also Demographics JSNA Chapter

[22] https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/culturalidentity/ethnicity/datasets/ethnicgroupbyageandsexinenglandandwales/2021/ethnicgroupagesex11.xlsx

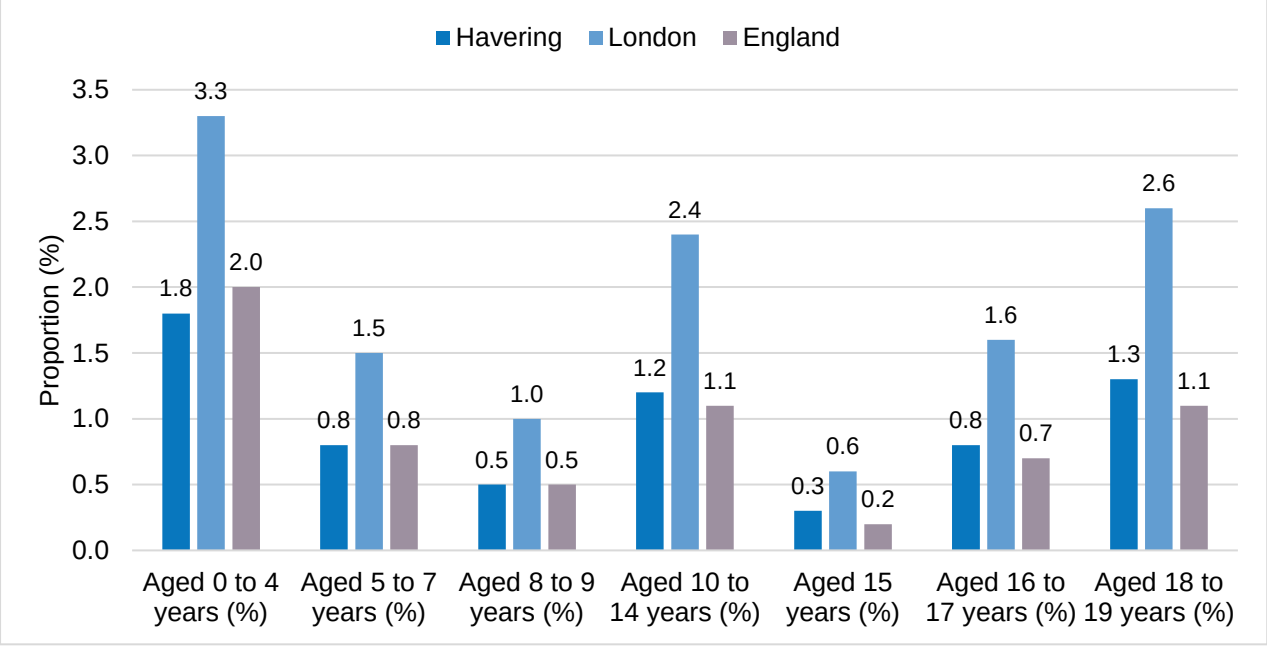
According to the 2021 Census, Havering has **fewer** children born outside the UK arriving in the borough (6.6%) than London in general (12.5%), and similar to England (7.3%) (Fig.8). Within Havering, more children aged 0-4 were born outside the UK than other ages (Fig.9).

Figure 8. Proportion of the Havering Population Born Outside the UK aged 0-17 (2021).



Source: Census 2021, Produced by: LBH PHI 2023

Figure 9. Age of arrival of children to Havering, London or England if born outside of the UK (Census 2021).



Source: Census 2021, Produced by: LBH PHI 2023

- In 2021, 7 of the top ten wards in London where diversity increased the most were in Havering; these were wards with very low diversity in 2011 and were still below the London average in 2021[23].
- Migration into the borough was predominantly from within the UK. 7.7% of Havering households have moved from within the UK, whilst 0.6% have moved directly from abroad.

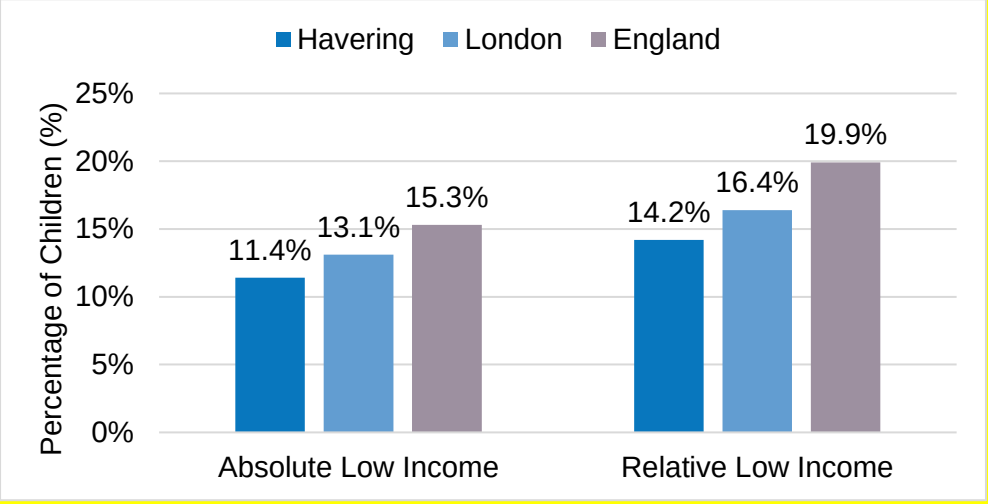
3.4 Deprivation and Inequality

Deprivation or poverty means living with a level of income or resources well below what you need as a minimum, for example, not being able to heat your home, pay rent or buy essentials for your children. There is a scale of deprivation which compares how much a household has to spend with the average income of a household across the UK. If you put all of the income from every household in the UK in order, lowest to highest, the middle value, with half the people having more income and half the people having less would be the median income. Relative low income refers to people living in households with an income below 60% of the median in that particular year. Absolute low income refers to people with an income below 60% of the median income in a chosen base year – usually 2010/11, and adjusted for inflation. Census 2021 data shows us that:

- The estimated number of households in Havering in 2021 was 101,277, an increase of 4% from 2011 (97,199)[24].
- More people in Havering live in lone parent households (13%) than England (11.0%), similar to London[25].
- Compared to London (51.9%) and England (51.6%), Havering has a higher proportion of households living in deprivation (52.7%).
- The proportion of households with dependent children (i.e. families) in Havering has increased in the last decade from 20% to 21.4%[26].
- Compared to 2011, the number of households with no children in 2021 fell by 14% whilst those with dependent children has risen by 28%, with families with non-dependent children increased by 12%.
- In 2021/22, 11.45% of children aged under 16 years lived in absolute low income families in Havering and 14.2% in relative low income[27]. These rates are **better** than both London and England for absolute and relative low income, but still represent a significant need for children in the borough (Fig. 10).

[23] Census-2021-Topic-Summary-Demography-and-Migration.pdf (haveringdata.net)
[24] Census, 2021
[25] Population - UTLA | Havering | Report Builder for ArcGIS (haveringdata.net)
[26] www.ons.gov.uk/visualisations/censusarechanges/E09000016
[27] Child and Maternal Health - OHID (phe.org.uk)

Figure 10. Percentage of Children Aged Under 16 Years in Havering Living in Absolute or Relative Income 2021/22.



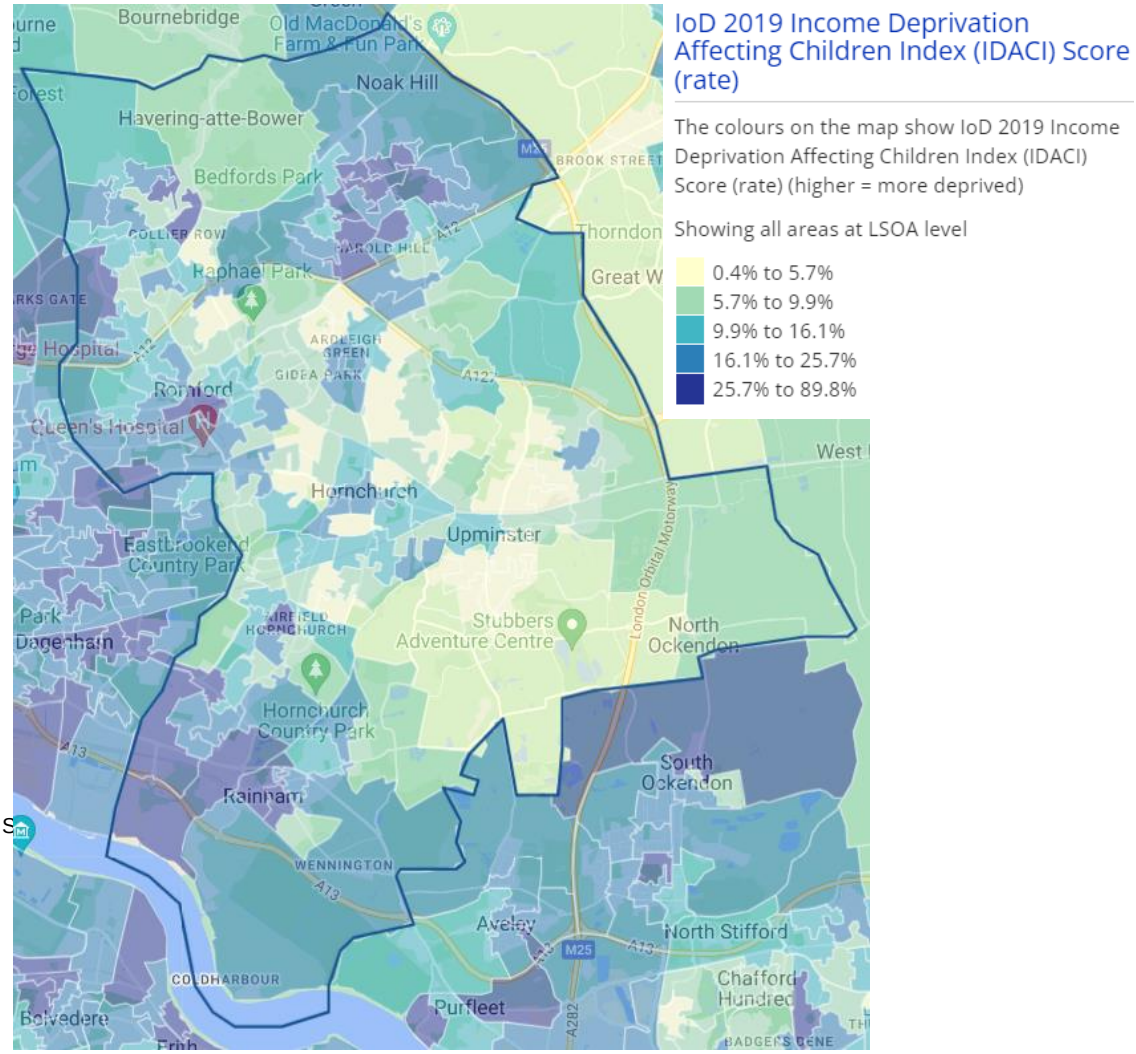
Source: OHID Fingertips, Produced by: LBH PHI 2023

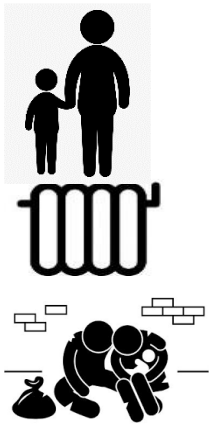
People in the most deprived areas spend around a third of their lives in poor health, twice the proportion spent by those in the least deprived areas. This means that people in more deprived areas spend, on average, a far greater part of their already far shorter lives in poor health[28]. One way of measuring the degree to which deprivation affects children is the Income Deprivation Affecting Children Index (IDACI). The IDACI measures the proportion of all children aged 0-15 years who are living in income deprived families within a group of around 650 households (~1,500 residents), known as a Lower Super Output Area (LSOA) [29].

- The IDACI showed in 2019 that on average 16.0% of all children in Havering live in income deprived households compared to 17.1% in England[30].
- More people in Havering in 2021 lived in households with 5 or more people (9.2%) than England (6.9%) but slightly less than London (10.1%)
- In several areas of Havering, up to 1 in every 3 children lived in a low income household where the adults in that home are on low earnings or are out of work according to the 2019 IDACI (Fig. 11).

[28] What are health inequalities? | The King's Fund (kingsfund.org.uk)
[29] DLUHC Open Data : i. Income Deprivation Affecting Children Index (IDACI) (opendatacommunities.org)
[30] Public health profiles - OHID (phe.org.uk)

Figure 11. Map of Neighbourhoods Experiencing Income Deprivation as per the IDACI Score (2019)





- 7.7% of households in Havering in the 2021 census were lone parents with dependent children (7,821 families). This is **higher** than the percentage of single parent households in England as a whole (6.9%), but **similar** to London (7.8%)[31].
- More children in Havering (10.7 per 1,000) live in homes without central heating than England (10.1 per 1,000), but less than London as a whole (20.7 per 1,000).
- The rate of families with dependent children or pregnant women being unintentionally homeless and accepted for assistance was **higher** in Havering 2.5 per 1,000 than England (1.7 per 1,000) but lower than London (3.2 per 1,000).

[31] Household composition - Office for National Statistics (ons.gov.uk)

3.5 What This Data Means for Havering

Between 2011 and 2021, Havering has seen a significant growth in population. This growth is focused on populations who have the greatest healthcare needs – the very young and the very old. In addition, there are more people of an age more likely to start a family, between 25 and 39 years old. This growth in population has undoubtedly put a strain on existing, and already stretched services, for example where we already have a high ratio of number of patients seen by each GP - over 2,500 patients per GP. Understandably, worried parents who may not be able to get a timely GP appointment due to capacity, are more likely to visit A&E services and shift the demand to another heavily burdened service.

The growth in population was also higher amongst families from Global Majority ethnicities and families who live in areas of higher deprivation. Cultural competence of services and self-help information via the internet and social media need to take into account the changing demographic and need for information translated into a variety of languages.

Whilst migration into the borough was predominantly from within the UK, the constant shift in population for employment or housing leaves families with young children particularly vulnerable to lack of social support. As a result, there will likely be the need to enhance community cohesion to provide other forms of social networking.

These issues and challenges are described in more detail in the following sections, focusing on key life stages.

4. Maternal and Newborn Health

4. Maternal and Newborn Health

4.1 Conception, Contraception and Abortion

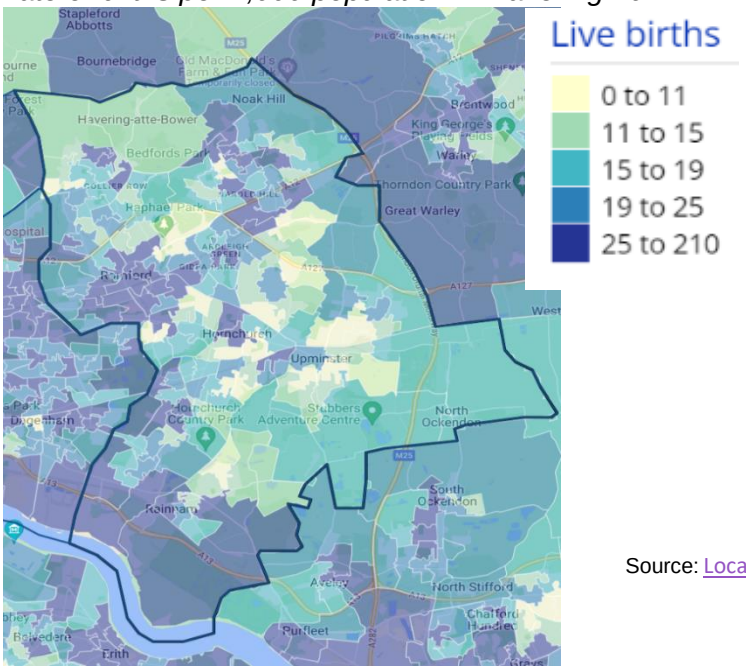
Maternal health goes hand in hand with reproductive health, where prevention of unplanned pregnancy is just as important as ensuring people who do get pregnant stay healthy themselves. As a rapidly growing borough, Havering has more women of ages able to get pregnant, more pregnancies and more young children.

- Havering's **General Fertility Rate** (GFR, 2021) is **higher** (58.5 per 1,000) than London (52.9 per 1,000) and England (54.3 per 1,000); Havering has the 8th highest GFR out of the London boroughs[32].
- Overall conception rates per 1,000 women aged 15 to 44 years in Havering, London and England in 2021 have all been steadily declining since 2012. Between 2011 and 2021, across England, women aged 35 to 39 years and aged 40 years and over were the only groups to see an overall increase in conception rates[33].
- Havering's **conception rates** (81.3 per 1,000) remain **above** both London (70.8 per 1,000) and England (71.5 per 1,000) rates. This means that there continues to be a growth in the population of children[34].

- Compared to other North East London boroughs, in 2021 Havering had a **lower** conception rate (81.3 per 1,000) than Barking and Dagenham (93.2 per 1,000), but higher than Tower Hamlets (60.1 per 1,000).
- According to the 2021 census, there are now **more people** of ages likely to have children living in Havering; 15% more aged 25 to 29 years; 33% more aged 30-34 years and 30% more aged 35 to 39 years old (Figure 1 above)[35].

However, younger women having children are also more likely to live in areas of higher deprivation (Fig. 12). Highest rates of live births were clustered in Harold Hill, Romford and South Hornchurch.

Figure 12. Rate of births per 1,000 population in Havering 2021.



Source: Local Insight (communityinsight.org)

[32] Public health profiles - OHID (phe.org.uk)

[33] Conceptions in England and Wales - Office for National Statistics

[34] ONS (2022) Conceptions in England and Wales - Office for National Statistics

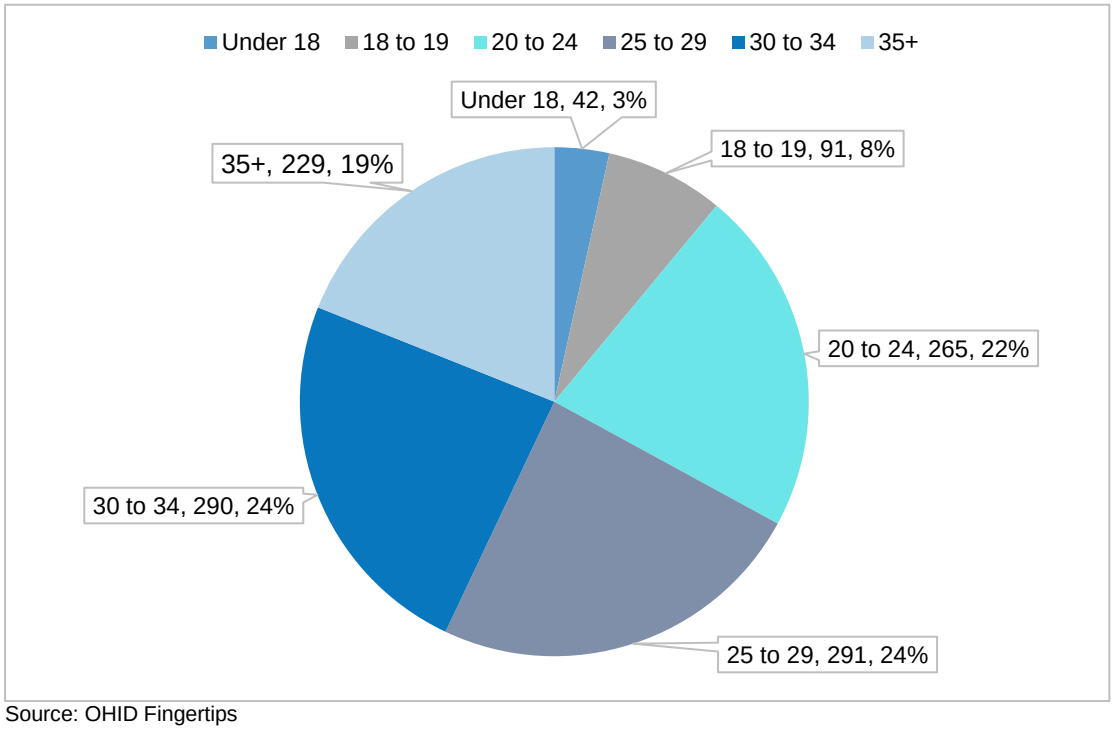
[35] Havering population change, Census 2021 – ONS

Conceptions/pregnancy can end in maternity, miscarriage or abortion; conception is the ability to conceive a pregnancy, whether or not the foetus is carried to term, whereas fertility rate is the number of live births occurring in a respective calendar year per 1,000 females aged 15-44 in a population. Conception statistics do not, however, include conceptions resulting in miscarriages or illegal abortions; figures are derived from combining numbers of maternities and abortions using information recorded at birth registration and abortion notification. In addition, it is estimated that around one in 8 pregnancies will end in miscarriage, so the actual conception figures are higher than reported above.

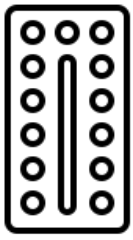
- The total abortion rate in Havering for 2021 was 23.6 per 1,000, **higher** than both London (20.9 per 1,000) and England (19.2 per 1,000)
- There were 1,208 abortions in 2021 in Havering
- 89.4% of abortions in 2021 were under 10 weeks; 94.8% of these were medical abortions

- Most abortions were amongst 25-29 age group and 30-34 years (Fig. 13)
- The rate of abortion in those aged over 25 years is **higher** in Havering (21.7%) than London (19.7%) and England (17.9%)

Figure 13. Number of Abortions, (% of total number of abortions) by age group, Havering 2021

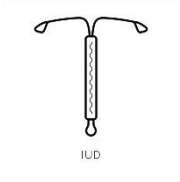


Source: OHID Fingertips



- 55.7% of Havering women visiting Sexual and Reproductive Health (SRH) services in 2020 chose user-dependent methods, similar to London (55.7%) and England; of these, 48.3% chose short acting hormonal contraception[36].
- More women in Havering in 2020 chose injections at SRH services as their main method of contraception (10.4%) than London (4.9%) and England (8.1%) as opposed to intra-uterine devices/systems.

[36] Public health profiles - OHID (phe.org.uk)



- Havering's total prescribed rate of Long Acting Reversible Contraception (LARC), including those fitted at either SRH clinics or GP surgeries, was 25.5 per 1,000 in 2021. This is **lower** than both London (30.4 per 1,000) and England (41.8 per 1,000)[37].
- The rate of women choosing to have their LARC fitted at GP surgeries in Havering in 20201 was slightly higher, at 13.0 per 1,000 women than those who chose to have their LARC fitted in SRH service clinics, at 12.4 per 1,000.

4.2 Teenage and Young People's Reproductive Health

Being a parent at any age is undoubtedly hard, but having a child as a teenage parent can sometimes lead to additional complications and challenges. The children of teenage mothers have been known to have a higher risk of low birth weight; there are more reports of complications in mother's pregnancy and delivery; higher numbers of children who die within the first 7 days after being born (perinatal death); lower child IQ and academic achievement; greater risk of having a fatal accident before age of 1 year; and a greater likelihood of being a teen parent themselves[38]. With good support, however, some of these risks can be reduced to some extent.

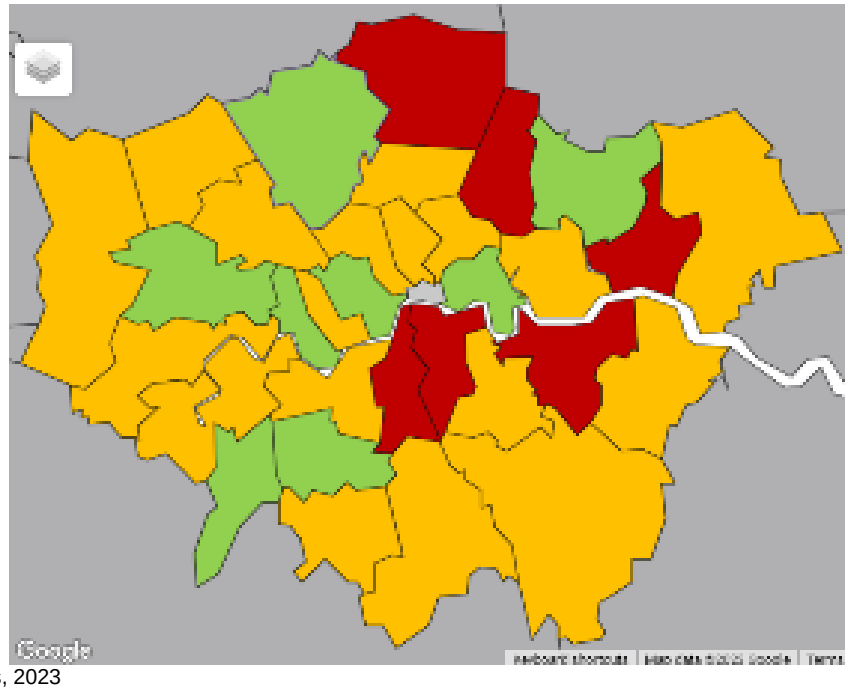
Teenage mothers who are pregnant have a higher risk of pregnancy induced hypertension (high blood pressure), premature labour, higher risk of post-partum depression and are less likely to seek prenatal care. Again, with good support, and open communication between teenagers, parents and professionals, many teenage parents go on to have healthy pregnancies.

Although under 18 and under 16 years conception rates are reducing, 2021 data shows that Havering still has a higher rate of both under 18 (12.5 per 1,000) and under 16 (1.7 per 1,000) conceptions than both London and England (Fig. 14)[39].

- Havering now ranks 8th **highest** in London for under 18 conceptions and 12th highest for under 16 conceptions, which is a large improvement from 2020 figures [40]. (see also Section 6).
- In 2021 in Havering, there were 57 known conceptions to women aged under 18 years[41] and 12 live births. The birth rate for under 18s was 2.6 per 1,000 women, **similar** to England (3.2 per 1,000) and London (1.9 per 1,000)[42].
- 0.5% of deliveries in Havering were with teenage mothers, aged between 12 and 17 years. This is **better** than England (0.6%), but **worse** than London (0.3%); the highest rate of deliveries to teenage mothers in London was Enfield at 0.8%[43].

[37] Public health profiles - OHID (phe.org.uk)
[38] NICE & Pilgrim, H. et al (2010) Systematic review of the long term outcomes associated with teenage pregnancy in the UK. contraceptive-services-for-socially-disadvantaged-young-people-additional-consultation-on-the-evidence-review-of-teenage-pregnancy-outcomes2 (nice.org.uk) ScHARR
[39] Public health profiles - OHID (phe.org.uk)
[40] Public health profiles - OHID (phe.org.uk)
[41] Office for National Statistics, 2021 Quarterly statistics on conceptions to women aged under 18 years
[42] Live births in England and Wales : birth rates down to local authority areas - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)
[43] Public health profiles - OHID (phe.org.uk)

*Figure 14. Under 18 conception rate per 1,000 by London borough, 2021, benchmarked against all in **London** region*



Source: OHID Fingertips, 2023

Despite this reduction in teenage pregnancy rates, the rate in under 18s conceptions leading to abortion continues to increase. 73.7% of under 18 conceptions in Havering in 2021 led to aborti on compared to 61.1% in 2011[44]. This suggests that, although fewer young women are getting pregnant, those who do are choosing and accessing abortion services rather than having a baby at a young age.

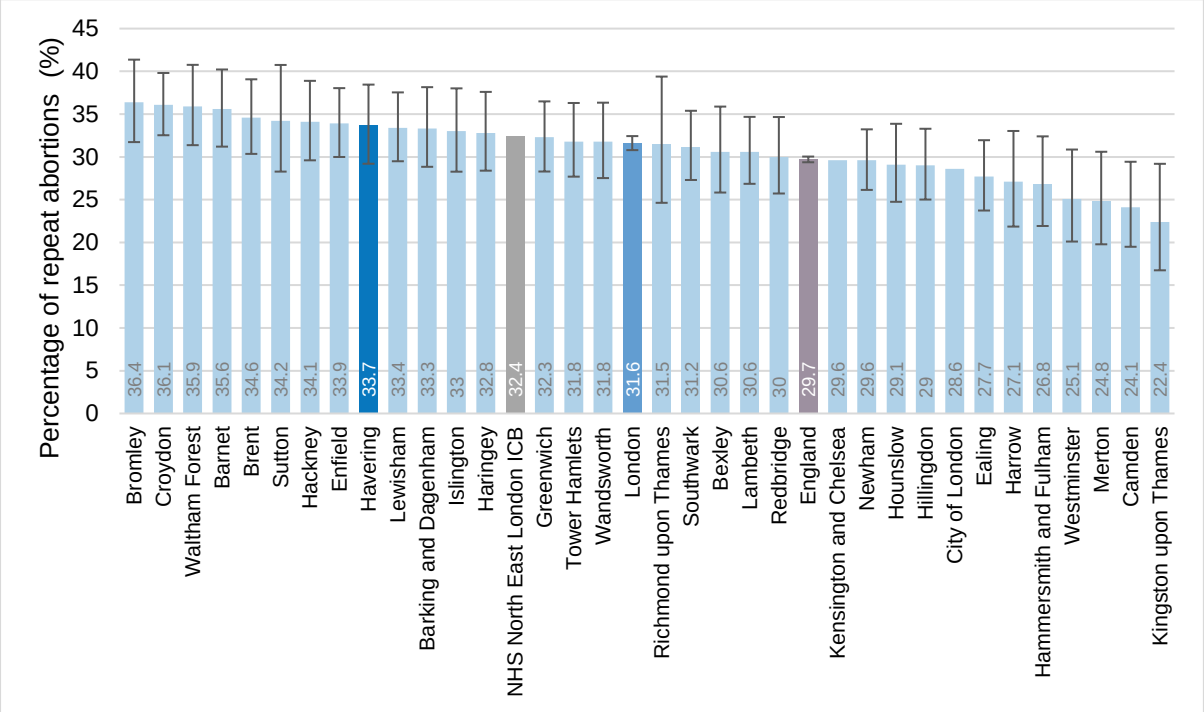
Of more concern, however, is the higher rate of those aged under 25 years using abortion as a repeat method. Access to effective contraception is therefore important, and needs to take into account where the young women themselves may not be enabled to access services, such as in cases of sexual exploitation or abuse.

- In 2021, 33.7% of abortions in women aged under 25 years involved a women who had a previous abortion in any year in Havering; this is **similar** to London (31.6%) and England (29.7%) (Fig. 15). This may be reduced with better access to contraception, particularly long acting reversible contraception (LARC).
- **Fewer** women aged under 25 years in 2021 attended specialist contraceptive services in Havering (50.9 per 1,000) than London (102.3 per 1,000) and England (82.6 per 1,000).

- Amongst those women aged under 25 years who were in contact with SRH services, 36.5% choose LARC as their main method of contraception. This is **similar** to London (33.8%) and England (37.3%)[45].
- In contrast, 56.9% of women in Havering in 2021 aged over 25 years who visited SRH services chose LARC, higher than London (50.6%) and England (53.4%)[46].

[44] Public health profiles - OHID (phe.org.uk)
[45] Public health profiles - OHID (phe.org.uk)
[46] Public health profiles - OHID (phe.org.uk)

Figure 15. Percentage (%) of repeat abortions in women under 25 years in Havering compared to all London boroughs, 2021.



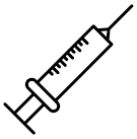
Source: OHID Fingertips

4.3 Maternal and Newborn Health and Wellbeing

Maternal and newborn health and wellbeing is supported in Havering by a range of services provided across the health and social care system. Pharmacies are a great asset as they not only offer opportunities to purchase pregnancy tests, but can provide advice on healthcare during pregnancy, such as folic acid supplementation, and signpost to maternity booking services. Similarly, Children's Centres offer outreach opportunities for ante-natal appointments with midwives as well as offering advice, social care early intervention and support and signposting to welfare, benefits or employment advice. The Babies, Children and Young People (BCYP) subgroup of the Borough Partnership provides a forum for representatives from key children's services to align strategies for delivery of these services. The following section gives an overview of key data relating to maternal and newborn health.

- There were 3,089 live births in 2022 in Havering[47], which equates to a crude birth rate of 11.7 per 1,000 population of all ages.
- 3.0% of babies born in Havering in 2021 were low birth weight; this means they had a recorded birth weight of under 2,500g and a gestational age of at least 37 weeks. This is **similar** to London (3.3%) and England (2.8%). 0.6% of babies born in 2021 were very low birth weight, <1,500g[48].
- Havering has the **second lowest rate** of neonatal mortality and stillbirth (3.52 per 1,000) in London, with only Westminster better (2.54 per 1,000).
- Havering has the 7th highest rate of multiple births (17.2 per 1,000) in London, compared to London (14.6) and England (13.7 per 1,000)

[47] ONS 2022 Live Birth Data by Local Authority
[48] Public health profiles - OHID (phe.org.uk)



- Only **30-34%** of women in North East London ICB took up the offer of an antenatal pertussis (whooping cough) vaccination in 2022-23, compared to around 60% nationally[49].

- In 2018/19, 9.5% of mothers smoked in early pregnancy in Havering; this is significantly **better** than the rate for London (12/8%) and England (29.1%)[50].
- **4.8%** of pregnant mothers were recorded as smoking at the time of delivery (SATOD) in Havering in 2022-23; this is significantly **better** than the rate for England (8.8%) and **similar** to rates in London (4.6%)[51].

- 91.5% of new birth visits, commissioned by the local authority and delivered by NELFT, are conducted within the target 14 days, **better** than London (81.6%) and England (79.9%)[52].
- 86.8% of infants received a 6-8 week review in Havering in 2022/23, **better** than both England (79.6%) and London (71.0%)[53].
- 57% of babies born in 2020-2021 in Havering were from women whose ethnicities were other than White British or White other 18% of babies were from mothers of Asian ethnicity (Bangladeshi, Indian, Pakistani or any other Asian group), 8.7% from Black (African/Caribbean/Other) and 8.0% from Mixed/multiple ethnic groups[54,55].

- In 2022, 40.4% of all live births were to mothers who were not born in the UK; this is lower than London (58.0%) and higher than England (31.1%)[56].
- Compared to the proportion of all ethnic groups in Havering, **more** women from GM groups had babies in 2021/22 than the relative propotion of people from white ethnicities.

Immunisation is one of the most cost-effective public health interventions which, as well as creating opportunities for children to thrive and get the best start in life, provides an important way to address inequalities. Uptake of vaccination for Measles, Mumps and Rubella (MMR) continues to be affected by the discredited research conducted in the late 1990s. Although even one dose of MMR vaccine by the time a child is 2 years old offers up to 80% protection against these illnesses, 2 doses are recommended for full protection[57].

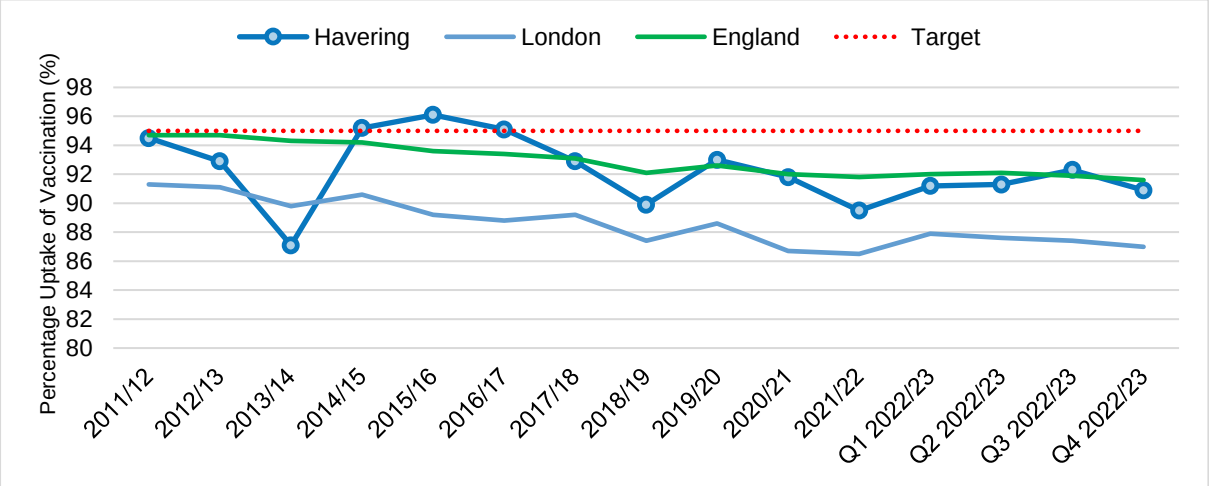
Figure 16. MMR Vaccination Uptake in Havering, London or England 2021-22

	Havering	London	England
MMR1 – one dose by 2 years	85.3%	79.9%	89.2%
MMR 1 – one dose by 5 years	91.5%	87.8%	89.2%
MMR 2 – two doses by 5 years	79.1%	74.2%	85.7%

[49] Prenatal pertussis vaccination coverage in England from January to March 2023 and annual coverage for 2022 to 2023 - GOV.UK (www.gov.uk)
[50] Public health profiles - OHID (phe.org.uk)
[51] Child and Maternal Health - Data - OHID (phe.org.uk)
[52] Public health profiles - OHID (phe.org.uk)
[53] Public health profiles - OHID (phe.org.uk)
[54] Live births by ethnicity and local authority, 2020 to 2021 - Office for National Statistics (ons.gov.uk)
[55] Previously referred to as BAME: Black and Minority Ethnic Groups
[56] Parents' country of birth - Office for National Statistics (ons.gov.uk)
[57] Cover of vaccination evaluated rapidly (COVER) programme: annual data - GOV.UK (www.gov.uk)

Despite Havering being relatively compliant and supportive of immunisations as a whole, there has been a steady decline in uptake, from achieving the 95% uptake target for childhood immunisations between 2014 and 2017 to around 91% by 2022-23 (Fig 17)[58].

Figure 17. Uptake of Primary Childhood Vaccinations (DTap/IPV/HiB) by 12 months in Havering, London and England 2011/12 to 2022/23



Source: OHID Fingertips Produced by LBH PHI, 2023

- 76.9% of babies in Havering in 2021/22 had breastmilk as their first feed.
- Whilst this is **better** than the average for England (71.7%), it is the 3rd lowest rate in London (average 87.7%).
- There is currently a lack of robust data on breastfeeding prevalence at 6-8 weeks after birth.

- 98.5% of children eligible for a newborn hearing screening had their test completed by 4 weeks corrected age, **similar** to both London and England (98.7% for both).
- Havering had the 3rd highest rate of newborn infant physical examination (NIPE) screening out of the London boroughs (97.8%). This was **better** than the rates for both London (96.8%) and England (96.6%)..

- Perinatal mental ill health affects up to 27% of new mothers.
- In 2017, there were an estimated 77 women with severe depressive illness in the postnatal period; up to 386 women with mild-moderate depressive illness and anxiety and up to 773 women with adjustment disorders and distress in the perinatal period.
- Nearly ¾ of mothers with new-born babies in the UK in 2023 report that the cost of living crisis is affecting their mental health and wellbeing.

4.4 Mothers who are Additionally Supported (SEN/SEND)

Research studies have shown that women with learning disabilities experience poorer maternal wellbeing and pregnancy outcomes compared to the general population. There have been reports of increased rates of pre-eclampsia, venous thromboembolism, premature birth, low birth weights of babies and lower (poor) Apgar scores for babies on delivery for women with learning disabilities. Pregnant women with learning disabilities are

[58] Public health profiles - OHID (phe.org.uk)

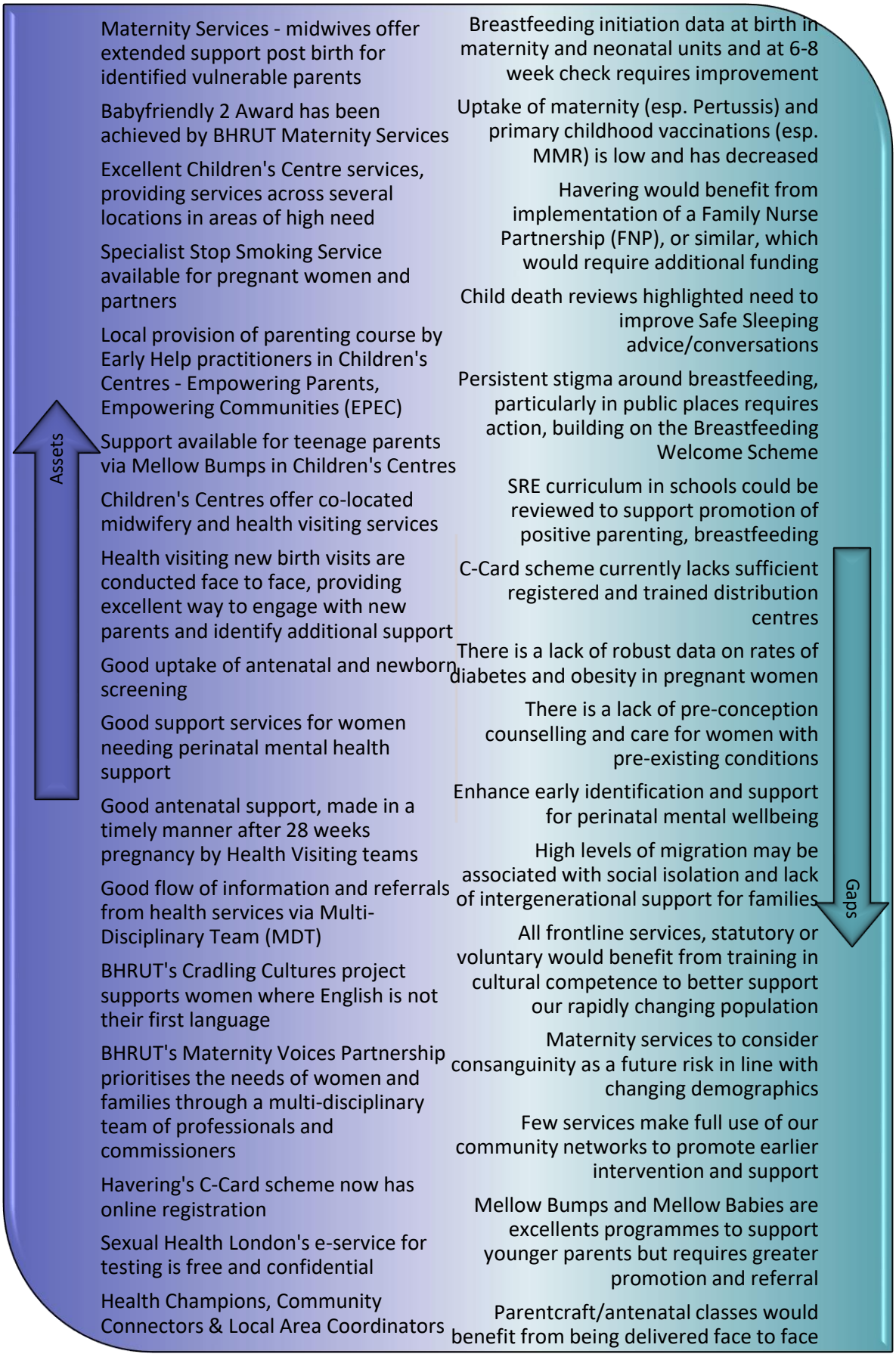
also less likely to seek or attend regular antenatal care and may have challenges understating the often text-based antenatal information[59].

There is little data available on the needs of women with learning disabilities who have children. QOF prevalence data for Havering in 2019/20 suggest that 0.4% of the general population have a learning disability, which would equate to around 1,048 people[60]. Across NEL in 2021/22, the percentage of women with learning disabilities was 0.54% among 18-24 year olds, 0.32% in 25 -34 years and 0.28% in 35-44 years[61]. If these rates are applied to the number of women in those age groups who had live births, this would be less than 10 women, and is likely to be an underestimate of the actual prevalence. For example, out of the nearly 2,000 respondents to Mencap's Big Learning Disability Survey 2022, 6.3% stated that they lived with their children[62]. This is significantly greater percentage than the QOF prevalence and suggests there may be many more women locally who require a different approach to support during their pregnancy. Offering plain language or easy read versions of text-based information would be recommended.

In the absence of clear data on learning disability during pregnancy, maternity services are recommended to engage with mothers to ascertain their needs and offer appropriate support.

[59] Health_inequalities_Pregnancy and birth.pdf
[60] Learning Disability Profiles - Data - OHID (phe.org.uk)
[61] Health and Care of People with Learning Disabilities, Experimental Statistics 2021 to 2022 - NHS Digital and Microsoft Power BI
[62] Report_BLDS2022.pdf (mencap.org.uk)

4.5 Assets and Gaps



4.6 What This Data Means for Havering

In addition to migration into and out of the borough, a key factor in the population increase in Havering is the rise in General Fertility Rate (GFR), and high conception rates that remain above both London and England. In particular, the rise in population aged 25 to 39 years old, who are the most likely ages to start or continue growing their family, is likely to place increasing demand for housing of suitable size, employment, maternity and health visiting services, nursery provision and education.

Being able to choose whether or not to have a family is partly dependent on access to good contraception. Evidence tells us that long acting reversible contraceptives (LARC) are more effective than other methods. The annual pregnancy rates for LARC are less than 1% compared to 9% for oral contraceptives and 18% for condoms. Amongst people in Havering who visited SRH services however, more chose user-dependent methods, such as short acting hormonal contraception than long acting reversible contraception. We need to work with people in Havering to understand why this is their preferred method and where possible address any concerns regarding use of LARC and improve access to such services.

The proportion of under 25 year olds having an abortion who had a previous abortion in any year (repeat abortion) is higher for Havering than London. Engaging with younger people may again help us understand why this is happening and what their needs are regarding access to contraception.

Not everyone has a choice regarding pregnancy, however, and it is essential that as a co-ordinated system we are alert for and recognise signs of sexual exploitation and abuse.

For those women who do become pregnant, a key concern arising from the data above is the low percentage of women to take up the offer of a pertussis (whooping cough) vaccination antenatally. Since the maternal pertussis programme was introduced in 2013, the number of cases has dropped significantly from 1,625 in 2013 to just 9 in 2022. The vaccine can help prevent 78% of pertussis cases in infants less than 2 months old. However, if uptake continues to decrease, we may see a surge in pertussis cases and its related complications, including infant death.

The health of the mother is also critical for a healthy baby. With increasing rates of adult obesity across the UK, it is likely that we will see more mothers overweight or obese in their pregnancy, although there is no reliable data at present. This places an additional health burden on the mother, increasing her chances of gestational diabetes, high blood pressure, pre-eclampsia, blood clots and miscarriage; babies have a higher chance of being born early (before 37 weeks) and an increased chance of stillbirth. However, there is a lack of reliable and robust data on obesity and diabetes in pregnant women. Taking a whole systems approach to tackling obesity will undoubtedly support the healthiness of women pre-conceptually, but additional support may be required for those with additional risk factors, including obesity and diabetes, in the pre-conception and antenatal periods.

Mental wellbeing of the mother in the postnatal period is crucial to parent-child bonding and laying the foundations for good child development. However, we know that the Covid-19 pandemic had a significant impact on maternal mental health and the current cost of living crisis is having a similar affect. Promotion of mental health self-care, signposting to forms of social support and early identification of signs of poor mental wellbeing in mothers by well-trained frontline staff will be key to preventing escalation of ill health.

4.7 Recommendations:

1. •Government funding should be sought to increase the capacity of Health Visiting Services in line with population growth in Havering
   •Such capacity would improve early identification and support for families to reduce risks for safeguarding and child development
2. •Engage with and involve local residents in co-production and service design at all stages of commissioning services and ensure that services delivered are culturally sensitive to the changing population
3. •In response to Child Death reviews, utilise Making Every Contact Count (MECC) principles to raise awareness of Safe Sleeping practices across all services in Havering
   •Support earlier identification and intervention where safeguarding issues may be indicated (Early Help services)
4. •Data flow for sharing breastfeeding initiation at birth in maternity and neonatal units and breastfeeding continuation at 6-8 week reviews requires improvement
   •Improving data access will enable actions to be taken to provide targeted support to women to encourage greater breastfeeding initiation
   •These support the whole systems approach to obesity
5. •Consider ways to fund and implement a pre-conception counselling and care service for women with pre-existing long term conditions and/or risk factors for poorer birth outcomes (diabetes, obesity)
6. •Engage with residents to better understand and address low/decreasing uptake of immunisations, particularly maternal pertussis and primary childhood vaccinations, especially MMR
7. •Increase promotion and uptake of LARC, improving access to LARC and other contraceptive methods
   •Reduce number of teenage pregnancies and repeat abortions in women under 25 years

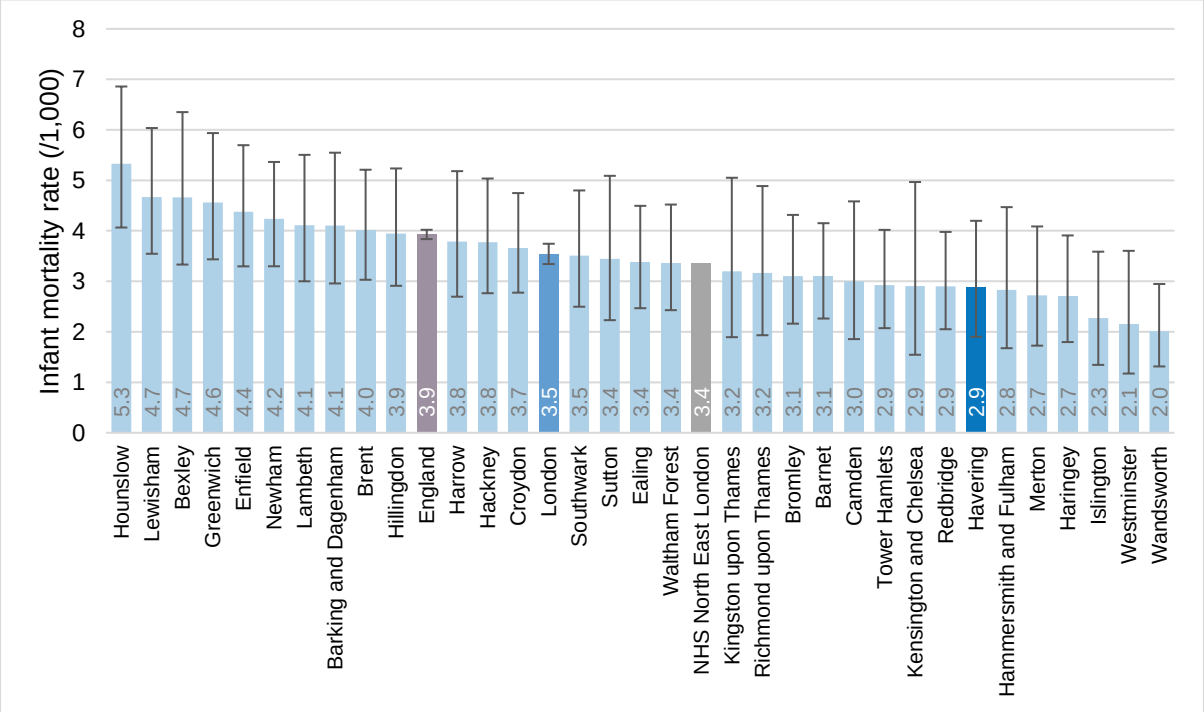
5. Early Years & Families

5. Early Years and Families (0-4 years)

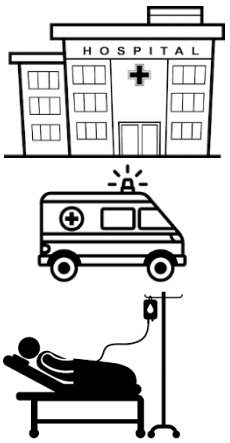
5.1 Young Children's Health and Wellbeing (0-4 years)

Infant mortality rate, or the number of deaths in children aged under 1 year of age per 1,000 live births, is an indicator of the general health of an entire population. Havering's rate of infant mortality for 2019 to 2021 is lower (2.9 per 1,000) than both London (3.5 per 1,000) and England rates (3.9 per 1,000) (Fig. 18)[63].

Figure 18. Infant Mortality Rate per 1,000 Children Aged Under 1 Year by London Borough, 2019-2022



Source: OHID Fingertips, Produced by: LBH PHI 2023



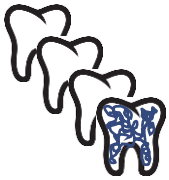
- Havering had a **lower** rate of A&E attendances for children aged 0-4 years in 2021/22 (488.9 per 1,000) than London (854.5 per 1,000) and England (762.8 per 1,000). This was the lowest rate out of the London boroughs[64].
- Havering has the **lowest** rate of A&E attendances for children under 1 year old (872.2 per 1,000) out of the London boroughs (1302.6 per 1,000) and **better** than England (1094.5 per 1,000).
- Emergency Admissions for 0-4 year olds in Havering are at a **lower** rate in Havering (263.2 per 1,000) than in London (341 per 1,000) and England (483.7 per 1,000)[65].
- There were **fewer** emergency admissions caused by unintentional and deliberate injuries in children aged 0-4 years in Havering in 2021/22 (67.2 per 10,000) than London (82.9 per 10,000) and England (103.6 per 10,000)[66].

[63] Child and Maternal Health - OHID (phe.org.uk)
[64] Child and Maternal Health - OHID (phe.org.uk)
[65] Child and Maternal Health - OHID (phe.org.uk)
[66] Child and Maternal Health - OHID (phe.org.uk)

- For children aged 0-9 years with long term conditions, Havering had a **higher** rate of admissions for **Asthma and Diabetes** than London and England, but a **lower** rate of admissions for **Epilepsy** (Fig. 19).

Figure 19. Admissions for Long Term Conditions in Children aged 0-9 Years, 2020/21

Admissions (0-9 years) for LTC in 2020/21	Havering	London	England
Asthma	210.3	172.6	172.7
Diabetes	30.0	27.5	37.0
Epilepsy	60.1	78.2	89.7



- One in 4 children in Havering (24.8%) had experienced visually obvious dental decay in 2021/22. This was **better** than London (25.8%) but **worse** than England (23.7%).
- The rate of hospital admissions for dental caries has reduced since 2015/16-2017/18 from 179.5 to 136.5 per 100,000 by 2018/19-2020/21 in Havering; this rate is also **lower** than both London (280.1) and England (220.8)

5.2 Children in Need or in Care

A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled[67]. Children in need of help and protection make up a small minority of all children, those assessed and supported through children's social care. Over the course of a year, it is estimated that around 6 percent of all children in England will be in need at some point. Children in need are a group supported by children's social care, who have safeguarding and welfare needs, including[68]:

- children on child in need plans
- children on child protection plans
- looked after children
- disabled children

All of these children have needs identified through a children's social care assessment or because of their disability, meaning they are expected to require services and support in order to have the same health and development opportunities as other children.

Early Help can reduce problems and improve outcomes for children, young people and families. Early Help is aimed at early intervention in order to prevent escalation of need, designed to empower families to be independent of services. Havering's Early Help Service uses the Outcomes Star which both measures and supports progress for service users towards self-reliance[69].

- Since 2019, there has been an increase in the numbers of children being referred to children's social care, and in the number of children who have child protection plans (Fig.20). The number of children in care has slightly reduced in 2022-23 from 2021-22 as there is annual

[67] Children Act 1989 (legislation.gov.uk)
[68] Review of children in need - GOV.UK (www.gov.uk)
[69] Early help assessment | The London Borough Of Havering

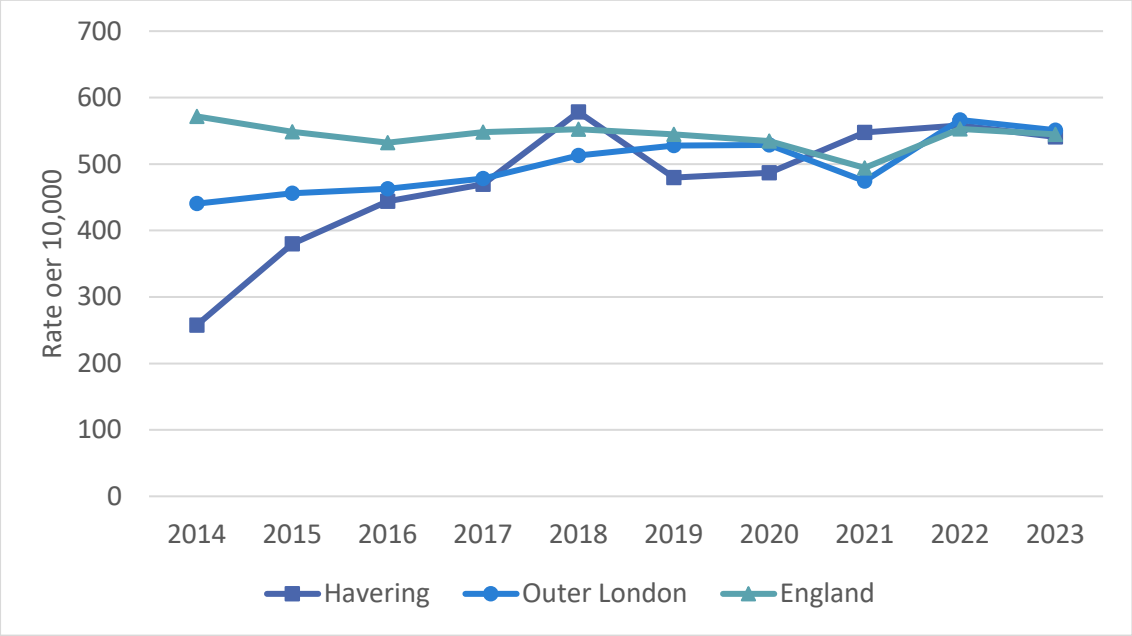
variation in absolute numbers, but the overall trend has been increasing.

Figure 20. Change over time in rates of children recorded by Children's Social Care, Numbers of Children

	2018-19	2019-20	2020-21	2021-22	2022-23
Referrals to Children's Social Care	2,759	2,843	3,232	3,267	3,167
Number of children subject to a child protection plan	207	142	192	237	261
Number of children in care	247	232	206	265	241

- Havering's Children in Need (CIN) rate as at 31st March 2023 was higher, at 402.1 per 10,000, than London (369.8 per 10,000) and England (342.7 per 10,000)[70].
- During 2022/23 there were 3,167 referrals to Children's Social Care in Havering; referrals were 3% lower than the previous year but 15% higher than in 2018/19[71].
- The rate of referral to Havering's Children's Social Care, 541 per 10,000 children is in line with London, England, and boroughs with a statistically similar population profile as Havering (Fig. 21)[72].

Figure 21. Rates per 10,000 of referrals to Children's Social Services in Havering, London, England and Statistical Neighbours as at March 31st 2014 to March 31st 2023

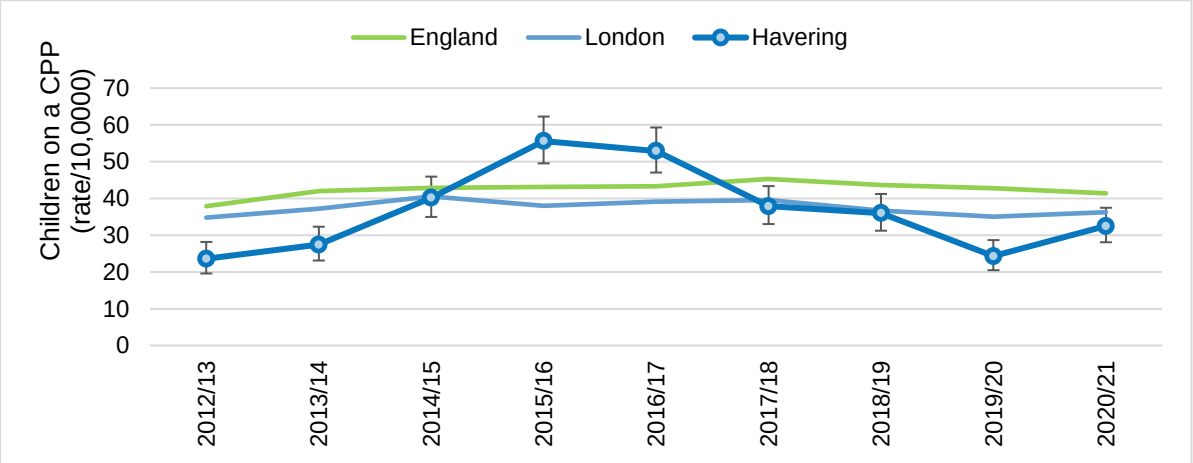


Source: Local Authority Interactive Tool, 2023; reproduced by Public Health 2023

[70] Create your own tables, Table Tool – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)
[71] Local authority interactive tool (LAIT) - GOV.UK (www.gov.uk)
[72] Local authority interactive tool (LAIT) - GOV.UK (www.gov.uk)

Since 2019 there has been a rise of 13% in the rate of children requiring child protection plans. Compared to Outer London boroughs Havering's increase has been slightly higher. Our statistical neighbours have seen a reduction in the rate of children with CP plans (Fig.22).

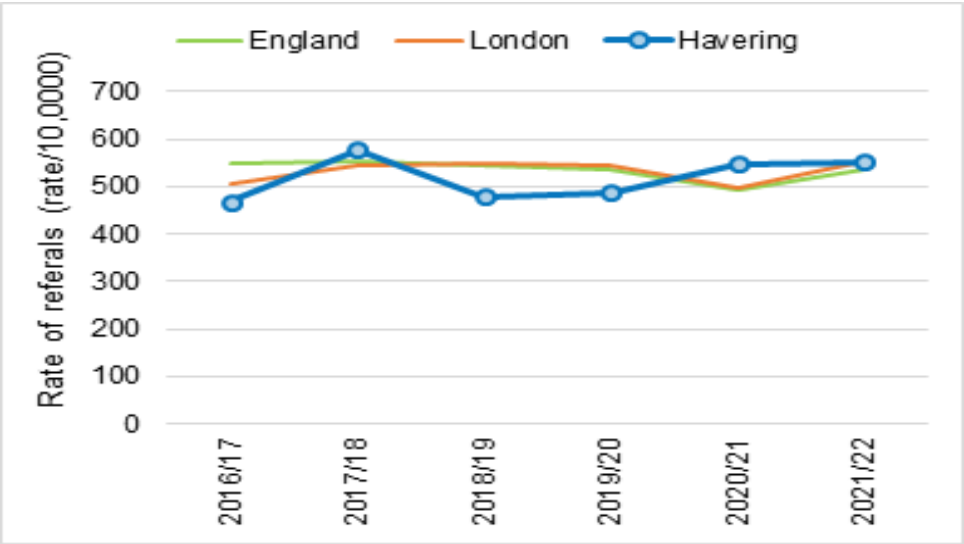
Figure 22. Children on Child Protection Plans in Havering, rate per 10,000 children Aged Under 18 Years Compared to London and England 2012/13 to 2020/21



Source: OHID Fingertips, Produced by: LBH PHI 2023

- As at 31st March 2023, Havering had 241 children in care (CIC). This was a reduction from 265 at the end of March 2022[73].
- Havering has a rate of 45 children in care per 10,000. This is better than both London (52 per 10,000) and England (70 per 10,000)[74].
- Using the most recent comparative data, Havering's rate per 10,000 population was **lower** than England, outer London or statistically similar boroughs (Fig. 23)[75].

Figure 23. Rate of Children in Care per 10,000 Children aged under 18 years as at 31st March in Havering, Outer London, Statistical Neighbours or England in 2016 to 2022.



[73] Local authority interactive tool (LAIT) - GOV.UK (www.gov.uk)
[74] Public health profiles - OHID (phe.org.uk)
[75] Local authority interactive tool (LAIT) - GOV.UK (www.gov.uk)

Source: Local Authority Interactive Tool, 2023

5.3 Supporting Children's Healthy Development & Addressing Inequalities

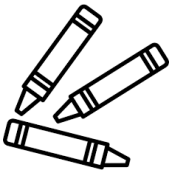
There are a range of universal as well as targeted services available to support children in their development and address inequalities. However, take up of these services in not always equitable, particularly by vulnerable groups/those affected by deprivation. For example, the offer of free education and childcare for 2-year olds is available to targeted families if they receive benefits, such as income support, jobseekers, or employment and support allowance, child tax or working tax credit. It is also available to any child in care, any child who has an EHC plan or has left care under an adoption order[76]. Up to 30 hours childcare is available universally to all 3 and 4 years olds who live in England[77]. Anyone more than 10 weeks pregnant, or have a child under 4 years who is claiming benefits, or is under 18 years old can apply for the Healthy Start Scheme which can support families in buying healthy foods such as milk or fruit and get free vitamin supplements[78].

- In 2021/22, 88% of eligible children in Havering received a 12 month review, **better** than for London (73.4%) and England (82.0%)[79].
- There are 392 Ofsted registered providers of early years care to 0-5 years; 62% of these are signed up to deliver funded early education and care[80].
- 67.1% of 2-year old children in Havering took up the offer of free early education, **better** than London (65.2%) but **worse** than England (73.9%). The percentage of children taking up this offer has been increasing steadily since a significant dip in 2021[81].

- 94.2% of 3 and 4 year olds took up the offer of free early education in Havering, compared to 83.7% in London and 93.7% in England[82].
- 22 children in care (CIC) who were 2 years old in 2021/22 accessed a funded place with early years providers[83].

- 76.0% of children in care (CIC) were up to date with their vaccinations according to 2022 data. This is **similar** to London (76.0%) but **worse** than the rate for England (85.0%)[84].
- 81.4% of children in Havering received a 2-2½ year review in 2022/23, **better** than London (61.2%) and England (73.6%)[85]; however, only 73.2% of 2-2 ½ year reviews conducted in 2022/23 recorded use of the ASQ3 tool.

- 82.1% of children achieved a good level of development across all 5 domains in the 2–2½ year check in 2022/23. This is **better** than London (69.4%) and England (79.2%)[86].



- By the end of Reception year in 2021/22, the percentage of children achieving a good overall level of development and at least the expected level of development in communication, language and literacy was **similar** to London and England:

[76] Help paying for childcare: Free education and childcare for 2-year-olds - GOV.UK (www.gov.uk)
[77] 30 hours free childcare - GOV.UK (www.gov.uk)
[78] Healthy Start - GOV-UK Find a grant (find-government-grants.service.gov.uk)
[79] Local data
[80] Draft Childcare Sufficiency Report 2023 _ 2027.pdf (havering.gov.uk)
[81] Local authority interactive tool (LAIT) - GOV.UK (www.gov.uk)
[82] Local authority interactive tool (LAIT) - GOV.UK (www.gov.uk)
[83] Draft Childcare Sufficiency Report 2023 _ 2027.pdf (havering.gov.uk)
[84] Child and Maternal Health - OHID (phe.org.uk)
[85] Child and Maternal Health - OHID (phe.org.uk)
[86] Child and Maternal Health - OHID (phe.org.uk)

	Havering	London	England
Good level of Development	64.5%	67.8%	65.2%
Communication,Language,Literacy	79.7%	79.1%	79.5%

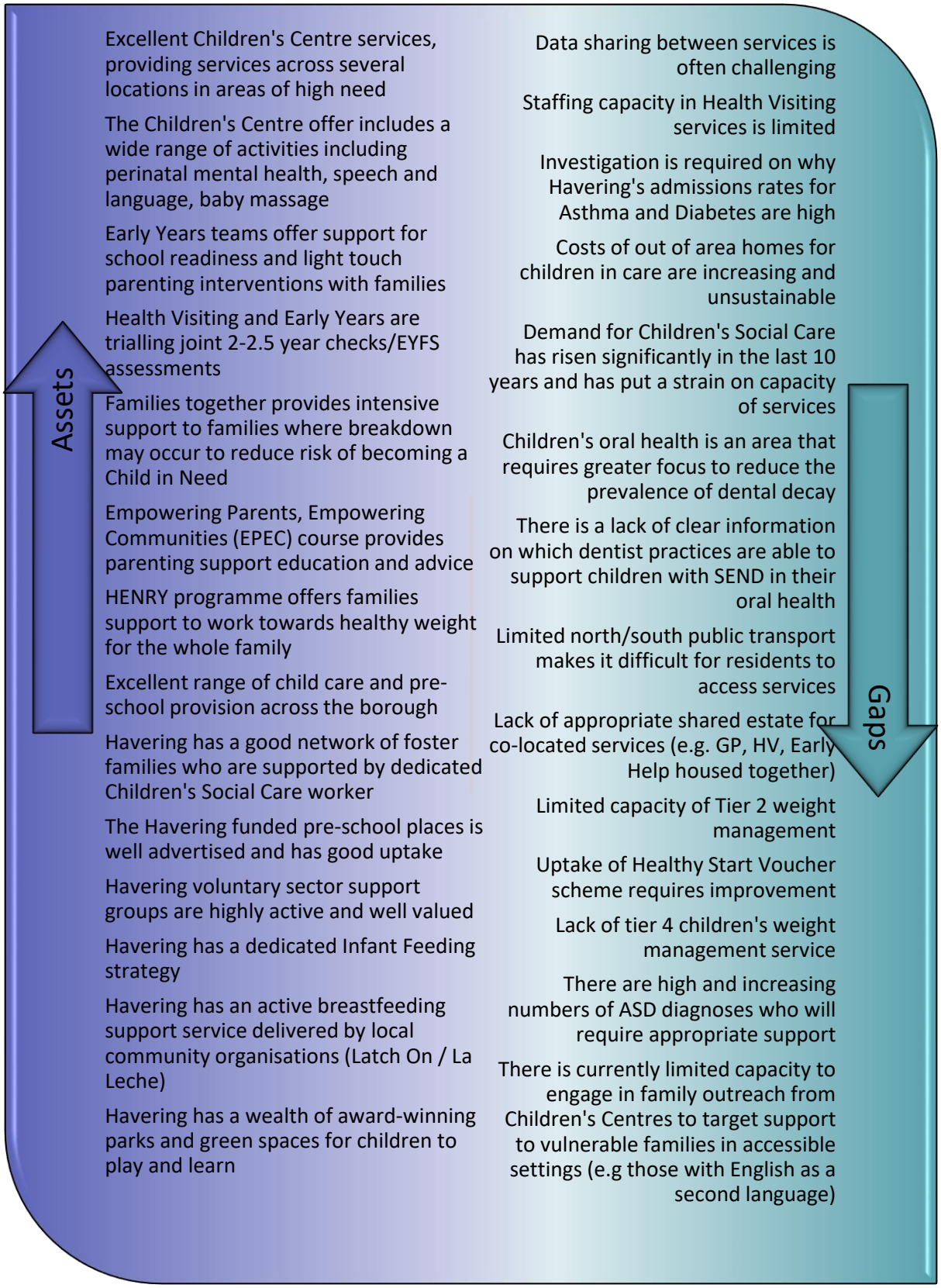
- Children from GM ethnic groups were equally likely to achieve a good level of development by the end of Reception in Havering (71%) as those not from BAME communities (71%).

Good food is essential for children's development. However, the Covid-19 pandemic and cost of living crisis have impacted income significantly, which in turn has likely impacted the nutrition families with young children.

- 66% of those eligible in Havering took the Healthy Start voucher in 2023[87].
- 13.6% of Havering residents responding to the 2021 GLA Survey of Londoners reported their children were [sometimes or often] unable to have balanced meals due to not enough money
    - 7.32% had cut the size of their children's meals
    - 3% had gone a whole day without food due to not enough money

[87] Healthcare professionals – Get help to buy food and milk (Healthy Start)

5.4 Assets and Gaps



5.5 What This Data Means for Havering

The health of children in their early years living in Havering is generally better than London or England, with lower mortality rates and fewer A&E attendances and admissions to hospital. With a high rate of admission to hospital for Asthma and Diabetes, further work is needed locally. Whilst also recognising that health crises for both of these conditions do happen occasionally, appropriate support may help children maintain their health and wellbeing whilst living with a long term condition.

Statutory services, such as health visiting are delivered well in Havering, and there is good uptake of early funded childcare provision, but these services are challenged to meet the rising demand as the population increases. The percentage of children achieving a good level of development across all 5 domains in the 2 – 2 ½ year check is better than London or England, but still indicates that 18% of children require additional support to meet their development needs. Increased co-location of services would assist in early identification of need and referral to onward services, particularly where this relates to child development and their readiness for school. However, the clinical criteria for many services, such as CAMHS, reflect the severity for that condition and level of intervention required; as such a referral may not result in acceptance of a child for treatment/support. Earlier identification and intervention is designed to reduce the risk of worsening conditions before it gets to the point of clinical intervention. As a system, therefore, it is important to consider which agencies may provide that earlier support, and how to grow that provision for earlier intervention.

All children who meet the prescribed criteria are able to access high quality early education regardless of their parents' ability to pay – benefiting their social, physical and mental development and helping to prepare them for school. The quality of early years provision in Havering is predominantly good or outstanding. Although there is no statutory duty to provide additional funding for children who are in receipt of 2-year-old Early Education funding, support within Havering is not age dependent, so provision is made for this age group too[88]. Around 2/3 of 2-year old children took up this funded early education offer, and with further promotion and awareness-raising the take-up could be higher. Requests for additional funding can also be made if a child has an identified need that requires additional support.

Although the rates of children in care are generally lower than London and England, there has nevertheless been an increase in absolute numbers of children with additional needs with the growing population. Often the needs of these, and other children, are more complex, which adds an additional strain to an already stretched service. This is discussed further in the School Age Children section.

The range of support offered by Children's Centres/Early Help services in Havering is excellent, and driven by expressed want and needs of local residents. The centres provide a combination of early help and early years activities, such as parenting programmes, support for teenage parents, parent-child bonding and baby massage. Current actions to improve outcomes for CYP in Havering are captured in the following key strategies; these will require reviewing in the light of this JSNA evidence.

- Strategy for the Delivery of Early Intervention Services in Havering 2022-2024
- HSCP Neglect Strategy 2021-2023 (havering.gov.uk)
- the best start for life - the first 1001 days | Havering Directory

[88] Draft Childcare Sufficiency Report 2023 2027.pdf (havering.gov.uk)

5.6 Recommendations:

1	•Increase focus on the recruitment and retention of staff in Early Years roles to meet capacity in lin with population gowth •This is especially required in Health Visiting, Community Paediatrics and Early Years practitioners, supported by appropriate levels of funding to increase capacity of service according to population growth
2	•School readiness by end of Reception year is a priority. •Focus on early intervention to improve school readiness by increase delivery of Joint 2-2.5 year checks with Health Visiting and Early Years staff in Early Years settings to improve school readiness
3	•Utilise outcomes from the 2-2.5 year check to signpost to a relevant early support offer to improve School Readiness and grow non-clinical offer e.g. Speech and Language Theapy, Physiotherapy, Family Support services for children wtih additional needs (ASD/ADHD etc.)
4	•In response to Child Death reviews, utilise Making Every Contact Count (MECC) principles to raise awareness of Safe Sleeping practices across all services in Havering
5	•In response to increasing population and significant rise in referrals to Children's Social Services, ensure resources are made available to meet Corporate Parent responsibilities
6	•Good long term condition management support is required to prevent admissions to hospital, especially for childhood asthma and diabetes
7	•Make the most of existing assets to signpost parents to relevant community services e.g. Health Champions, Local Area Co-ordinators, Community Connectors
8	•Consider ways the local integrated system can focus on good oral health for children, to reduce avoidable dental caries

6. School Age Children

6. School Age Children 4-18 years

6.1 School Age Children's Health and Wellbeing (5-18 years)

- The child mortality rate (pooled for 3 years 2018 to 2020) for children aged 1-17 years in Havering is **too small to be calculated** and by default lower than the rates for both London (9.8 per 100,000) and England (10.3 per 100,000)[89].

- In 2022, Havering's rate of emergency hospital admissions caused by unintentional and deliberate injuries to children was **lower** (54.7 per 10,000) than England (84.3 per 10,000)[90].
- 1.9% of pupils in Havering had social emotional and mental health needs in 2021/22[91]; this was lower than the rate estimated for London (2.7%) and England (3.0%). This rate has been increasing steadily from 2.4% in 2017/18.

- National data suggests that in 2020, 1 in 6 (16%) of children aged 5 to 16 years were identified as having a probable mental disorder. This has increased from 1 in 9 (10.8%) in 2017[92], with increases for both boys and girls[93]. Amongst 17 to 22 year olds more young women were likely to have a probable mental disorder (27.2%) than young men (13.3%)[94].

- Data from the Mental Health Services Dataset (MHSDS) showed that in August 2023, 11 to 15 year olds represented the group (in 5-year age bands) with the highest number of contacts with mental health services (240,000), with 5 to 10 year olds a close second (133,000) contacts nationally[95].

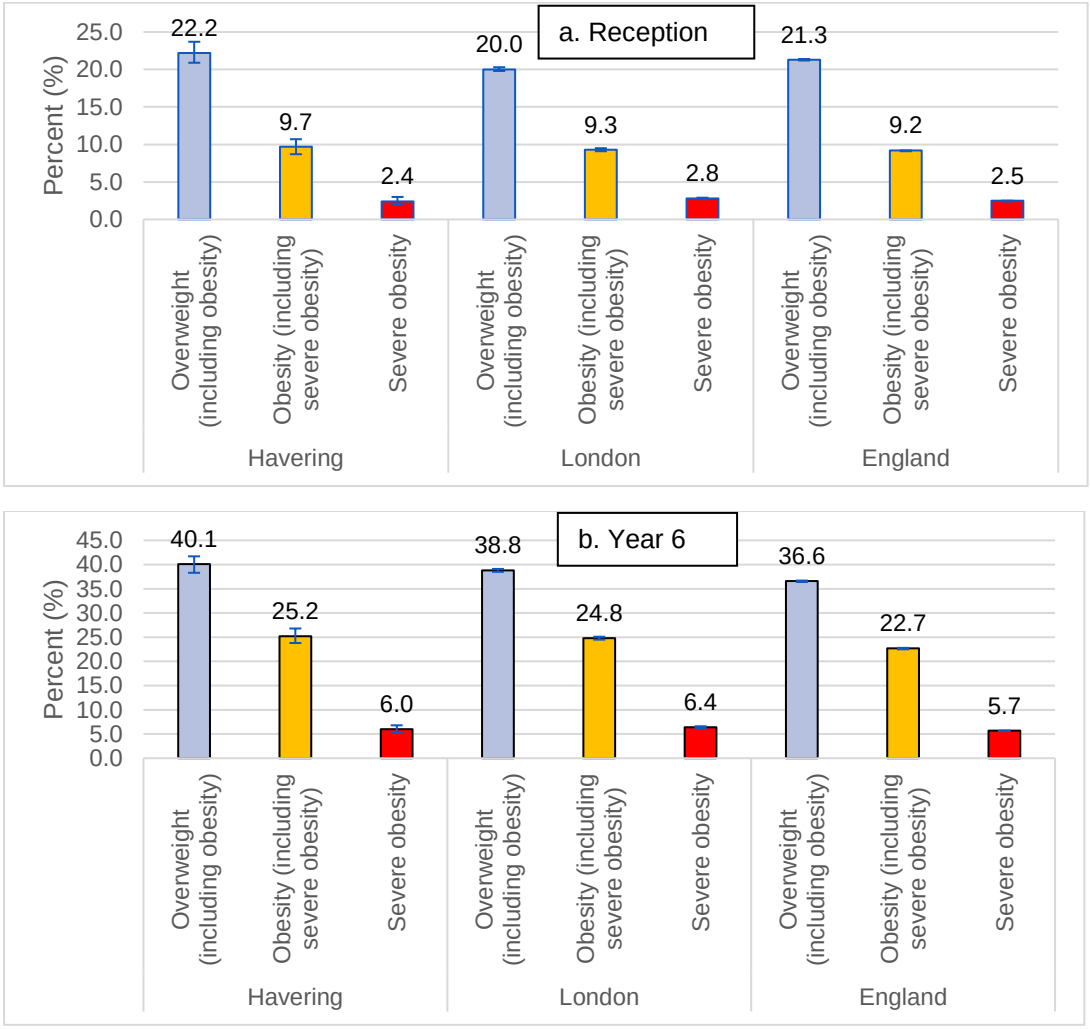
- Over the 5 months April to August 2023, NHS North East London ICB had a total of 4,630 closed CYP referrals where the children were discharged with at least 2 care contacts[96]. 27% of those contacts showed measurable improvement as a result of contact with those services in NEL ICB in August 2023.
- Amongst children aged 10-24 years, Havering had a **lower** rate of hospital admissions as a result of self-harm (200.3 per 100,000) than London (229.7 per 100,000). This rate was **significantly lower** than the rate of admissions for self-harm in England (427.3 per 100,000)[97].

- Havering's rate of hospital admissions for asthma for all children under 19 years was 146.5 per 100,000 (see section 4.1 above for rate under 9 years). This was, was **higher** than London (142.3 per 100,000 and England (131.5 per 100,000)[98].

[89] Public health profiles - OHID (phe.org.uk)
[90] DfE Interactive Local Authority Tool, 2023
[91] Public health profiles - OHID (phe.org.uk)
[92] Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey - NHS Digital
[93] Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey - NHS Digital
[94] Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey - NHS Digital
[95] Microsoft Power BI
[96] Microsoft Power BI
[97] Public health profiles - OHID (phe.org.uk)
[98] Public health profiles - OHID (phe.org.uk)

Preventing overweight and obesity and the health issues caused by overweight and obesity are priorities for Havering Council and the NHS. Havering's rates of obesity are **similar** to London and England for Reception, but higher for children in Year 6. Of more concern, however, is the significant increase in obesity between Reception (a.) and Year 6 (b.) (Fig. 20).

Figure 20. Prevalence of Overweight and Obesity in Havering, London and England in Reception (top) and Year 6 (bottom) Children 2021-22.



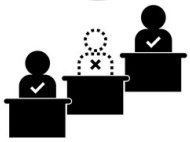
6.2 Educational Attendance

Being in school is important to a child's academic achievement, wellbeing, and wider development. Regular school attendance is a key mechanism to support children and young people's educational, economic and social outcomes. Schools can facilitate positive peer relationships, which contributes to better mental health and wellbeing. Attendance at school is crucial to prepare young people for successful transition to adulthood, and to support their longer term economic and social participation in society. There is also evidence that the students with the highest attendance throughout their time in school gain the best GCSE and A level results[99].

Non-attendance, whether authorised or unauthorised can have a detrimental impact not just on educational attainment but their overall development. There may be very valid reasons

[99] Why is school attendance important and what support is available? - The Education Hub (blog.gov.uk)

why a child is absent from school, but pupils who have missed more than 10% of school sessions are considered 'Persistently absent'[100]. Students who attend school less frequently perform worse academically and are more likely to be excluded from school and to drop out. They may also feel less connected to their classmates and find it hard to get back into school. This may hinder their social and emotional growth. Absences from school may also have long-term consequences that extend beyond school and into adulthood; children who are persistently absent are more likely to obtain no qualifications and to be out of the labour force by mid-adulthood[101].



- 89.7% of families were offered their preferred first choice of primary school in 2023. This is **worse** than the 92.5% offered their first choice in England, better than the rate offered in inner London (87.2%) and similar to that offered across outer London (89.3%)[102].
- Havering had **fewer** (1.5%) unauthorised absences in schools than both London (1.9%) and England (1.8%) in 2022.
- Amongst primary schools, the rate of unauthorised absence was 1.1% and in secondary it was 2.0%[103].
- Total persistent absence (missing more than 10% of all sessions) was **lower** in Havering in 2022 (19.7%) than England (22.5%)[104].
- There were **fewer** permanent exclusions in Havering's schools in 2022 (0.01% of the total school population) than England (0.08%) and boroughs with similar population profiles (0.07%)[105].
- In 2022, 4.52% of all pupils in the total school population received a suspension. This was **lower** than England (6.91%) and similar boroughs (6.43%)[106].

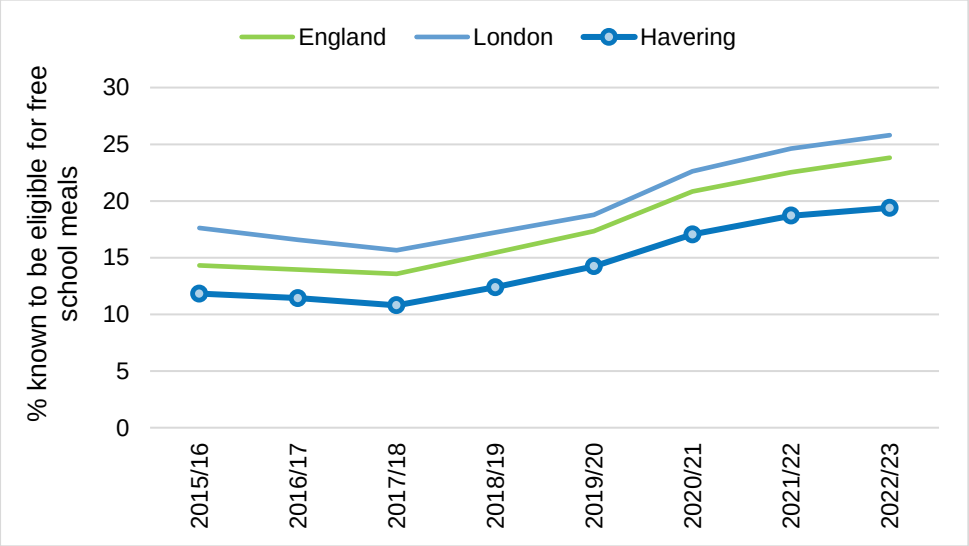
6.3 Inequality and Deprivation

- Data from the Mental Health of Children and Young People in England Survey 2020 showed that 11 to 16 year olds in the 4th quintile of deprivation were the most likely to have a possible or probable mental health disorder (29.4%). This compares to 13.8% in the 1st quintile (least deprived)[107].
- Amongst 5 to 10 year olds, children in the 2nd quartile (2nd least deprived) were most likely to have a possible or probable disorder (24.7%). However, this may be as a result of equity of access to services.
- National data shows that children aged 5 to 16 years with a probable mental health disorder were more than twice as likely to live in a household that had fallen behind with payments (16.3%) than children unlikely to have a mental disorder (6.4%).

[100] Why is school attendance important and what support is available? - The Education Hub (blog.gov.uk)
[101] Persistent absence from school is a growing threat to children's education (theconversation.com)
[102] Secondary and primary school applications and offers, Academic year 2023/24 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)
[103] DfE Interactive Local Authority Tool, 2023
[104] DfE Interactive Local Authority Tool, 2023
[105] DfE Interactive Local Authority Tool, 2023
[106] DfE Interactive Local Authority Tool, 2023
[107] https://files.digital.nhs.uk/2C/48CB60/mhcyp_2020_tab.xlsx

- Amongst children who have been in care for at least 12 months, the rate of unauthorised absence in 2022 was 2.9%[108]. This is higher than the rate amongst all pupils (1.5%) and **slightly higher** than the rates of absence for CIC in England (2.3%) and Outer London (2.7%).
- Children in Need (CIN) in Havering in 2022 missed **fewer** sessions through unauthorised absence than CIN children in England (7.0%) and boroughs whose populations are similar to Havering (6.6%)[109].
- 19.4% of all pupils in Havering are known to be eligible for free school meals (FSM) in 2022/23. Although this is lower than the rate for both London (25.8%) and England (23.8%), it is on an increasing trajectory (Fig. 21) and the 9th lowest rate in London.
- Amongst primary school pupils only, 19.5% are known to be eligible for FSM, compared to 26.5% in London and 25.2% in England
- Uptake of FSM, amongst all pupils and primary school pupils is **less** than the percentage of pupils eligible (Fig. 22).
- For those children with FSM status, 64.5% achieved a good level of development at the end of Reception year, **similar** to both London (67.8%) and England (65.2%).

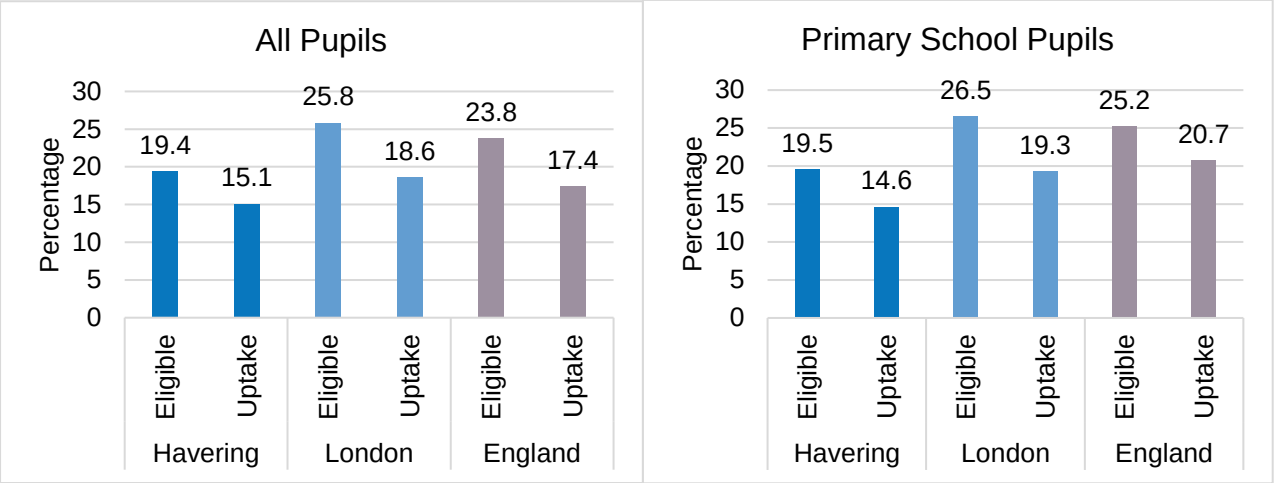
Figure 21. Trend in Percentage of All Pupils Eligible for Free School Meals (FSM) 2015/16 to 2022/23 in Havering, London and England.



Source: OHID Fingertips, Produced by: LBH PHI 2023

[108] DfE Interactive Local Authority Tool, 2023
[109] DfE Interactive Local Authority Tool, 2023

Figure 22. Difference Between Percentage of i) All Pupils and ii) Primary School Pupils Eligible for FSM and Uptake for Havering, London and England 2022-23.



Source: OHID Fingertips

6.4 Special Educational Needs and Disabilities (SEN/SEND) in School Age Children (5-25 years)

Special educational needs and disabilities (SEND) can affect a child or young person's ability to learn, including, for example, their:

- behaviour or ability to socialise, for example they struggle to make friends
- reading and writing, for example because they have dyslexia
- ability to understand things
- concentration levels, for example because they have attention deficit hyperactivity disorder (ADHD)
- physical ability

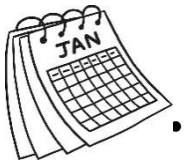
An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs.

- 12.5% of pupils in school in Havering in 2022/23 had a statutory plan of Special Educational Needs[110]. This is **lower** than the rate for London (16.9%).
- 3.9% of Havering pupils in 2022/23 have an Education Health and Care Plan (EHCP) compared to 4.8% in London[111].
- In 2022/23 8.7% of Havering pupils had SEN support, compared to 12.1% across all London boroughs.
- In 2021/22, 29.0% of children in care (CIC in Havering had a statement of SEN or EHC plan, compared to 34.7% of CIC in London[112].
- Amongst Children in Need (CIN), 31.6% had a statement or EHC plan compared to 32.6% in London[113].

[110] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform
[111] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform
[112] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform
[113] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform

- The number of children with EHCPs in Havering has **increased** from 1,534 in 2019 to 2,182 by 2023.
- Among primary schools, in Havering in 2022/23, 40.3% of SEN pupils had a primary need related to speech, language and communication, slightly less than the London average of 42.0%[114].

- The second most common need for SEN pupils in Havering was moderate learning difficulty. At 24.3% of all SEN pupils, this was a much higher proportion than that for London (8.1%)[115].
- 95.1% of new Education Health Care plans in Havering were issued within 20 weeks in 2022 (including exceptions). This is an increase of 55% from 2021 and compares favourably with statistically similar boroughs who achieved 57.3% of new EHCs issued within 20 weeks[116].



- In 2022, 50.9% of newly issued statements and plans were for children who went to a mainstream school.

- In 2021/22, 4.2% of Special School pupils received a suspension, which was better than the rate in England (9.6%) and boroughs with similar populations (8.4%)[117].
- There were no permanent exclusions amongst pupils in Havering attending a Special School.

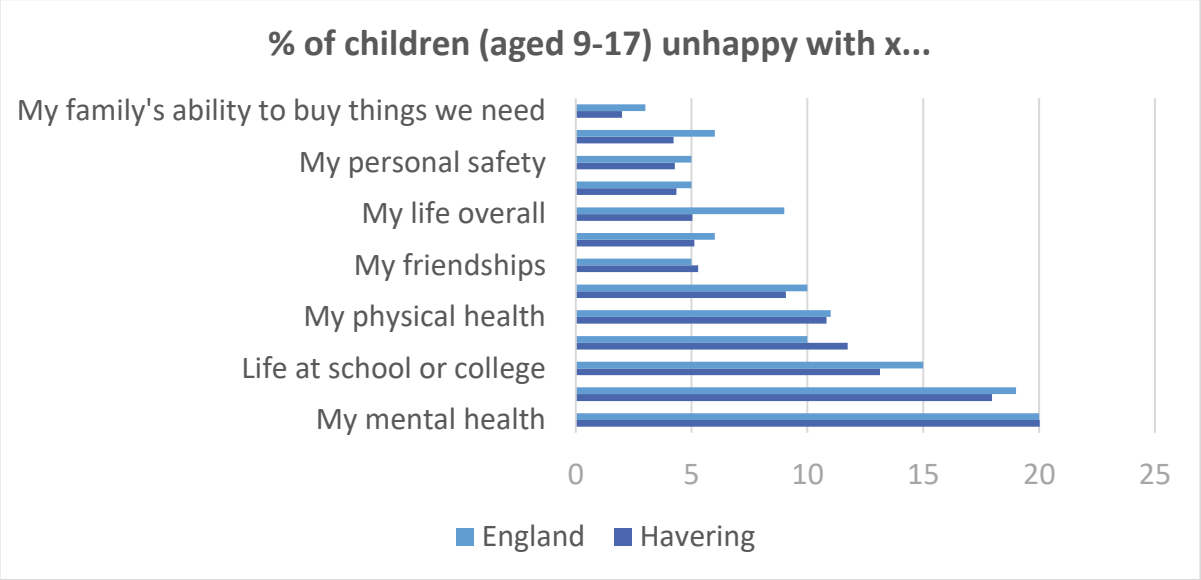
6.5 Children's Views on their Needs

Engagement with children and young people has given valuable insight into what they feel their needs are, for now and for the future. In its Corporate Plan, Havering Council made a commitment to 'continue to grow the number of children and young people that are actively involved in consultation, coproduction and service design across the community'. It is positive that over the past two years, there have been several large scale exercises to ensure that children's voices are heard and considered, both within and external to the Council, including The Big Ask delivered by the Children's Commissioner and the Shout: We are Listening Survey and BeeWell survey conducted by Havering Council.

- 1,200 children aged 9-17 responded to The Big Ask, conducted by the Children's Commissioner in 2021
- The top reason for being unhappy for children in Havering was their mental health (20%) and the choice of things to do their local area (18%) (Fig. 23).
- 70.9% of Havering respondents to The Big Ask felt that having a good job or career was important, compared to 69% across England. However, 39.9% also felt worried about having a good job or career, which was their top worry in Havering.
- 60% of Havering respondents thought they were likely to have a better life than their parents.

[114] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform
[115] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform
[116] DfE Interactive Local Authority Tool, 2023
[117] DfE Interactive Local Authority Tool, 2023

Figure 23. Percentage of Havering Children unhappy with aspects of their lives compared to the England Average (2021)



The Shout survey, conducted between end November and end December 2022, was a universal survey aimed at children and young people in year 6 and up, promoted through Havering's schools. It was delivered digitally, through the Mind Of My Own (MoMo) website; MoMo is also the application used by Children's Services to capture the views of children with a social worker. Its purpose was to gain feedback, insights, views and experiences of children in Havering. The topics covered by the survey were set by Children's Services and based largely on some of the themes of our Children and Young People Plan, namely: raising aspirations for our children and young people; putting the child's voice at the centre of our work; and responding to and challenging racism, inequality and discrimination. The additional two themes added to these were: money / the cost of living, and how children feel about their local area.

Out of over 1,000 responses to the Shout Survey, 70% were aged between 10 and 12 years and around 54% identified themselves as White or British.

- 50% felt they are listened to a lot by their parents/carers; around 45% felt they were listened to by friends and just under 40% felt they were listed to by Teachers at school.
- The survey gave valuable insight into the range of other people children felt listened to them, including grandparents, cousins and other family members, trusted adults at clubs and advisers on the internet (Fig. 24).

Who Children Felt Listened to Them

How Children Felt About the Future

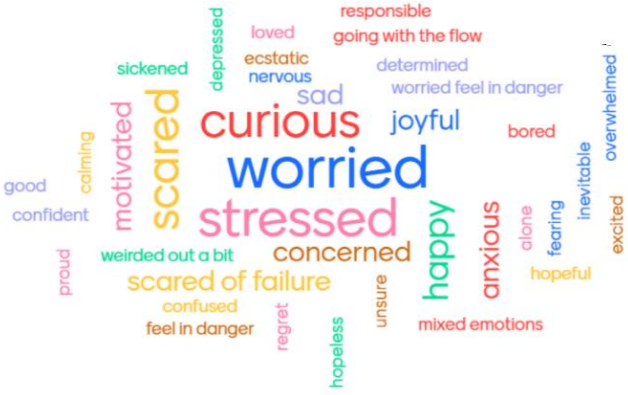
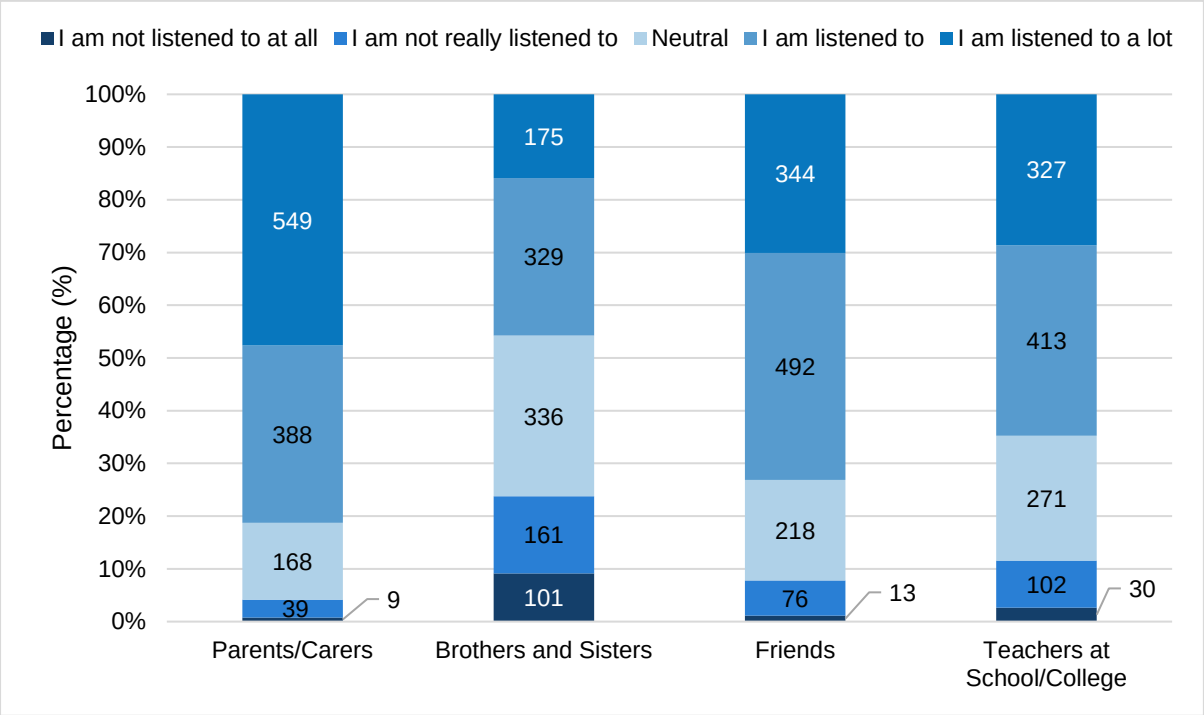


Figure 24. How well children felt listened to by various people in their lives; Shout Survey



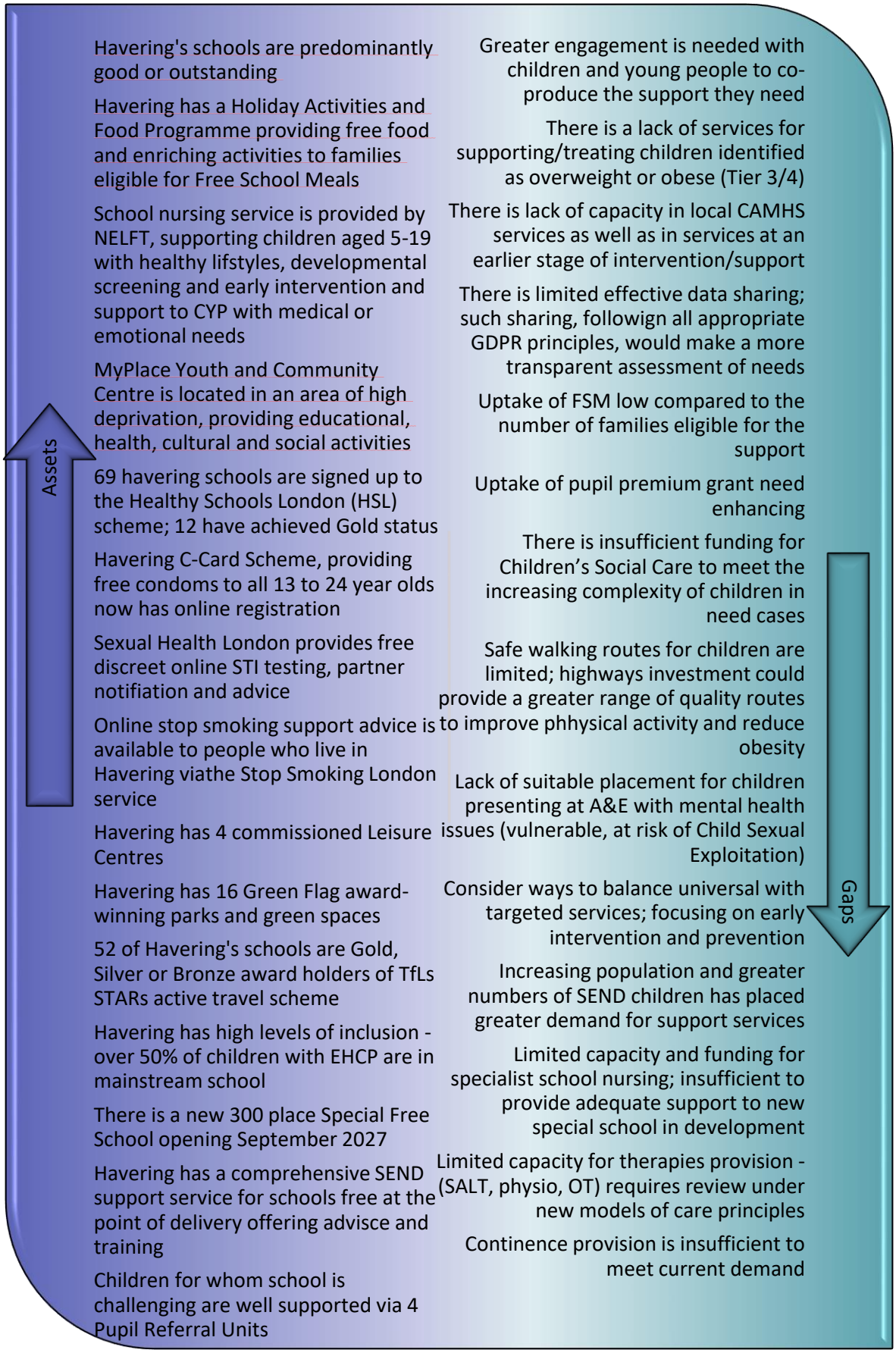
Source: SHOUT survey, Produced by: LBH PHI 2023

- The children's main worries about money centred on: Future student debt (43.2%); somewhere to live (41.5%); Jobs (41.5%); Food / Healthy Food (29.5%); Clothes (23.8%) and Location of Further Education (23.4%)
- 42.1% felt that money worries did NOT affect their physical or emotional wellbeing
- 68% were Hopeful and 47.6 % were Excited when asked the top 4 words they could to use to describe their thoughts about the future. However this was closely followed by Unsure (49.2%), Anxious (47.7%). Worried and Stressed were recurring themes, which suggests that children's mental and emotional wellbeing may be at risk.
- In response to the question, "Is there anywhere in Havering you feel unsafe?", 56.7% felt unsafe on the streets and 34.1% felt unsafe at bus stops and train stations. However, 30.4% did feel safe everywhere.

The #BeeWell work in particular aims to provide a forum for young people to affect change, by creating a youth steering group that will consider the results from the wellbeing census and commission some small projects to support improvements in young peoples' wellbeing. The Council is also consulting children and young people on its budget for the first time[118].

[118] Budget Consultation - Children and Young People Version - London Borough of Havering Council - Citizen Space

6.6 Assets and Gaps



6.7 What This Data means for Havering

Children's mental and emotional wellbeing in the aftermath of the Covid-19 pandemic, and cost of living crisis has been significantly affected and will need to be a priority. More and more national and local anecdotal evidence is being reported that there is growing demand for supporting children's mental wellbeing. According to the MHSDS, 11-15 year olds represented the group with the highest number of people in contact with mental health services in August 2023. Reports from schools locally are that they have seen a rise in children needing support for the mental or emotional health and wellbeing. However, a survey by the mental health charity stem4 found that 54% of patient aged 11 to 18 years referred to CAMHS services by GPs are rejected[119]. This is not surprising given the demand for care amongst this age group, and the burden that places particularly on CAMHS services and highlights the need to address the capacity for such services. It could also be that the referrals do not meet the clinical criteria for CAMHS-level intervention and support and raises the issue of capacity in the borough for lower level intervention at an earlier stage to prevent escalation of issues. Now is the time to think about how Havering's services can take a whole systems approach to mental wellbeing; a co-ordinated strategy which takes into account services which act an earlier stage would be recommended.

Alongside increasing mental health and emotional needs, more children have more complex needs and the rate of children with EHCPs is likely to continue to increase. In addition there has been significant increase in movement into the borough of children often with highly complex needs including SEND, domestic abuse and safeguarding. In circumstances when children enter the borough as a non-targeted transfer, it is the responsibility of children's services to provide the support to these individuals. In the majority of non-targeted transfer cases, there are often numerous and challenging complex issues, which further increases the demand on the service.

There is a lack of capacity for specialist school nursing, and school nursing in general and compounded further by the overall increase in population of children in Havering. Increases in children with more complex needs also draws on the capacity of these services, such as school nursing, to contribute to multi-disciplinary safeguarding conferences, Physio, SALT, CAMHS etc .Whilst it is acknowledged that managing safeguarding issues should be a shared responsibility across all frontline services, the partnership may need to consider how to work more collaboratively and provide support at an earlier point for children who are having trouble coping, experiencing distressed feelings or difficult thoughts, sensory issues and promote wellbeing for parents, carers and children.

Children's development by the end of Reception year in school is similar to both London and England, but as a borough we could be more aspirational for them. There do not appear to be any inequalities in achievement for children from global majority ethnicities. However, there are differences in the levels of development amongst more vulnerable groups, such as those who are eligible for FSM. Continuing support for children's educational attainment is key to their future, increasing opportunities for good employment and thus breaking the cycle of deprivation/poverty.

The voices of children and young people should be heard, and in order to build upon the good foundations laid in 2022 and 2023, partners should develop a shared annual engagement plan. This will ensure that work to consult and coproduce with children and young people is co-ordinated, mitigating the risk of duplication and over-surveying, and

[119] More than half of GP referrals to CAMHS services rejected, poll reveals | GPonline

demonstrating the range of opportunities for children and young people to have influence and shape the provision of services and decisions that affect them.

6.8 Recommendations:

1. •Children's emotional wellbeing is a priority
   •Partners are recommended to develop a suitable joint strategy to improve Children and Adolescents Mental Health
2. •Partners are recommended to develop a shared annual engagement plan to ensure that work to consult and coproduce with children and young people is co-ordinated and avoids duplication
3. •Work in partnership with schools to seeks ways to include promotion of breastfeeding, positive parenting, consent and weight management for pregnancy into the SRE curriculum in schools
4. •Work collaboratively and in a whole systems approach to address high rates of obesity amongst children, focusing on Tier 1/2 actions to prevent obesity
   •Consider how to provide a comprehensive Tier3/4 weight management service
5. •Partnership to consider how to improve asthma and diabetes care to reduce the high rate of hospital admissions for children with these conditions
6. •Capacity of school nursing, specialist school nursing and support for children with special educational needs and disabilities requires support/additional investment and prioritisation

7. Adolescent Health & Transition to Adulthood

7. Adolescents' Health and Transition to Adulthood (15-24 years)

7.1 Adolescents' Health and Wellbeing (15-24 years)

- The percentage of 15 year olds in 2015/15 Havering with 3 or more risky behaviours (15.8%) was similar to England (15.9%) but higher than London (10.1%)[120].
- 13.8% of 15 year olds were physically active for at least one hour a day, seven days a week. This was better than London (11.8%) and similar to England (13.9%). However, this is still a disturbingly low figure for the level of activity engaged in by this age group.[121]

- The rate of new referrals to secondary mental health services for children under 18 years in 2019/20 in Havering (4,086 per 100,000) was lower than London (4,639 per 100,000) or England (6,977 per 100,000)[122].
- The rate of admissions for mental health conditions for children under 18 years was **better** in Havering (68.3 per 100,000) than England (99.8 per 100,000) and **similar** to London (75 per 100,000)[123].

- For children under 18 years, there were **more** attended visits with community and outpatient mental health services in Havering in 2019/20 (30,196 per 100,000) than London (25,930 per 100,000) and England (28,395 per 100,000)[124].

- There were 200.3 per 100,000 hospital admissions as a result of self-harm amongst 10-24 year olds in Havering. This was **better** than England (427.3 per 100,000) and **similar** to London (229.7 per 100,000)[125].

- The prevalence of eating disorders amongst 16-24 year olds is similar in Havering (13.1%) to the England average (13.1%). This is higher than the prevalence of eating disorders amongst 5-16 year olds at 3.4%) for Havering in 2020.

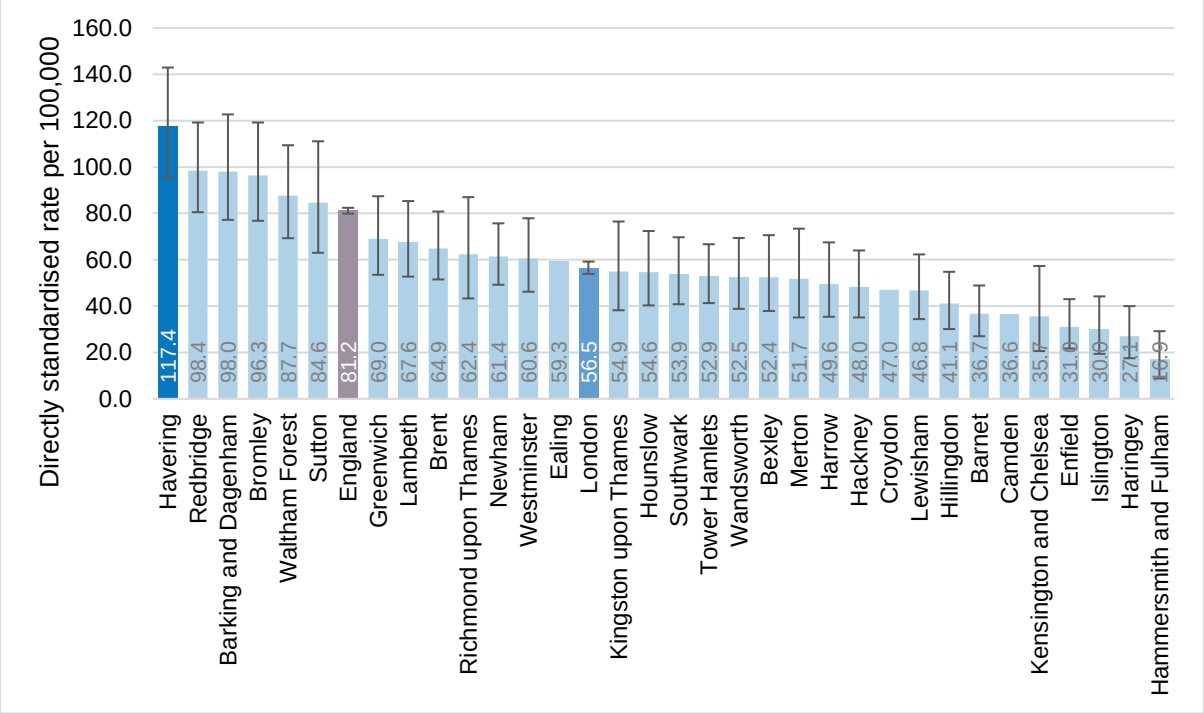
Whilst taking risks is an important part of growing up, normal neural development in teenager's brains makes it hard for them to think about the consequences of a behaviour, or what might happen in the future. The most common risk-taking behaviours are outlined below, with the rates of occurrence in Havering compared to London and England.

- Smoking prevalence at age 15 has been steadily declining, from 21% in 2004 to around 3% regular smokers nationally by 2021, and 6% occasional smokers. The most recent data available for Havering is the WAY survey, conducted in 2014/15 and may not reflect an accurate picture; this suggested 6.1% were current smokers and 3.4% regular smokers[126].

[120] Child and Maternal Health - OHID (phe.org.uk)
[121] Child and Maternal Health - OHID (phe.org.uk)
[122] Mental Health and Wellbeing JSNA - OHID (phe.org.uk)
[123] Public health profiles - OHID (phe.org.uk)
[124] Mental Health and Wellbeing JSNA - OHID (phe.org.uk)
[125] Mental Health and Wellbeing JSNA - OHID (phe.org.uk)
[126] Public health profiles - OHID (phe.org.uk)

- In London, the Survey of Smoking, Drinking and Drug Use (SSD survey) among young people showed that more girls were current smokers (3%) than boys (1%)[127].
- Admissions to hospital for alcohol-specific conditions in all children under 18 years over the period 2018/19 to 2021 is **similar** in Havering (11.4 per 100,000) top London (14.3 per 100,000) and **better** than England (29.3 per 100,000). There has been a steady downwards trend in rates since 2006/07[128].
- However, amongst 15-24 year olds specifically in the period 2018/18 to 2021/22, the rate of hospital admissions due to substance misuse in Havering is **significantly worse** (117.4 per 100,000) than both London (56.5 per 100,000) and England (81.2 per 100,000). Havering had the highest (worst) rate out of all the London boroughs over this period (Fig. 25)[129].
- The rate of hospital admissions due to substance misuse in 15-24 year olds was significantly worse for males (130 per 100,000) than females in Havering (104.2 per 100,000).

Figure 25. Directly Standardised Rate per 100,000 of Hospital Admission due to Substance Misuse in 15-24 year olds in Havering compared to London Boroughs 2018/19 to 20/21



Source: OHID Fingertips, Produced by: LBH PHI 2023

[127] Smoking, drinking and drug use among young people in England - NHS Digital
[128] Public health profiles - OHID (phe.org.uk)
[129] Child and Maternal Health - OHID (phe.org.uk)

- The conception rates for under 18 years old has been steadily decreasing since 1998, such that the rate in Havering (2021) is now 15.5 per 1,000. However, this remains higher than the rates for both London (9.8 per 1,000) and England 13.0 per 1,000) (Fig. 26)[130].
- Havering ranks 8th out of the London boroughs for under 18 conceptions and 12 for under 16 conception rates (1.7 per 1,000) (Fig 27).

Figure 26. Trend in under 18's conception rate per 1,000 females aged 15-17 in Havering 1998 to 2020

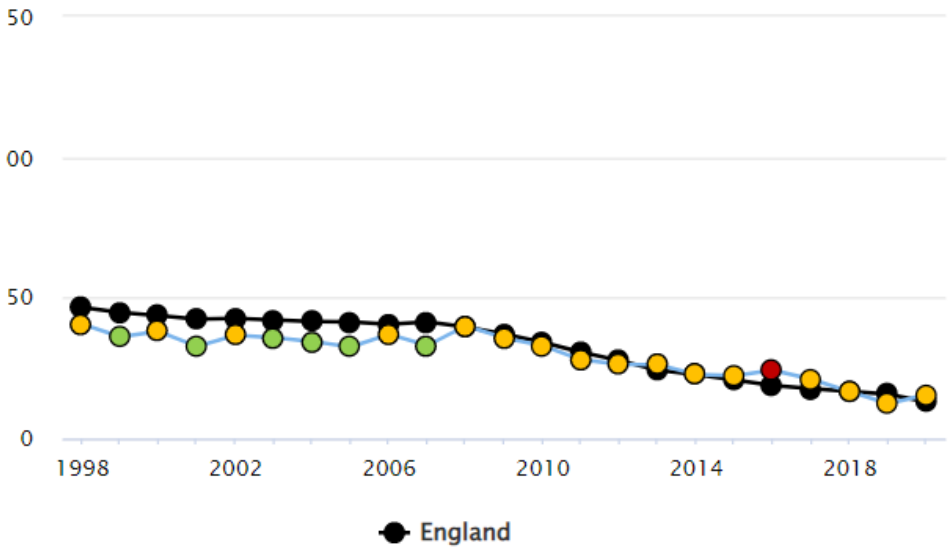
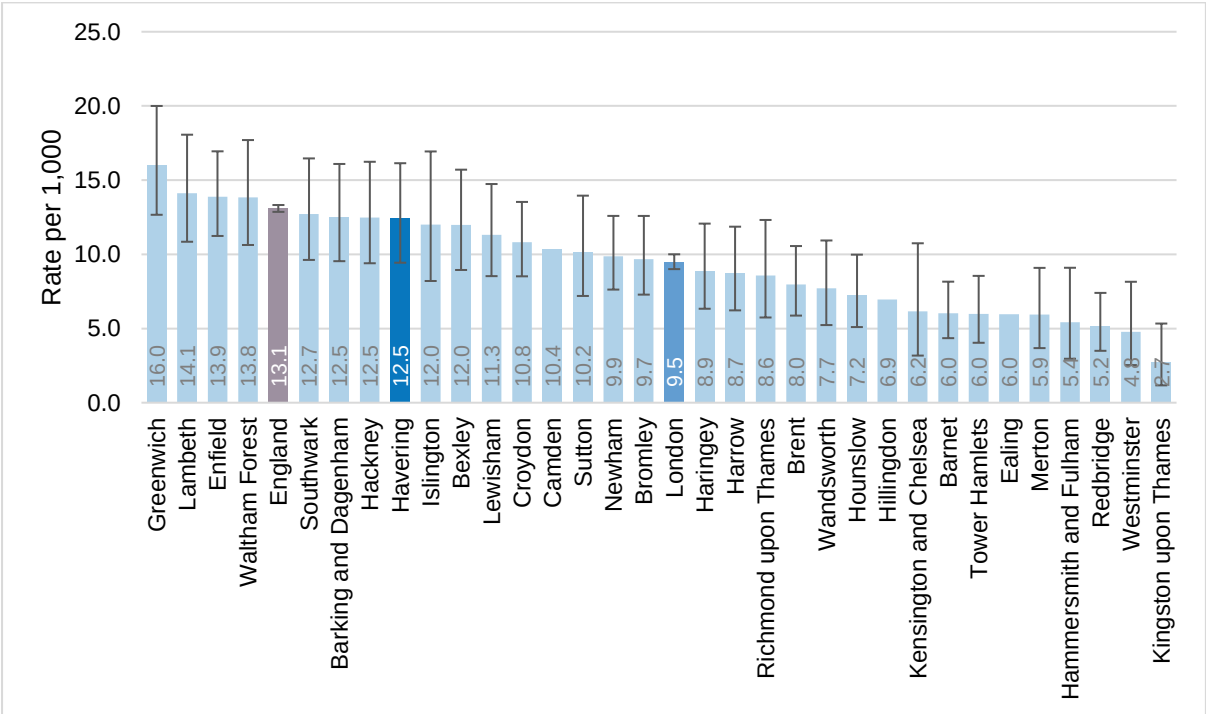


Figure 27. *Under-18s conception rates /1,000 in London local authorities benchmarked against **England**, 2021*

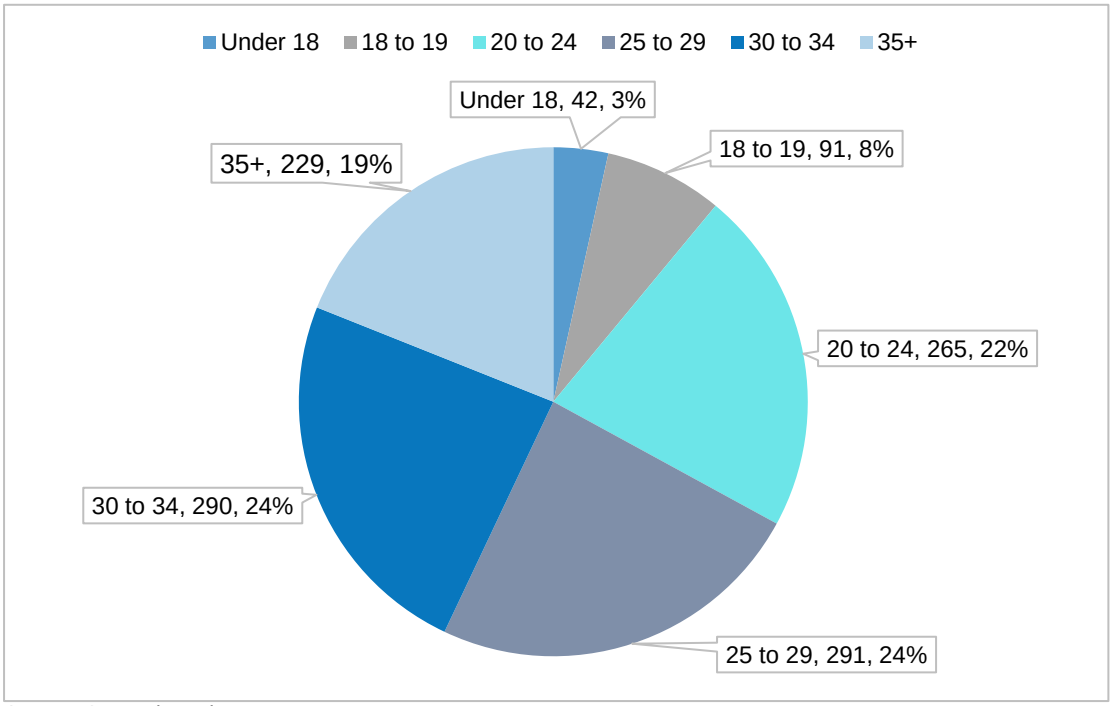


Source: OHID Fingertips, Produced by: LBH PHI 2023

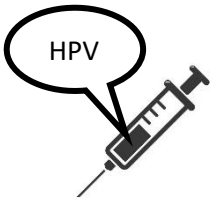
[130] Public health profiles - OHID (phe.org.uk)

- 3% of abortions undertaken in 2021 were amongst women aged under 18 years and 8% were in 18 to 19 years olds (Fig. 28).
- The rate of repeat abortions amongst women aged under 25 years is similar in Havering (33.7%) to London (31.6%) and England (29.7%).

Figure 28. Number and Percentage of Abortions by Age Group in Havering, 2021

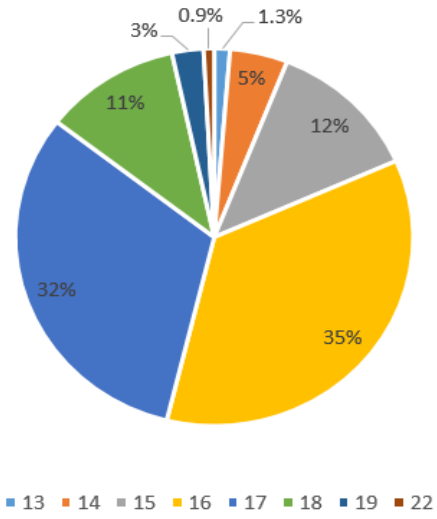


Source: OHID Fingertips



- The chlamydia detection rate amongst females aged 15 to 24 years in Havering is 1,606 per 100,000. This is well below the target detection rate of 3,250 per 100,000, but neither London (2,137 per 100,000) nor England (2,110) rates reach this target either.
- 85.8% of 12 to 13 year olds had the HPV vaccination in Havering. This is the highest uptake out of all the London boroughs (61.6%) and better than England (69.6%). The target uptake is ≥ 90%.
- In 2021-22 there were a total of 234 registrations, a significant improvement from the 38 achieved during the height of the Covid-19 pandemic in 2020-21. However, despite this recent improvement, the overall trend in use of the C-card scheme has declined since its inception in 2013. (Fig. 29).

Figure 29. Percentage of C-Card Registrations by Age, Havering, 2021.



Out of the 234 registrations in 2021-22, 69% were male, 29% were female, and 2% were non-binary or transgender. Just over one third of registrations were for young people aged 16. Over this same period, 3,659 condoms were distributed; 79% of these were distributed to males, 21% to females. The most popular condom distribution site was Havering College, Ardleigh Green Campus, which distributed 75% of all condoms given out by the scheme that year

7.2 Educational Attainment and Inequalities

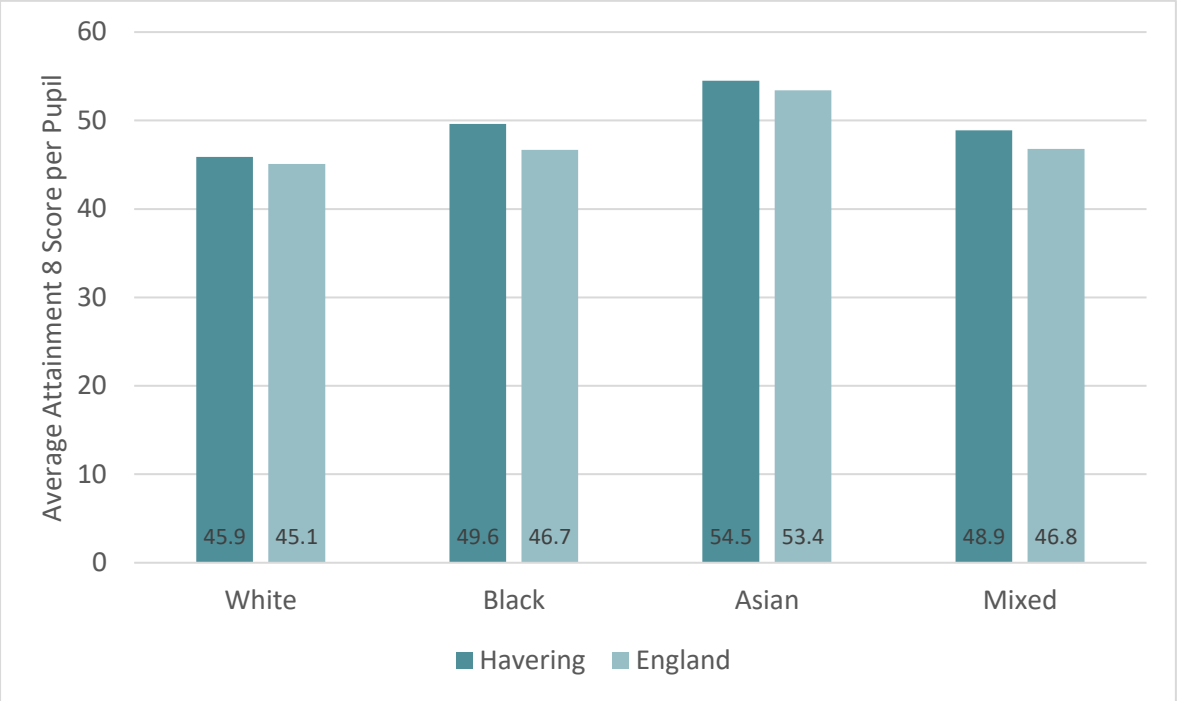
A good indicator of inequality, is how well children are performing in educational attainment. Children with poorer mental health are more likely to have lower educational attainment and there is some evidence to suggest that the highest level of educational qualifications is a significant predictor of wellbeing in adult life. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. Educational attainment is influenced by both the quality of education children receive and their family socio-economic circumstances.

The attainment 8 score measures pupil's attainment across 8 qualifications, including Maths, English, Science, Computer Science, History, Geography and Languages.

- In 2023, the average Attainment 8 score per pupil was 47.3 for Havering children, **better** than England (44.6), but lower than the average score for pupils across the whole of Outer London (51.0)[131].
- Average Attainment 8 scores were **significantly worse** for **children in care** than the general secondary school population. Amongst children in care, Havering's score of 24.8 was similar to London (24.7) but better than England (23.2).
- Attainment 8 scores were also worse in disadvantaged pupils in Havering in 2023 (37.1) than non-disadvantaged pupils (50.3)[132].
- Amongst pupils from different global majority ethnicities, Asian pupils had a higher Attainment 8 score than those from White, Black or Mixed backgrounds in both Havering and England in 2023 (Fig. 30).

[131] DfE Interactive Local Authority Tool, 2023
[132] DfE Interactive Local Authority Tool, 2023

Figure 30. Average Attainment 8 Score per Pupil in Havering or England (2023) by Ethnicity

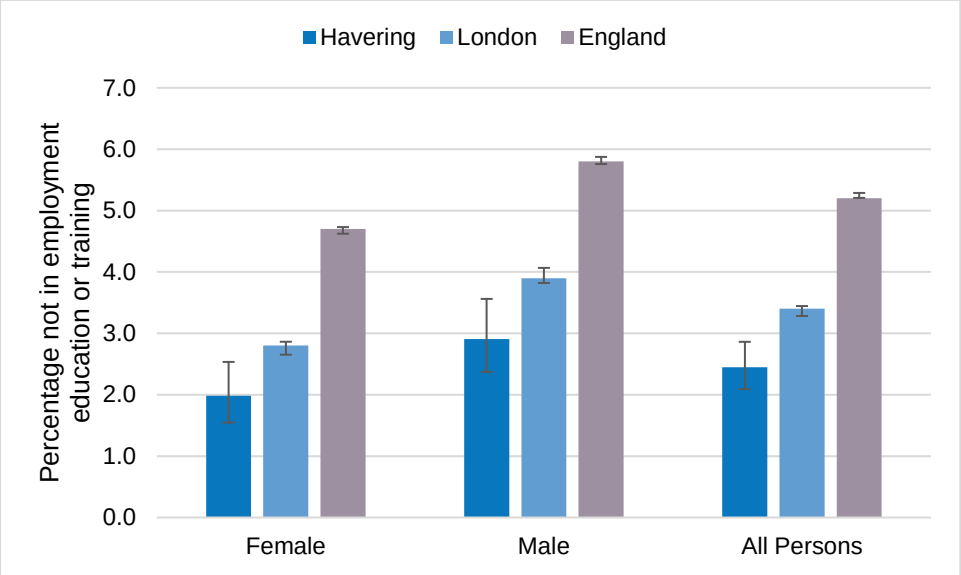


Source: DfE Interactive Local Authority Tool, 2023, produced by Public Health, 2023

- 69.2% of Havering pupils in Key Stage 4 in 2023 achieved a 9-4 pass in English and Maths. This is **better** than England (60.5%) and boroughs with similar populations (65.3%)[133].
- Children who were eligible for free school meals (FSM) in Havering in 2023 **did not progress** as much as an average pupil not eligible for FSM. Havering FSM pupils had a Progress 8 score of -0.65 compared to -0.53 in England[134].
- For those not eligible for FSM, Havering pupils scored 0.04 in their Progress 8 score compared to 0.13 in England.
- 18.5% of young people taking A-Levels in Havering in 2023 achieved grades of AAB or Better. This was lower than England (25.2%) and boroughs with similar population profiles (20.6%)[135].
- It is compulsory for young people ages 16 and 17 years to stay in education or training, and could include full time education, an apprenticeship or traineeship or at least 20 hours a week working or volunteering whilst in part time education. **Fewer** 16 to 17 year olds in Havering were not in education, employment or training (NEET) in 2021 than London and England (Fig. 31)[136].

[133] DfE Interactive Local Authority Tool, 2023
[134] DfE Interactive Local Authority Tool, 2023
[135] DfE Interactive Local Authority Tool, 2023
[136] Public health profiles - OHID (phe.org.uk)

Figure 31. Percentage of 16 to 17 Year Olds in Havering Not in Education, Employment or Training (NEET) compared to London and England, 2021.



Source: OHID Fingertips, Produced by: LBH PHI 2023

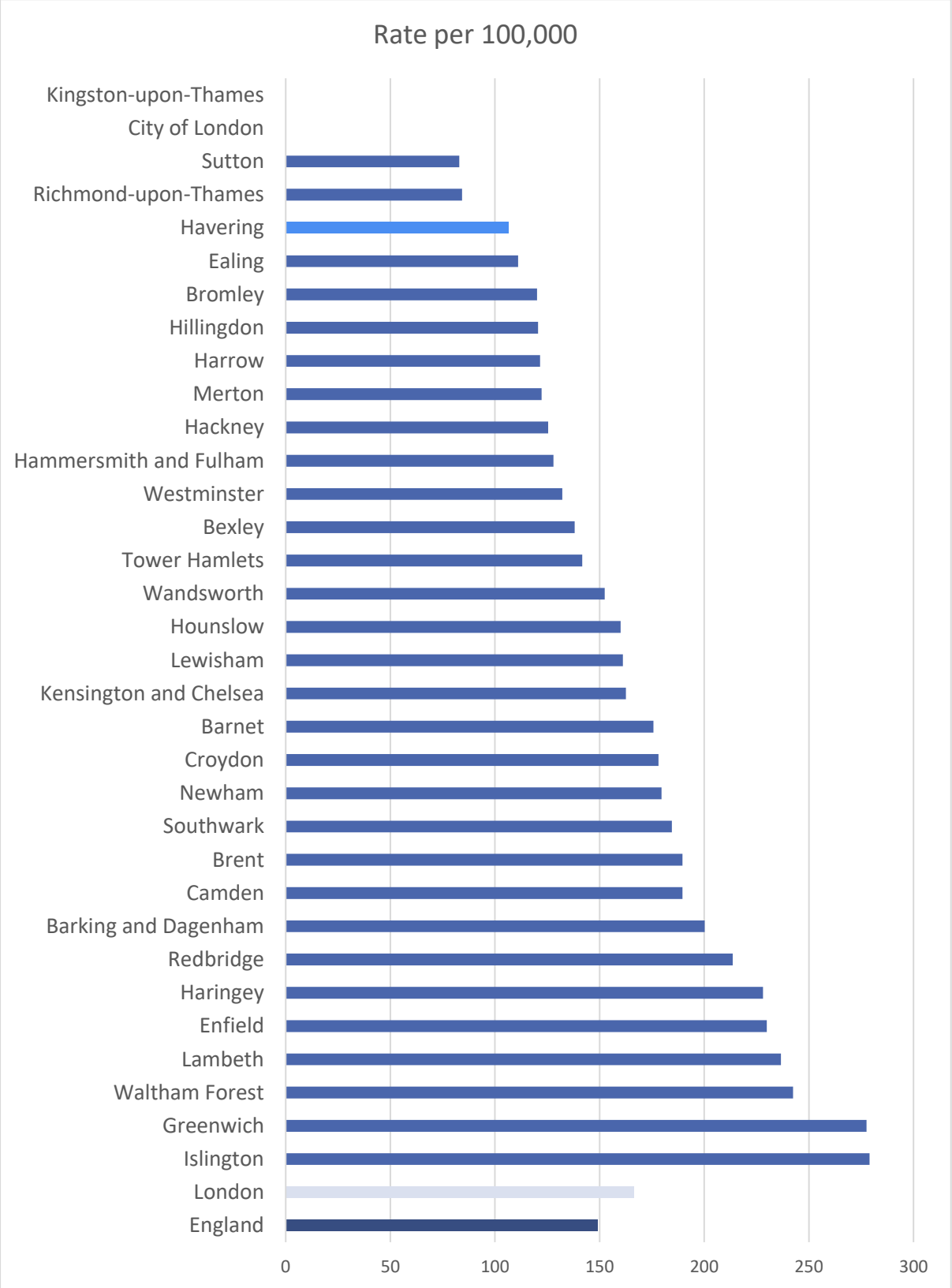
7.3 Crime and Youth Justice

Children and young people at risk of offending or within the youth justice system (YJS) often have more unmet health needs than other children

- The rate of first time entrants to the youth justice system aged 10 to 17 years in Havering in 2022 (106.5 per 100,000) was **similar** to England (148.9 per 100,000) and **better** than London (166.3 per 100,000) (Fig 32). [137].
- The rate of all children aged 10 to 17 years who were cautioned or sentenced in the YJS in 2020/21 in Havering was **better** (2.6 per 1,000) than London (3.5 per 1,000) and **similar** to England (2.8 per 1,000)[138].
- Havering residents are generally supportive of the actions used by the Metropolitan Police Service to deter crime. 80% of Havering residents who responded to the Mayor's Office for Police and Crime (MOPAC) survey Q1 2023-24 supported Stop and Search, and 77% felt Stop and Search was used fairly[139].
- From April 2022 to March 2023 the majority of children worked with by the Havering YJS were young men aged 14 to 17 years old; 48% of all children open to the Youth Justice Service were open to Children's Social Care. 34% a Child in Care, 11% on a Child Protection Plan and 4% on a Child in Need Plan [140].

[137] Public health profiles - OHID (phe.org.uk)
[138] Public health profiles - OHID (phe.org.uk)
[139] Police and Crime Plan Monitoring (airdrive-secure.s3-eu-west-1.amazonaws.com)
[140] YJ2 - Youth Justice Plan 2023-24.pdf (havering.gov.uk)

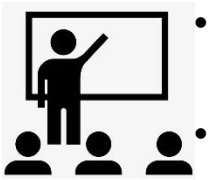
Figure 32. First Time Entrants to the Youth Justice System in 2022 by London Borough, rate per 100,000.



7.4 Special Educational Needs and Disabilities (SEND) in Adolescents (15-24 years)

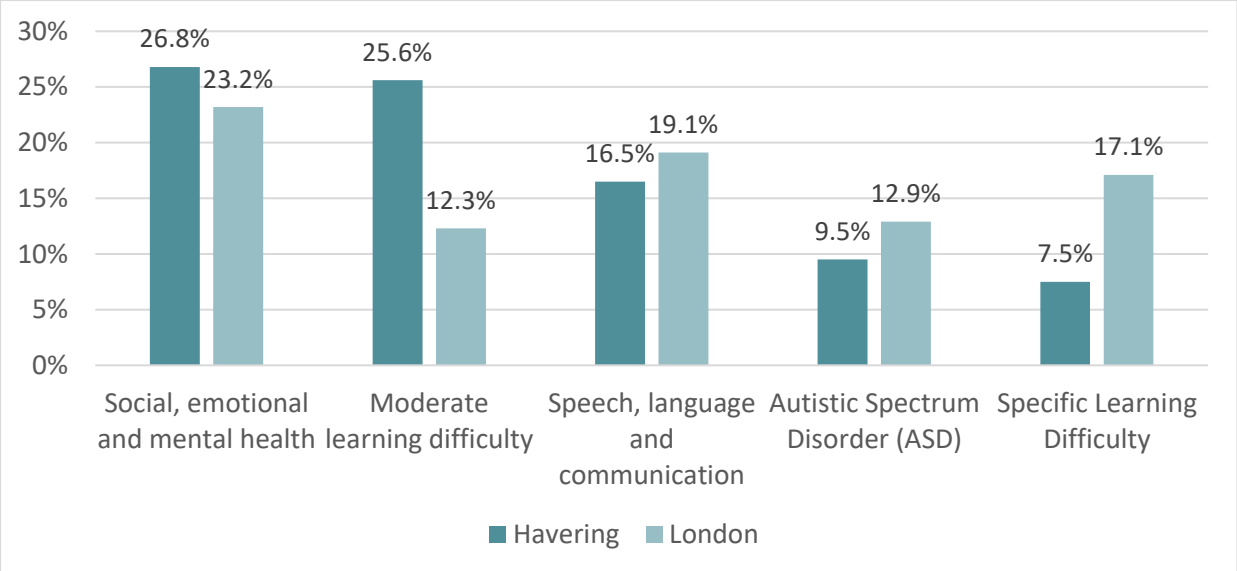
- In secondary schools, the primary need for pupils with SEN in Havering in 2022/23 was social, emotional and mental health needs (26.8%). This was closely followed by moderate learning difficulty at 25.6% for Havering pupils (Fig. 33)[141].

- 42.6% of children attending Special School in Havering in 2022/23 had the primary need of Severe Learning Difficulty, compared to 15.9% in London. In contrast, the main need for pupils attending SEN schools across London was Autism Spectrum Disorder (ASD); 42.8% compared to 15.9% in Havering[142].
- 8.7% of Havering children with a statement of SEN or EHC plan achieved a grade 9 – 5 in English and Maths in 2022/23 compared to 51.7% in those with no identified SEN[143].



- 91.7% of Havering young people aged 16-18 years with SEN remained in sustained education, apprenticeship or employment; this compares well with 93.5% among those with no identified SEN[144].
- More 16-17 year olds with SEN in Havering were recorded as NEET (7.0%) than the London average (5.4%); only 2.3% of those without SEN were recorded as NEET in havering in 2022/23[145].

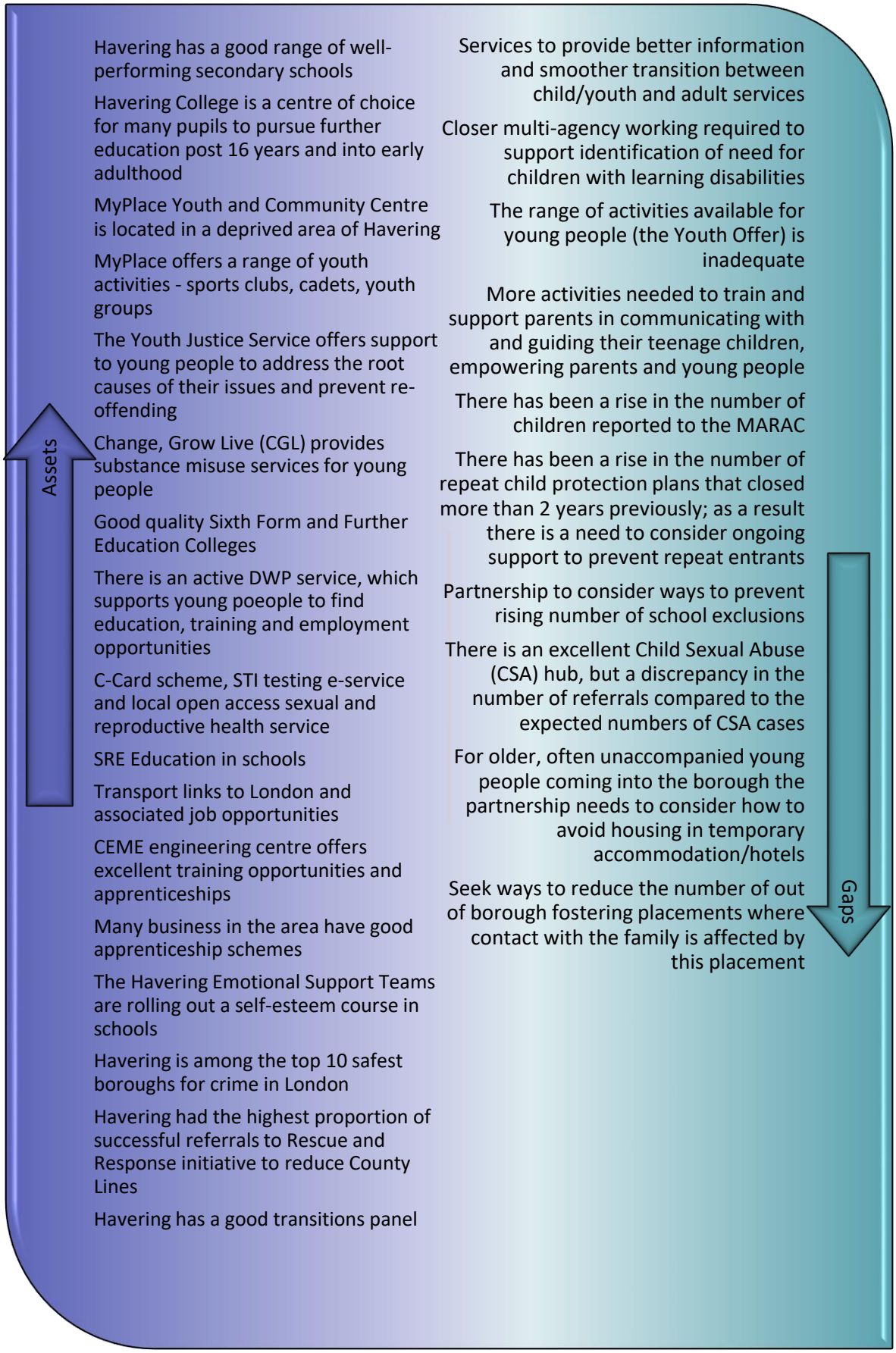
Figure 33. Top 5 Main Needs for SEN Pupils in Havering Secondary Schools (%) compared to London, 2022/23



Source: LG Inform and DfE, 2023

[141] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform
[142] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform
[143] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform
[144] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform
[145] Local area Special Educational Needs and Disabilities report for London Borough of Havering | LG Inform

7.5 Assets and Gaps



7.6 What This Data Means for Havering

Taking risks, such as drinking, smoking, having sex for the first time, learning to drive etc. is all part of learning to become independent. Not only is it an innate biological drive to move away from our parents control, but there is a high degree of optimistic bias amongst our young people – feeling as though the risks they are taking won't have any negative consequences for them individually. As adults, it is our responsibility to help young people to navigate their path to adulthood as safely as possible.

When the risks young people are taking become problematic, or turn into addictions, there are services available locally to support them back to health. Substance misuse services, discreet, online services for sexual health testing and community mental health services are available and perform reasonably well in Havering. However, the funding streams and inclusion criteria for these services often mean an abrupt change between adult and children's services. A smoother transition is essential to help young people navigate their path to managing their own lifestyles. For example, many long-term conditions are first diagnosed in childhood. Whilst some may reduce in severity, such as asthma, most are conditions that the young person will have to manage for the rest of their lives. Transition to adult services for ongoing care and support is a challenging time for young people. Engagement is therefore required with young people to better understand how the service can cater to their unique needs, at least up to 25 years old.

Mental wellbeing is of great concern in Havering. Whilst the rate of referrals to secondary mental health services and admissions for mental health conditions for children under 18 years may be better than London or England, we should nevertheless be aspirational in our actions to reduce these rates further. Indeed, the data in this JSNA show that Havering had more attended visits with community and outpatient mental health services, which evidences our need, and also need for earlier intervention/support. Our relationship with schools is vital here to share the intelligence on their observations of young people's need, which can be as powerful as routinely collected quantitative data, but which could in fact be collected and reported on a regular basis.

As young people start to explore their sexuality, access to good quality advice and information is just as important as access to condoms, contraception and support in the case of sexual abuse or exploitation. Havering provides free condoms to all 13-24 year olds registered for the C-Card scheme, but uptake is currently low. In addition, young people who visit Sexual and Reproductive Health Service choose user-dependents methods such as condoms or short acting hormonal contraception over longer term reversible contraceptive methods. Greater awareness raising through parents, SRE education in schools and outreach by providers would all work to reduce risks to health from sexual activity.

Whilst Havering's rate of youth crime is low, for those children who have committed offences, Havering's focus is one of rehabilitation, tackling the underlying causes of youth offending, and delivering a system that gives children the support they need to break the cycle of offending, and build productive and fulfilling lives. 'Child First' is an evidenced based model for delivering Youth Justice Services. Remaining in school, with additional support for those with SEN, and good opportunities for onward employment, will help young people prepare for adulthood.

7.7 Recommendations:

1. •Good quality engagement with young people is required to understand how to better manage their transition from child-focused to adult services for ongoing care and support, whether related to health or social care
2. •The voice of young people should be incorporated into democratic decision-making for all service provision across the Integrated Care System
   •Capitalise on Havering's Youth Council and other forums to capture their views on both child and adult services
3. •Improve awareness and uptake of preventative services, including registrations for the Havering C-Card Scheme and STI testing and LARC as chosen form of contraception to reduce the rate of repeat abortions amongst under 25 year olds
   •Partners to work to embed testing as routine practice amongst young people, e.g. for chlamydia and HIV.
4. •Havering statutory and voluntary sector partners to consider ways of intervening earlier to prevent admission to hospital as a result of self-harming; actions to align with overall suicide prevention strategy for Havering
5. •Increase capacity of support for young people, including provision of youth-centred clubs and activities accessble across the whole borough
6. •Partners to work collectively to decrease the inequalities in educational outcomes for young people

This page is intentionally left blank

Havering Demographic Profile

Joint Strategic Needs Assessment 2023-2024

Table of Content

Document Control

Version history

Version	Change	Date	Author /Analyst	Dissemination
V0.1	First Draft	1/11/2022	Anthony Wakhisi Mark Holder	Working Group
V0.2	Complete draft for HWB	11/12/2023	Anthony Wakhisi Mark Holder	Public Health SMT
V0.3	Addressed feedback from Mark Ansell, DPH & SMT	13/12/2023	Anthony Wakhisi Louse Dibsdall Mark Holder	Havering HWB

Infographic & Executive Summary

Infographic Summary

POPULATION

The estimated population of the London Borough of Havering in 2021 was 262,057, a 10.4% increase since 2011. The increase was greater than the London (7.7%), and England (6.6%) averages.

In 2021, Havering was home to around 16.7 people per football pitch-sized piece of land, compared with 15.1 in 2011. This was the second-least densely populated local authority area across London (after Bromley).

Havering's population is relatively old compared with the London average (35 years) with a median age of 39 years; but younger compared to the median of 40 years in 2011.

The number of births among Havering women in 2022 was 3082. Number of annual births are projected to increase to 3,257 by 2030 and 3,345 by 2035.

The latest (2021) general fertility rate (GFR) for Havering is 59/1,000 women aged 15-44, higher than London (53/1,000) and England (54/1,000).

.The largest increases in population will occur among older people age groups (65 years and above). Age group 65 -84 is predicted to increase from 39,226 in 2021 to 51434 in 2036 (31%), age group 85+ from 7051 in 2021 to 9575 in 2036 (36%).

Havering's ethnic structure has significantly changed in the last 10 years. 66% of its residents were recorded as White British in the 2021 census as compared to 83% in 2011. The proportion of Havering's White British population is higher than the London average (37%) but lower than England average (74%).

HEALTH OUTCOMES

IThe life expectancy at birth in Havering is 79.7 years for males which is lower than London (80.3) but similar to England (79.4).The female life expectancy is 83.5 years which is lower than London (84.3) but similar to England (83.1).

A significant proportion of life expectancy in Havering (19% for men and 23% for women) is impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services. However, the healthy life expectancy rates for Havering males (63.8) and females (64.6) are similar to London and England.

The life expectancy at age 65 years in Havering is 18.2 years for males which is lower than the average for London (19.2) and England (18.7). For females, it is 21.2 years which is lower than the average for London (22) but similar to England's.

Residents living in the most disadvantaged decile of the borough have a significantly lower life expectancy (7.3 years for males and 7.6 years for females) than peers in the least deprived decile.

The latest data for the period 2018-20 shows males in Havering have a healthy life expectancy of 9.8 years at 65 as compared to females who have a higher expectancy of 11.8 years. These rates are similar to the London and England averages.

In Havering an estimated 219,777 (83%) residents reported having a 'good' or 'very good' health in 2021. This proportion was higher than London (81.9%) and England (81.7%)

In 2021, 38,449 (15%) Havering residents disclosed that they had a disability or long term illness in 2021. This was however lower than London (16%) and England (18%).

HOUSEHOLD PROFILE

TAs of 2021, there were 101, 277 households in Havering, a 4% increase (4,078) since 2011.

Havering has the highest proportion of households that own their accommodation across all London boroughs, at 70.5% (71,355). This is higher than England (62.3%) and London (46.8%).

Havering has a lower percentage of households with no cars or vans (21.5%) compared to London (42.1%) and England (23.5%). It also has the higher percentage of households that have 2 or more cars (24.9%) as compared to London (13.6%) but lower than the England average (26.1%).

There are 774 homeless households with dependent children owed a duty under the Homelessness Reduction Act in Havering. The Havering's rate (24.3 per 1,000 households) is among the highest in London and significantly higher than London (17.4 per 1,000) and England (14.4 per 1,000) averages.

As of 2021, about 12.7% (12,838) of the Havering population aged 66 years and above were living in one-person households. This is the second highest proportion among London boroughs after Bexley (12.8%), higher than the London average (9.1%) but slightly lower than the England average (12.8%)

Havering saw a slight increase (0.5%) in the number of households who are overcrowded (7.4% (7,166) in 2011 to 7.9% (8,050) in 2021). Barking & Dagenham (0.3%) are the only other London borough to see an increase. This is consistent with the rising affordability ratio in Havering and nationally. Latest data (2022) shows Havering's affordability ratio (11.3) was higher than the national average (8.9) but lower than the London average (13.6).

ECONOMIC PROFILE

IThe average gross annual household income in Havering for full time workers (£36873) is lower than the London average (£39800) but higher than the England average (£33,582).

Over 7,000 children are estimated to be living in poverty in Havering. However, Havering is among the London boroughs with the lowest proportion of children living in poverty (16%). This rate is also significantly lower than the England average (17%)

Nearly 7,000 older people are estimated to be living in poverty in Havering. However, Havering is among the London boroughs with the lowest proportion of older people living in poverty (11.7%). This rate is also significantly lower than the England average (14.2%)

The overall employment rate in Havering (84%) is higher than the London (74%) and England (76%) averages.

The proportion of working age residents in Havering claiming out-of-work benefits (4%) is lower than London (5%) but similar to the England average (4%).

In 2023, the average Attainment 8 score per pupil was 47.3 for Havering children, better than England (44.6), but lower than the average score for pupils across the whole of Outer London (51.0).

Havering has lower percentage of persons aged 16 over in employment in the managerial and professional qualifications (31.9%) as compared to London (40.4%) and England (33.2%).

Executive Summary

1. Geographical Profile

- The London Borough of Havering is the 3rd largest borough in London (43 miles^2) and contains 20 electoral wards. It is mainly characterised by suburban development, with almost half of the area dedicated to open green space, particularly to the east of the borough.

- The principal town (Romford) is densely populated and is an area of major metropolitan retail and night time entertainment.

- The southern part of Havering is within the London Riverside section of the Thames Gateway redevelopment area and will be an area of increasing development and population change.

- Havering is relatively less deprived as compared to most of the London boroughs with an index of multiple deprivation score (IMD 2019) of 16.8 as compared to London's (21.8) and England's (21.7) average scores. However, within the borough levels of disadvantage vary with pockets of significant disadvantage in Harold Hill, Rainham and parts of Romford.

2. Population Profile

- The estimated population of the London Borough of Havering in 2021 was 262,057, a 10.4% increase since 2011. The increase was greater than the London (7.7%), and England (6.6%) averages.

- In 2021, Havering was home to around 16.7 people per football pitch-sized piece of land, compared with 15.1 in 2011. This was the second-least densely populated local authority area across London (after Bromley).

- Havering's population is relatively old compared with the London average (35 years) with a median age of 39 years; but younger compared to the median of 40 years in 2011.

- The number of births among Havering women in 2022 was 3082. Number of annual births are projected to increase to 3,257 by 2030 and 3,345 by 2035.

- The latest (2021) general fertility rate (GFR) for Havering is 59/1,000 women aged 15-44, higher than London (53/1,000) and England (54/1,000).

- From 2016 to 2020, Havering experienced the largest net inflow of children (ages 0 – 15 years) across all London boroughs. 1,574 children settled in the borough from elsewhere in the UK with significant inflows from neighbouring boroughs; Redbridge (407) and Barking & Dagenham (342).

- Havering's population is projected to continue to increase from 261,978 in 2021 to 274,901 in 2026 (5%), 281,866 in 2031 (8%) and 288,489 in 2036 (10%). The largest increases will be in Beam Park (4619 in 2021 to 5916 in 2026 (28%), 7545 in 2031 (63%) and 8394 in 2036 (82%)) and Hacton (8843 in 2021 to 9385 in 2026 (6%), 10966 in 2031 (24%) and 13297 in 2036 (50%)).

- The largest increases in population will occur among older people age groups (65 years and above). Age group 65 -84 is predicted to increase from 39,226 in 2021 to 51434 in 2036

(31%), age group 85+ from 7051 in 2021 to 9575 in 2036 (36%). Between years 2021 and 2036 an increase is expected for age groups 25-64 (8%), 18-24 (14%), 11-17 (1%) and a decline for age groups 0-4 (-3%) and 5-10 (-7%).

- Havering's ethnic structure has significantly changed in the last 10 years. 66% of its residents were recorded as White British in the 2021 census as compared to 83% in 2011. Nonetheless still the least diverse borough in London. The proportion of Havering's White British population is higher than the London average (37%) but lower than England average (74%).

- In 2021, a large proportion (91%) of Havering residents aged 16 and above identified as straight or heterosexual with 2% identifying as "Gay or Lesbian", "Bisexual" or "Other sexual orientation".

Recommendations

- *The local authority, NHS and other partners should continue to work together in supporting the needs of the increasing young and working age population by facilitating access to essential resources that may include childcare, school places, relevant health services and employment opportunities.*

- *Ensure priority services, particularly those who provide early help and support to prevent escalation of need, are adequately resourced at a capacity level to meet demand in our growing children's population.*

- *The local authority, NHS and partners should consider the implications of the increasing ethnic diversity in Havering in their plans including enhancing cultural competence in order to meet specific health and wellbeing needs of these in coming groups.*

- *The local authority, NHS and other partners should continue to work together in supporting the growing population of older people to remain as healthy and independent as possible for as long as possible and to ensure they receive the highest quality care when they need it.*

3. Health Outcomes

- The life expectancy at birth in Havering is 79.7 years for males which is lower than London (80.3) but similar to England (79.4).The female life expectancy is 83.5 years which is lower than London (84.3) but similar to England (83.1).

- A significant proportion of life expectancy in Havering (19% for men and 23% for women) is impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services. However, the healthy life expectancy rates for Havering males (63.8) and females (64.6) are similar to London and England.
- The life expectancy at age 65 years in Havering is 18.2 years for males which is lower than the average for London (19.2) and England (18.7). For females, it is 21.2 years which is lower than the average for London (22) but similar to England's.

- Residents living in the most disadvantaged decile of the borough have a significantly lower life expectancy (7.3 years for males and 7.6 years for females) than peers in the least deprived decile.

- The latest data for the period 2018-20 shows males in Havering have a healthy life expectancy of 9.8 years at 65 as compared to females who have a higher expectancy of 11.8 years. These rates are similar to the London and England averages.

1. Introduction

The Havering demographic profile is the first chapter of the local Joint Strategic Needs Assessment (JSNA). The JSNA is a systematic method for reviewing the issues facing a population, leading to agreed priorities and resource allocation that will improve health and wellbeing and reduce inequalities within the population.

The Health and Social Care Act 2012 supported the principle of local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs. Joint Strategic Needs Assessment (JSNAs) and Joint Health & Wellbeing Strategies (JHWSs) are an important, locally owned process through which to achieve this.

The purpose of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning. The core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, are used to help to determine what actions local authorities, the local NHS and other statutory and voluntary sector partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing[1]

This chapter provides a snapshot of key geographic, demographic and socio-economic facts and figures for the London Borough of Havering[2], with the intention that this will be the "one version of the truth" or reference document for all local stakeholders. The data presented in this chapter is complemented by an online tool to facilitate both the interrogation and further exploration of useful data, reports, and maps by interested stakeholders (Local Insight (communityinsight.org)).

The work to date on the Demographics chapter has been carried out by the Public Health intelligence team and overseen by the Director of Public Health.

[1] https://assets.publishing.service.gov.uk/media/5a7b88cced915d131105fdff/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

[2] Simply referred to as "Havering" throughout this document.

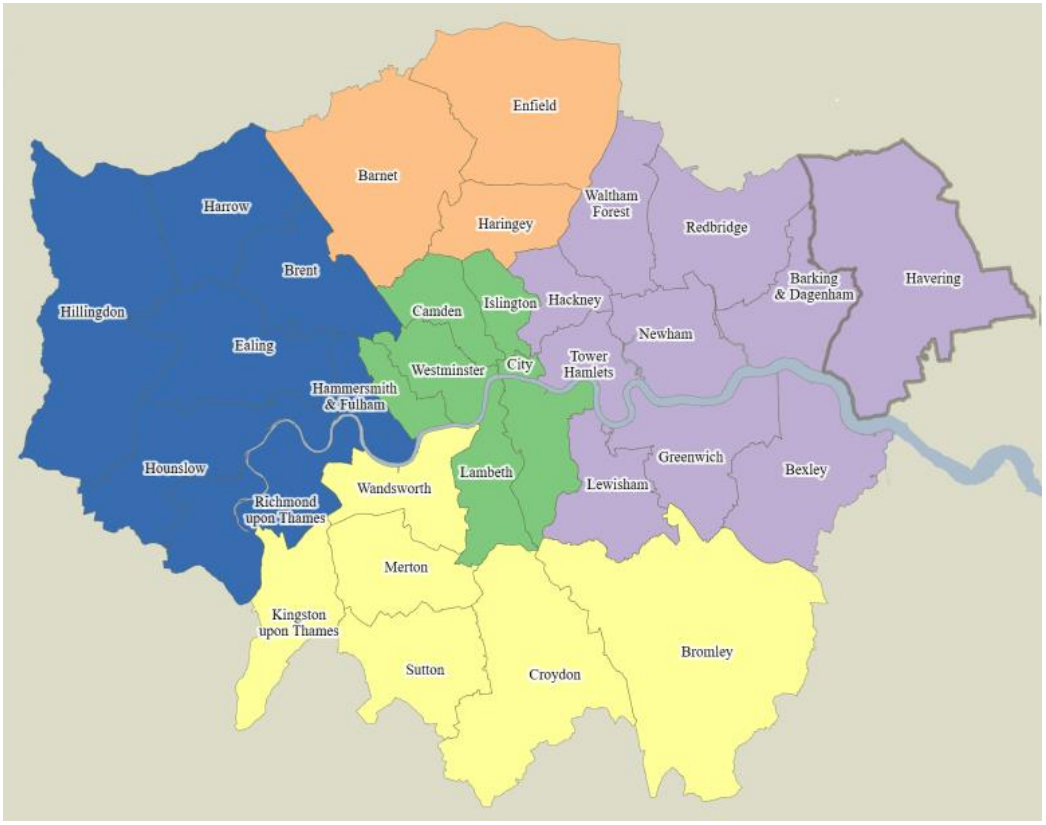
2. Geographic Profile

2. Geographic Profile

2.1 Geographical Location

Havering is the third largest London borough, covering some 43 square miles. It is located on the northeast boundary of Greater London. The location of Havering in the context of Greater London is presented in Figure 1. Havering is bordered to the north and east by the Essex countryside, to the south by a three mile River Thames frontage, and to the west by the neighbouring London boroughs of Redbridge and Barking & Dagenham.

Figure 1: The London Borough of Havering



Source: Trust for London

Havering has 20 electoral wards (see Figure 2). Residents' postcodes mainly fall into the Romford postal area (RM1 to RM7 and RM11 to RM14) but a small number fall into the Chelmsford postal area (CM12 and CM13).

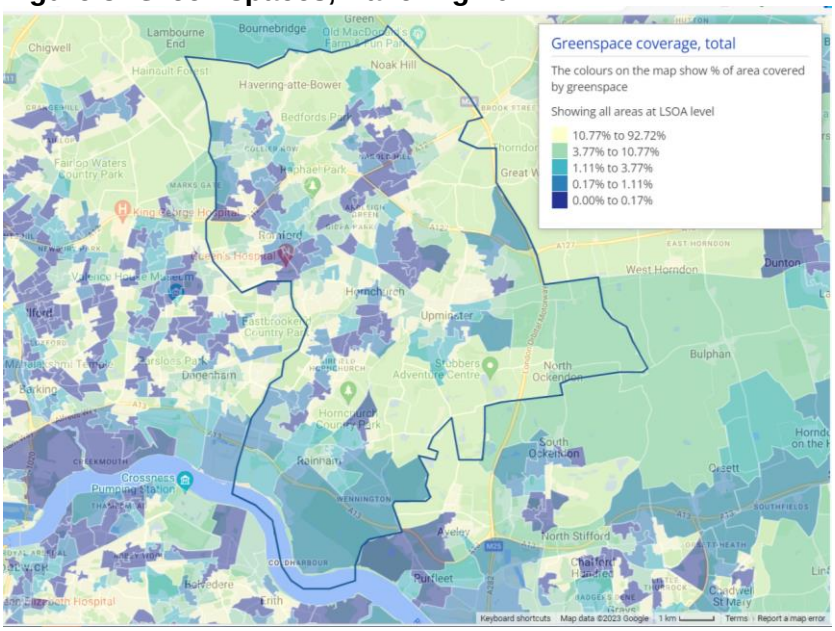
Figure 2: The London Borough of Havering ward boundaries

Source: The London Borough of Havering

2.2 Parks & Green spaces

Havering is mainly characterised by suburban development, with almost half of the area dedicated to open green space, particularly to the east of the borough where strict Green Belt restrictions have prohibited the extension of existing developments (see Figure 3).

Figure 3: Green spaces, Havering 2021

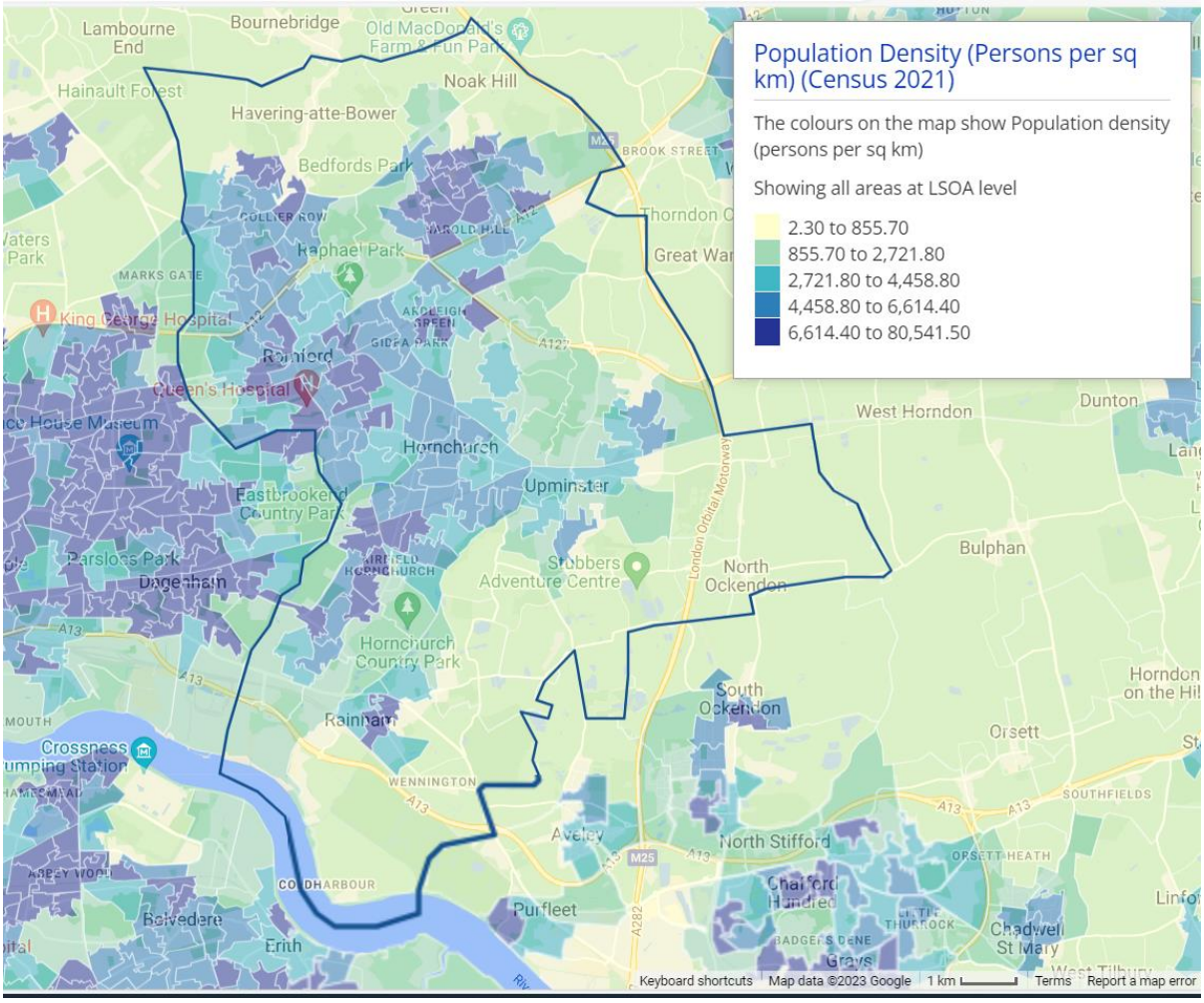


Source: Havering Local Insight

2.3 Population density

Havering's average population density relatively lower compared with other London boroughs and is estimated to be 2,332 persons per square kilometre (ONS Census, 2021).[3] On the other hand, its principal town (Romford), is densely populated (see Figure 4), and is a major metropolitan retail and night time entertainment centre. The southern part of Havering adjacent to the Thames is within the London Riverside section of the Thames Gateway redevelopment area. This will therefore continue to be a site of increasing development and population change.

Figure 4: Population Density, Havering 2021



Source: Havering Local Insight

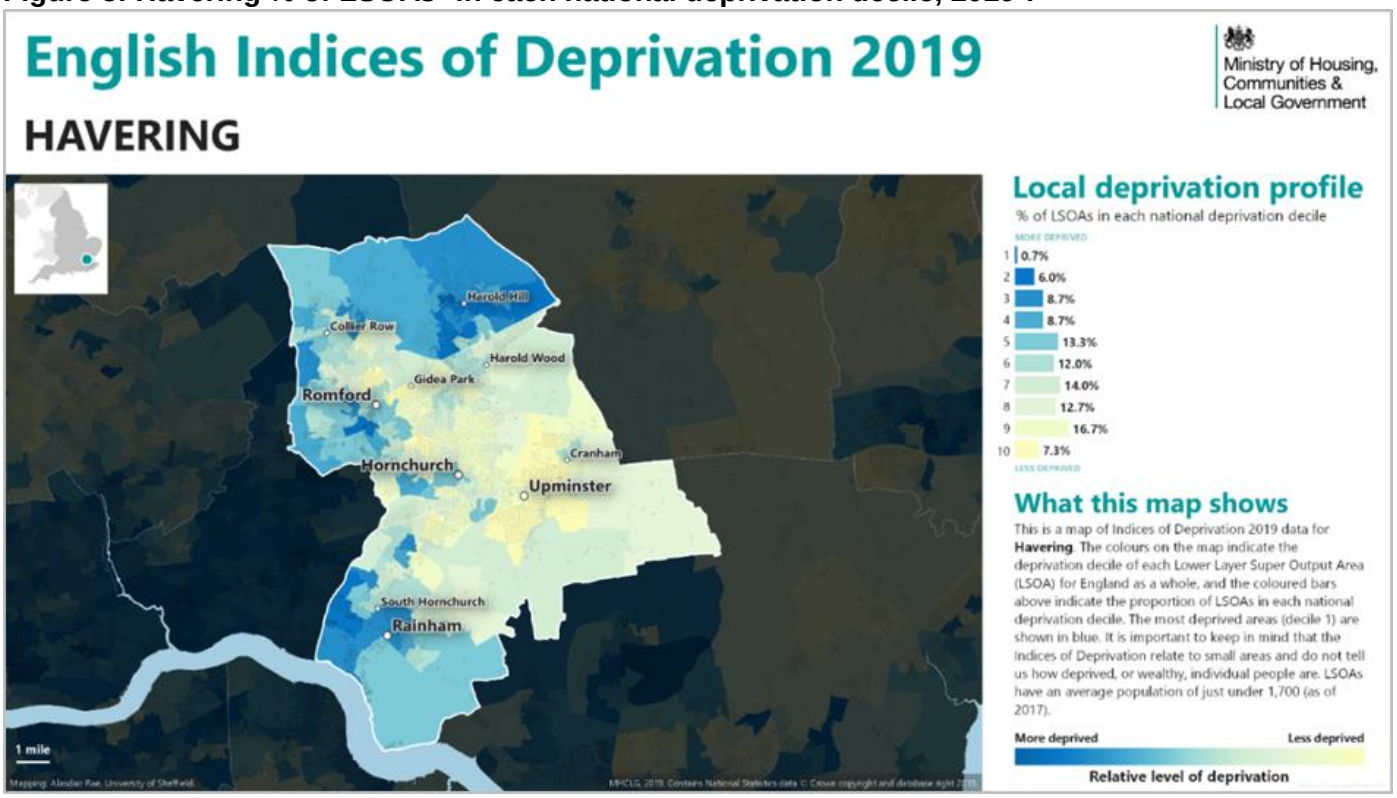
2.4 Deprivation

The Index of Multiple Deprivation (IMD)[4] combines many different facets of disadvantage into a single measure. Levels of disadvantage for Havering as a whole are modest but vary significantly within the borough with pockets of significant disadvantage in Harold Hill, Rainham and parts of Romford (see Figure 5).

[3] Population estimates - Office for National Statistics (ons.gov.uk)

[4] In September 2019, the Department for Communities and Local Government (CLG) published the English Indices of Multiple Deprivation 2019 (IMD 2019). This includes county and district summary measures, and a series of separate domains and other measures at the level of Lower Super Output Area (LSOA). The Indices of Deprivation are typically updated every 3 to 4 years, but the dates of publication for future Indices have not yet been scheduled.

Figure 5: Havering % of LSOAs[5] in each national deprivation decile, 2019[6].



Source: Ministry of Housing Communities & Local Government

The strong association between levels of disadvantage and life expectancy is evidence that the wider determinants are the most important driver of whether we are healthy or not. At local level, the levers to affect the socio-economic determinants of health tend to lie with councils rather than the NHS.

Health and wellbeing boards give NHS partners the opportunity to ensure that local plans regarding tackling poverty, employment opportunities, educational attainment, housing etc. are robust, focused on reducing inequality and those groups most vulnerable to poor health and wellbeing. However, the health and social care system also has a direct role to play in tackling disadvantage. Residents living with physical and mental illness are at greater risk of disadvantage in all its forms, worsening their wellbeing still further. Effective action to support people with health problems into work or stable accommodation can improve health and reduce demand on health and social care services.

In addition, NHS agencies and Councils have the opportunity to directly impact on the wider determinants to the benefit of local people e.g. by spending a greater proportion of their budget with local businesses. To this end, they should view themselves as 'anchor institutions[7]' and consciously seek to maximise the contribution they make to the local community over and above the direct provision of services e.g. by:

[5] LSOA - Lower Layer Super Output Areas are a geographic hierarchy used by Office for National Statistics (ONS) to improve the reporting of small area statistics. They are built from groups of contiguous Output Areas and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The minimum population is 1000 and the mean is 1500.

[6] Deprivation quintile: A 'quintile' basically represents 20% (or one-fifth) of a given population. Deprivation quintiles are derived when a population is ranked in order of deprivation and split into 5 groups – from the most deprived to the least deprived quintile.

[7] https://www.health.org.uk/newsletter-feature/the-nhs-as-an-anchor

- Further strengthening links (e.g. through work experience, apprenticeships, bursaries etc.) between the health and social care system and local schools and colleges to increase the numbers of young people who aspire to and train towards a relevant career, prioritising more disadvantaged groups and hard to recruit to professions.
- Providing an exemplary work place health scheme to employees and help local SMEs to improve the offer to their workforce.
- Routinely considering the potential for additional ‘social value’ when procuring goods and services; and how bids from local businesses can be facilitated.

3.Resident & GP Population

3. Resident & GP Population Profiles

3.1 Havering Residents Population

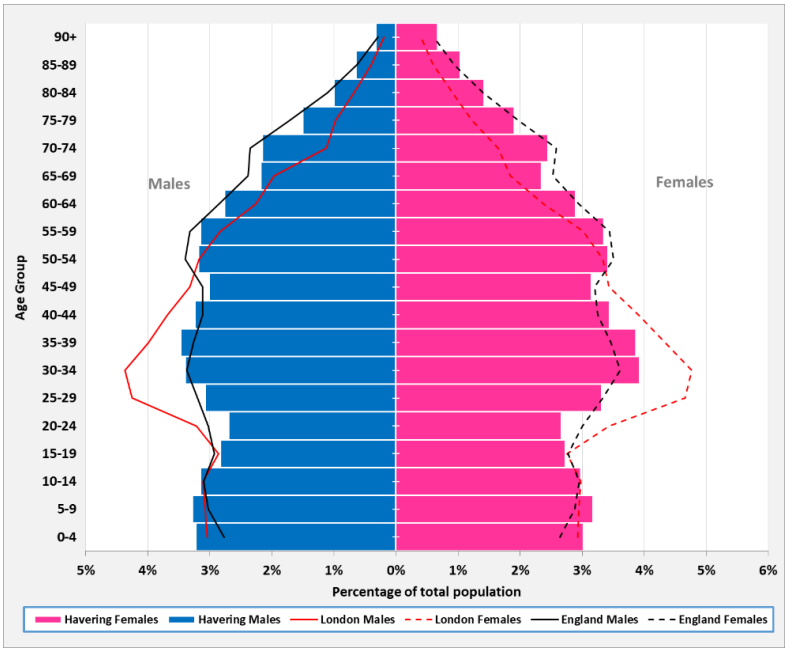
According to the ONS Census 2021, the Havering resident population is estimated as 262,052. The number of people that live in Havering has increased over the last decade from 237,232 in 2011 to 262,052 in 2021 (a 10.5% increase).Table 1 shows the Havering population breakdown by gender and five-year age bands and the population pyramid in Figure 6 compares the population figures for Havering with London and England by five-year age bands. Figure 6 shows a much older age structure for the population of Havering compared to London but similar to England.

Table 1: Estimated population of residents in Havering by gender and five-year age group, 2021

Age Band (Years)	Male	Female	Persons
00-04	8,454	7,918	16,372
05-09	8,590	8,323	16,913
10-14	8,242	7,799	16,041
15-19	7,406	7,164	14,570
20-24	7,056	6,975	14,031
25-29	8,048	8,682	16,730
30-34	8,901	10,279	19,180
35-39	9,090	10,140	19,230
40-44	8,494	9,016	17,510
45-49	7,887	8,246	16,133
50-54	8,338	8,939	17,277
55-59	8,254	8,769	17,023
60-64	7,229	7,591	14,820
65-69	5,699	6,140	11,839
70-74	5,632	6,428	12,060
75-79	3,932	5,006	8,938
80-84	2,618	3,726	6,344
85-89	1,695	2,713	4,408
90+	847	1,756	2,603
All Ages	**126,412**	**135,610**	**262,052**

Source: ONS Census, 2021

Figure 6: Havering, London & England 2021 Population Estimates Pyramid



Source: ONS 2021 Mid-Year Population Estimates

3.2 Havering GP Registered Population

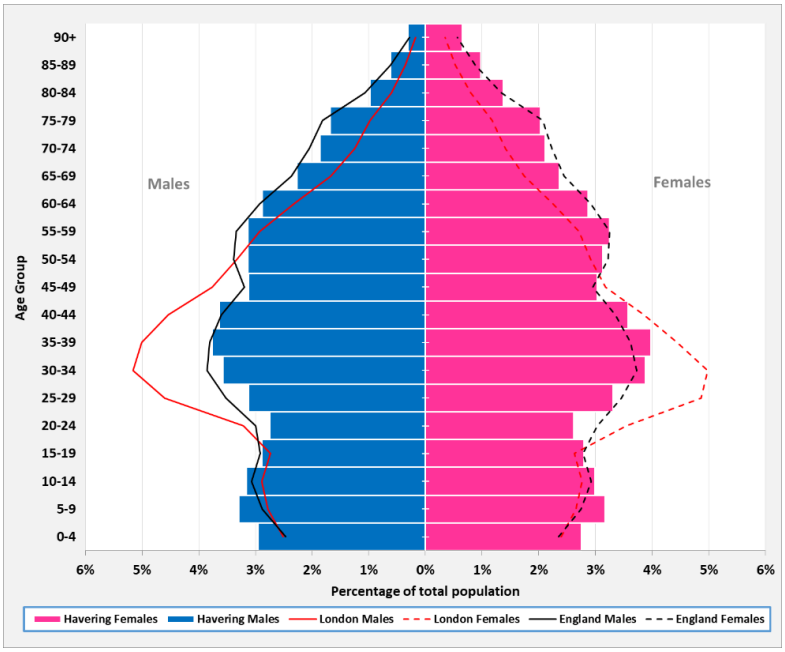
According to the NHS records, 291,795 persons are registered with GP practices in Havering. This is a higher figure by nearly 30,000 as compared to the resident population. This may be attributed to cross border registrations from neighbouring boroughs. However, the GP population structure (see Table 2 and Figure 7) is similar to the resident's one.

Table 2: Havering GP registered population by gender and five-year age groups, 2023

Age Band (Years)	Male	Female	Persons
00-04	8,611	8,038	16,649
05-09	9,602	9,257	18,859
10-14	9,214	8,716	17,930
15-19	8,431	8,163	16,594
20-24	8,013	7,644	15,657
25-29	9,114	9,661	18,775
30-34	10,413	11,316	21,729
35-39	10,975	11,605	22,580
40-44	10,620	10,439	21,059
45-49	9,111	8,857	17,968
50-54	9,146	9,150	18,296
55-59	9,140	9,476	18,616
60-64	8,390	8,392	16,782
65-69	6,611	6,899	13,510
70-74	5,424	6,174	11,598
75-79	4,914	5,936	10,850
80-84	2,852	4,007	6,859
85-89	1,810	2,856	4,666
90+	898	1,920	2,818
All Ages	**143,289**	**148,506**	**291,795**

Source: NHS Digital, June 2023

Figure 7: Havering, London & England GP registered population pyramid, 2023



Source: NHS Digital, June 2023

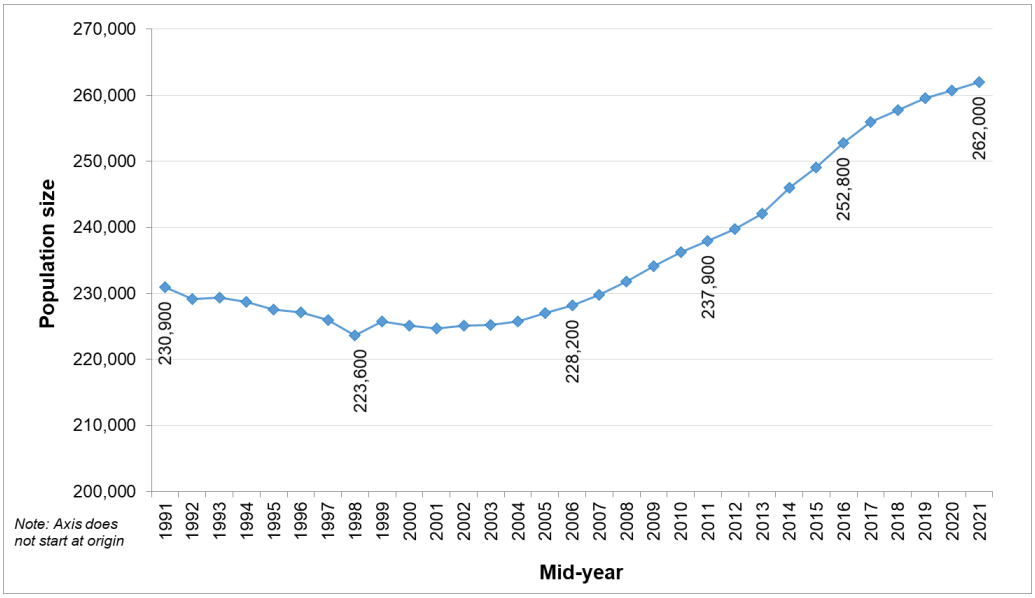
4. Population Change

4. Population Change

4.1 Annual Population Change and Associated Factors

Following a net population loss of 3% between 1991 (230,900) and 1998 (223,600), Havering's population has since increased year on year to approximately 262,000 in 2021 (see Figure 8).

Figure 8: Trend in population size in Havering, 1991-2021



Source: ONS 2021 Mid-year population estimates

The ONS mid-year population estimates show an increase, by 1,371 residents (0.5%) between 2020 and 2021. This increase is mainly due to natural change (births minus deaths, 327). Internal migration saw a reduction in population of 357 people (Table 3).

Table 3: Havering Components of Population Change, from 2020 to 2021

	Number	Percentage
Estimated Population mid-2020	260,651	
Estimated Population mid-2021	262,022	
Overall Population Change	**1,371**	**0.5%**
• Due to Births and Deaths	327	0.1%
• Due to Internal Migration	-357	-0.1%
• Due to International Migration	7	0.0%
• Due to Other Adjustments	1,394	0.5%

Source: ONS 2021 Mid-Year Population Estimates

4.2 Population change between 2011 and 2021 census

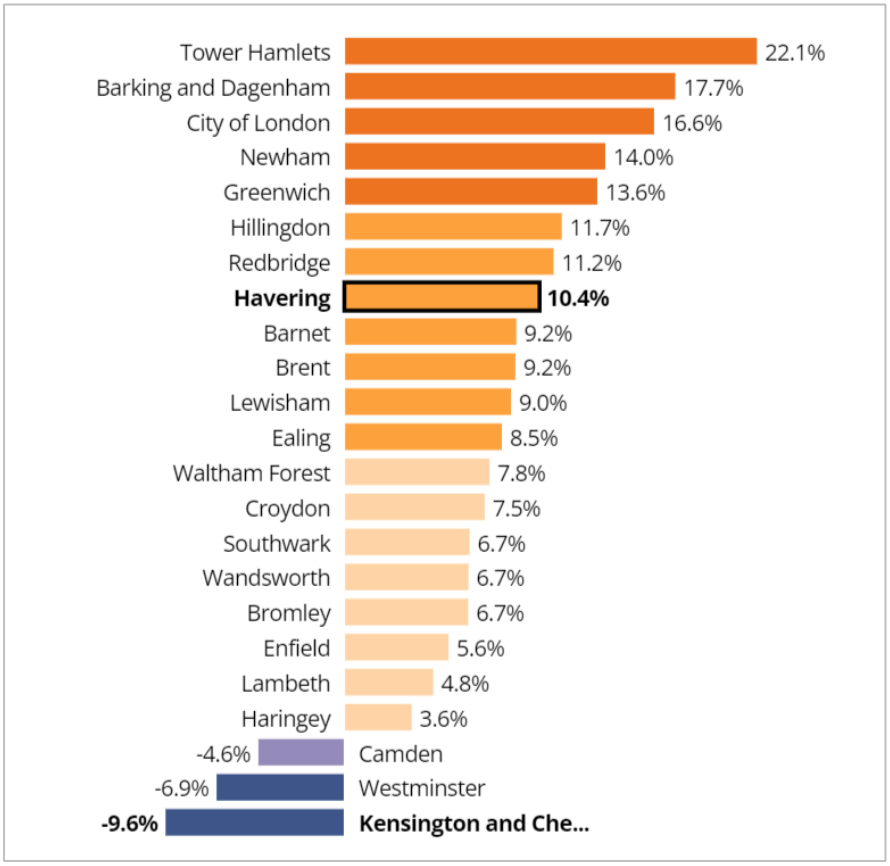
The number of people that live in Havering has increased over the last decade from 237,232 in 2011 to 262,052 in 2021. This is a 10.4% increase compared to a 7.7% increase across London and a 6.6% increase across England. Tower Hamlets had the highest population increase among London boroughs (22.1%) (Figure 8). Between the last two censuses, the median age in Havering decreased

by one year, from 40 to 39 years of age. This was higher than London as a whole (35 years) but slightly lower than England (40 years).

Table 4: Havering population change between 2011 and 2021 census

	Number	Percentage
Census Population 2011	237,232	
Census Population 2021	262,052	
Overall Population Change	**24,820**	**10.4%**

Figure 9: London boroughs percentage population change between 2011 and 2021 census



Source: ONS Census 2021

4.3 Ward Level population change

Between 2019 and 2020, Emerson Park ward saw the largest decline (of around 0.8%); Romford Town, Pettits, Hacton, St Andrews, Hylands, Mawneys and Hylands all had a small decline in population whereas all other wards experienced an increase. Brooklands, Heaton and Harold Wood experienced the highest percentage increase in population. The likely explanations for population increase include economic growth and new developments within Brooklands and inflow migration from neighbouring boroughs into bordering wards such as Gooshays, Havering Park and Harold Wood. Potential explanations for the slight decline in population within wards include outflow migration into bordering boroughs and residents migrating between Havering wards.

Table 5: Havering ward population change from 2019 to 2020

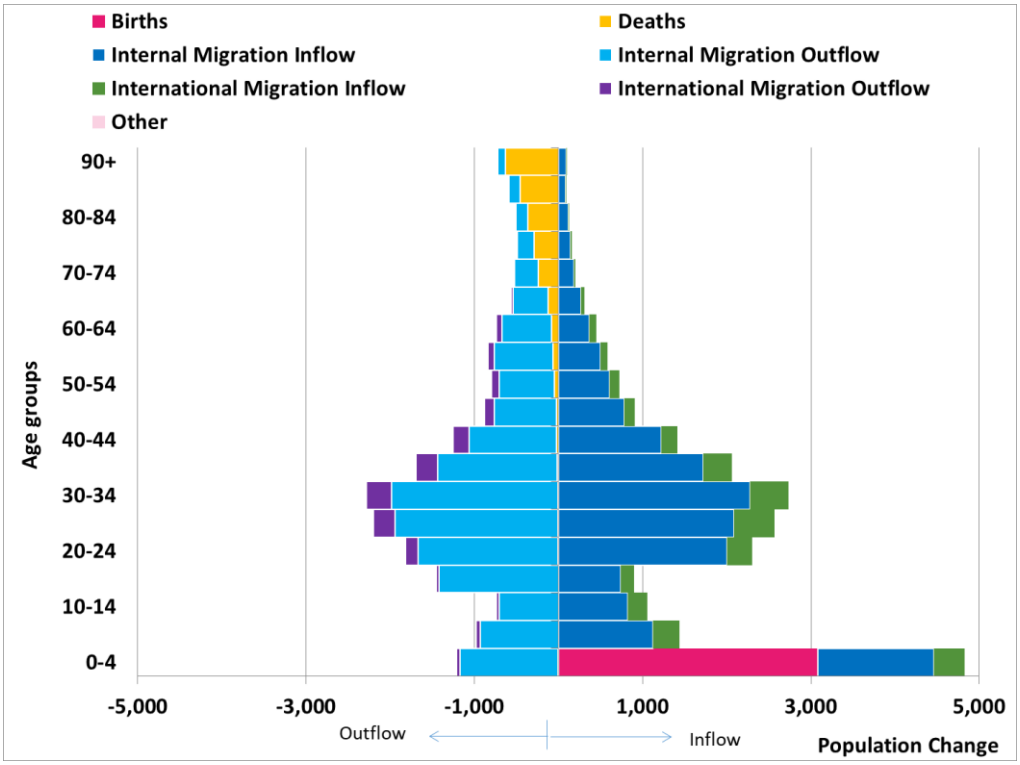
	Mid- 2019 Population	Mid- 2020 Population	Change	%Change	Rank of % Change (1 is highest, 18 is lowest)
HAVERING	259,552	260,651	**1,099**	**0.42%**	-
Brooklands	18,773	19,112	**339**	**1.81%**	1
Heaton	15,037	15,248	**211**	**1.40%**	2
Harold Wood	14,908	15,117	**209**	**1.40%**	3
South Hornchurch	14,839	15,039	**200**	**1.35%**	4
Havering Park	14,156	14,347	**191**	**1.35%**	5
Gooshays	17,284	17,443	**159**	**0.92%**	6
Upminster	13,178	13,260	**82**	**0.62%**	7
Rainham and Wennington	13,309	13,384	**75**	**0.56%**	8
Squirrel's Heath	14,260	14,295	**35**	**0.25%**	9
Cranham	12,971	12,973	**2**	**0.02%**	10
Hylands	13,294	13,284	**-10**	**-0.08%**	11
Mawneys	13,863	13,848	**-15**	**-0.11%**	12
Elm Park	13,107	13,072	**-35**	**-0.27%**	13
St Andrew's	13,875	13,819	**-56**	**-0.40%**	14
Hacton	12,434	12,374	**-60**	**-0.48%**	15
Pettits	13,313	13,253	**-60**	**-0.45%**	16
Romford Town	18,998	18,925	**-73**	**-0.38%**	17
Emerson Park	11,953	11,858	**-95**	**-0.79%**	18

Source: ONS Mid-Year Population Estimates

4.4 Age Population Change and Associated Factors

Figure 9 & Table 6 show the population change in Havering between 2021 and 2022 by contributory factor and age. Figure 10 shows the net change in population due to migration by five-year age groups. Inclusive of 'natural change' (i.e. births and deaths), children aged 0-4 years are the largest contributors to population change, largely due to births. The year 2022 saw a net increase in young adults (20-44 years) largely due to internal migration and a net decrease in adults aged 75 years and over largely due to deaths. There was a significant decrease of 15-19 year olds who may have left the borough to pursue higher education elsewhere in the country (see Figures 10 and 11).

Figure 10: Havering population change between 2021 and 2022 by component and five-year age-groups



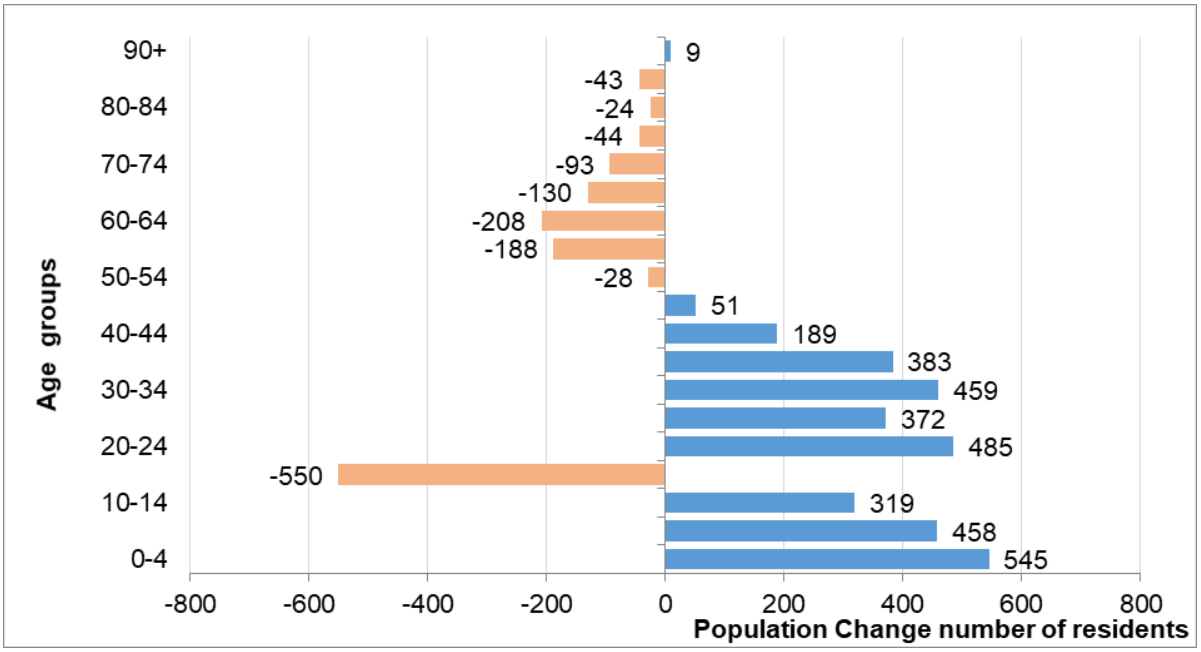
Data source: Mid-year population estimates 2022 Analysis Tool; Office for National Statistics (ONS); Produced by Public Health Intelligence

Table 6: Havering population change between 2021 and 2022 by component and five-year age-groups

Age group	Births	Deaths	Internal Migration Inflow	Internal Migration Outflow	International Migration Inflow	International Migration Outflow	Other
0-4	3,082	-9	1,379	-1,160	365	-39	
5-9	0	-1	1,119	-930	317	-48	
10-14	0	-3	823	-699	229	-34	
15-19	0	-3	743	-1,420	156	-29	
20-24	0	-4	1,999	-1,665	303	-152	
25-29	0	-8	2,085	-1,937	478	-254	
30-34	0	-9	2,274	-1,976	461	-300	
35-39	0	-12	1,720	-1,421	343	-259	
40-44	0	-27	1,218	-1,033	198	-194	
45-49	0	-26	782	-735	125	-121	
50-54	0	-46	609	-659	113	-91	
55-59	0	-69	496	-695	84	-73	
60-64	0	-85	369	-584	79	-72	
65-69	0	-127	270	-413	40	-27	
70-74	0	-241	182	-281	18	-12	
75-79	0	-293	144	-200	14	-2	
80-84	0	-361	113	-147	11	-1	
85-89	0	-459	81	-132	8	0	
90+	0	-633	96	-88	1	0	

Data source: Mid-year population estimates 2022 Analysis Tool; Office for National Statistics (ONS); Produced by Public Health Intelligence

Figure 11: Net population change due to migration in Havering, from mid-2021 to mid-2022, five-year age-groups.



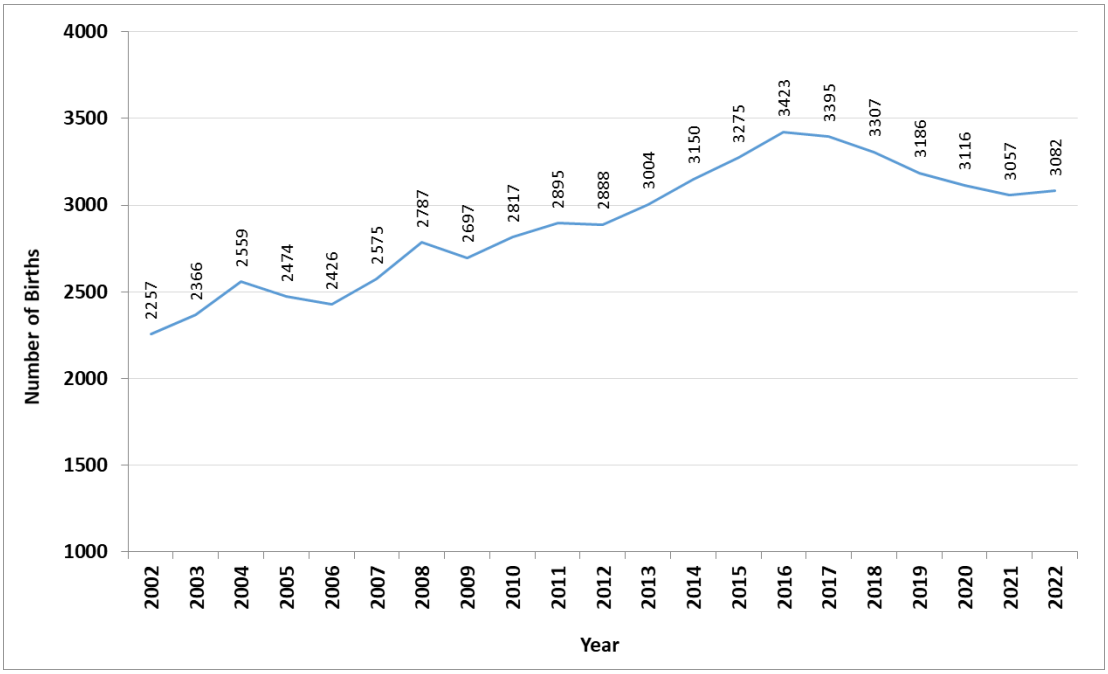
Data source: Mid-year population estimates 2022 Analysis Tool; Office for National Statistics (ONS); Produced by Public Health Intelligence

4.5 Births and Migration of Children

Up to 2017, the number of births among Havering women was on an upward trend. The decline continued thereafter until 2022 where a slight increase has been observed (25 births) (see Figure 12). The general fertility rate (GFR)[8] trend has been consistent with the number births as shown in Figure 13. The latest (2021) GFR for Havering was 59/1,000 women aged 15-44, higher than the outer London, London and England averages.

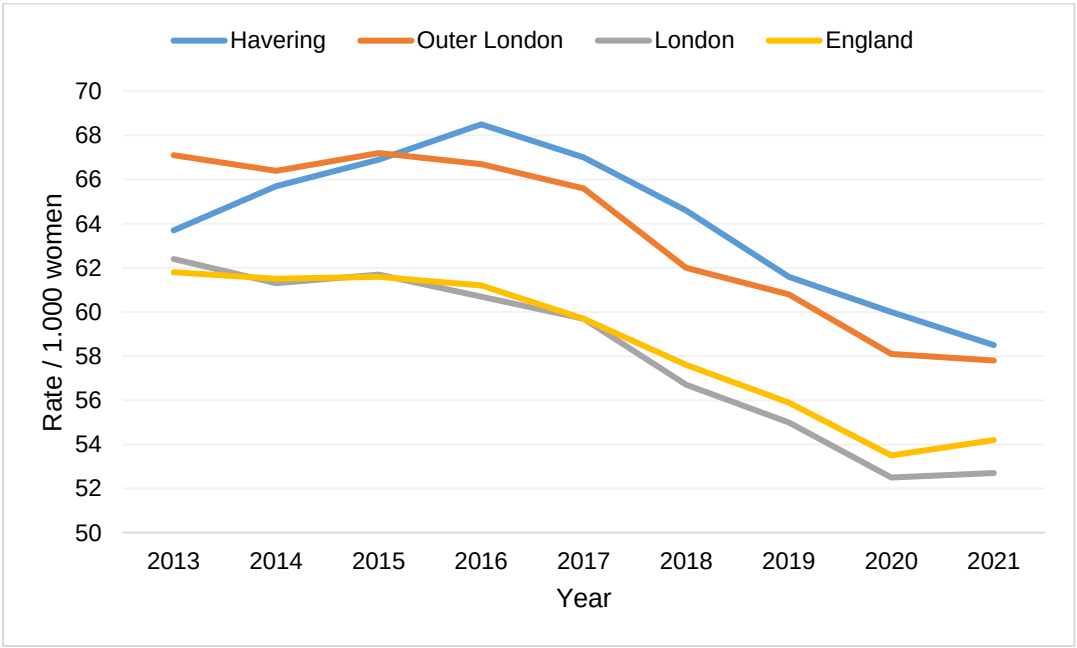
[8] This is a measure of current fertility levels and denotes the number of live births as a rate per 1,000 women aged 15 to 44 years. Fertility rates are closely tied to growth rates for an area and can be an excellent indicator of future population growth or decline in that area.

Figure 12: Number of live births to women residents in Havering, 2002 to 2022



Source: Nomis, Official Census and Labour Market Statistics

Figure 13: Trend in general fertility rate of women residents aged 15 to 44 years in Havering, Outer London, London and England, 2013 to 2021

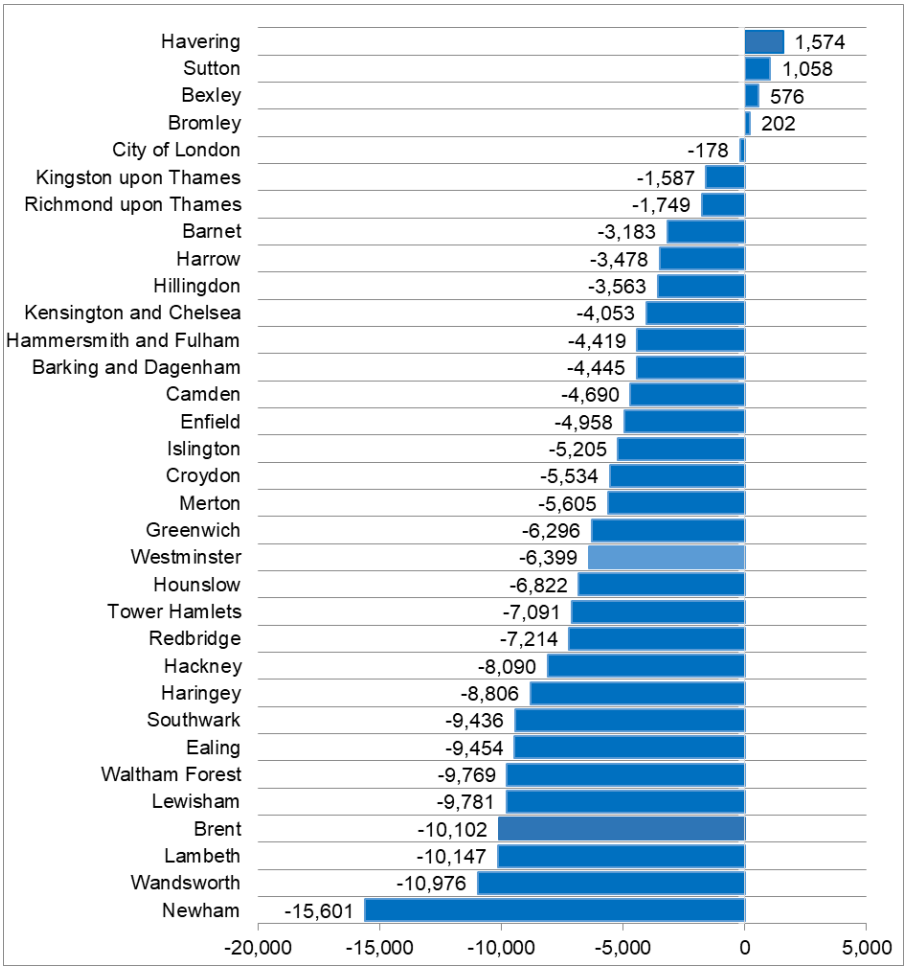


Source: Nomis, Official Census and Labour Market Statistics

In addition, Havering has experienced the largest net inflow of children across all London boroughs in recent years. In a four year period (from 2016 to 2020), 1,574 children have settled in the borough from another part of the United Kingdom (see Figure 14). Figure 14 also illustrates that there is migration of children out of Inner London Boroughs, which have experienced a negative net flow, into Outer London Boroughs. However, the biggest inflows of children into Havering in 2020 came

from neighbouring Outer London Boroughs, Redbridge (407 children) and Barking & Dagenham (342 children).

Figure 14: Net flow of children by London Borough, 2016-2020



Data source: Internal Migration Flows 2016-2020; Greater London Authority (GLA); Produced by Public Health Intelligence

4.6 Projected Population Change

4.6.1 Borough Level Projections

According to the Greater London Authority (GLA) Local authority population projections, housing led[9] (Table 4), Havering's population is projected to increase from 261,978 in 2021 to:

- 274,901 in 2026 (5%)
- 281,866 in 2031 (8%)
- 288,489 in 2036 (10%)

4.6.2 Ward Level Projections

Table 7 shows the projected population and projected percentage population change in Havering at ward level for the next 5, 10 and 15 years. The populations in Beam Park and Hacton wards are expected to increase the most over the next 10 – 15 years.

Table 7: Projected population growth among Havering wards from 2021 to 2036

Ward	2021	2026		2031		2036	
	No.	No.	% change from 2021	No.	% change from 2021	No.	% change from 2021
Beam Park	4,619	5,916	28.1%	7,545	63.3%	8,394	81.7%
Cranham	13,010	13,334	2.5%	13,356	2.7%	13,418	3.1%
Elm Park	16,068	16,666	3.7%	16,708	4.0%	16,648	3.6%
Emerson Park	8,956	9,164	2.3%	9,264	3.4%	9,504	6.1%
Gooshays	17,703	18,263	3.2%	18,084	2.2%	17,953	1.4%
Hacton	8,843	9,385	6.1%	10,966	24.0%	13,297	50.4%
Harold Wood	13,652	14,321	4.9%	14,275	4.6%	14,391	5.4%
Havering-atte-Bower	16,265	16,714	2.8%	16,817	3.4%	16,941	4.2%
Heaton	17,940	18,589	3.6%	18,299	2.0%	18,024	0.5%
Hylands & Harrow Lodge	14,057	14,534	3.4%	14,462	2.9%	14,689	4.5%
Marshalls & Rise Park	12,827	13,191	2.8%	13,219	3.1%	13,313	3.8%
Mawneys	14,454	14,792	2.3%	14,731	1.9%	14,725	1.9%
Rainham & Wennington	13,445	13,857	3.1%	13,977	4.0%	14,349	6.7%
Rush Green & Crowlands	15,410	16,674	8.2%	17,855	15.9%	18,806	22.0%
South Hornchurch	10,496	10,776	2.7%	10,848	3.3%	11,188	6.6%
Squirrels Heath	16,075	16,857	4.9%	17,148	6.7%	17,265	7.4%
St Alban's	8,770	10,278	17.2%	11,757	34.1%	12,110	38.1%
St Andrew's	14,585	15,128	3.7%	15,212	4.3%	15,391	5.5%
St Edward's	11,463	12,637	10.2%	13,274	15.8%	13,791	20.3%
Upminster	13,339	13,825	3.6%	14,069	5.5%	14,292	7.1%
Total	261,978	274,901	4.9%	281,866	7.6%	288,489	10.1%

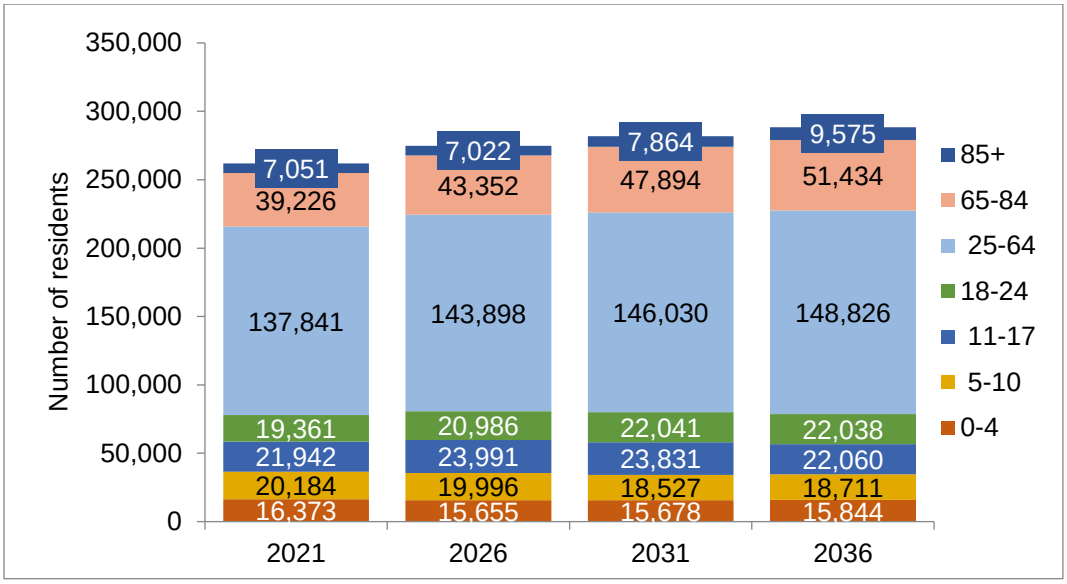
Data source: GLA 2021-based Demographic Projections – Local Authority population projection Housing-led Model; Greater London Authority (GLA); Produced by Public Health Intelligence

4.6.3 Age Level Projections

Figure 15 and Table 8 show change in population by age group as from 2021 to 2036.The population aged 25-64 will remain the largest age group up to 2036. It is projected that the largest percentage increases in population will occur among older people age groups (65 years and above).

[9] This models the population size for each age group based on trend data and strategic housing building plans (the assumption is that the proportion of people in each age group remains relatively stable over the next ten years). The tool is updated annually to reflect the latest ONS mid-year estimates. These projections incorporate assumptions about future development based on the results of the 2016 Strategic Housing Land Availability Assessment (SHLAA).

Figure 15: Projected population change by age group from 2021 to 2036



Data source: GLA 2021-based Demographic Projections – Local Authority population projection Housing-led Model; Greater London Authority (GLA); Produced by Public Health Intelligence

Table 8: Projected percentage population change by age group from 2021 to 2036

	Percentage change from 2021 to		
	2026	**2031**	**2036**
0-4	-4%	-4%	-3%
5-10	-1%	-8%	-7%
11-17	9%	9%	1%
18-24	8%	14%	14%
25-64	4%	6%	8%
65-84	11%	22%	31%
85+	0%	12%	36%

Data source: GLA 2021-based Demographic Projections – Local Authority population projection Housing-led Model; Greater London Authority (GLA); Produced by Public Health Intelligence

5. Protected Characteristics

5. Protected Characteristics

5.1 Ethnicity

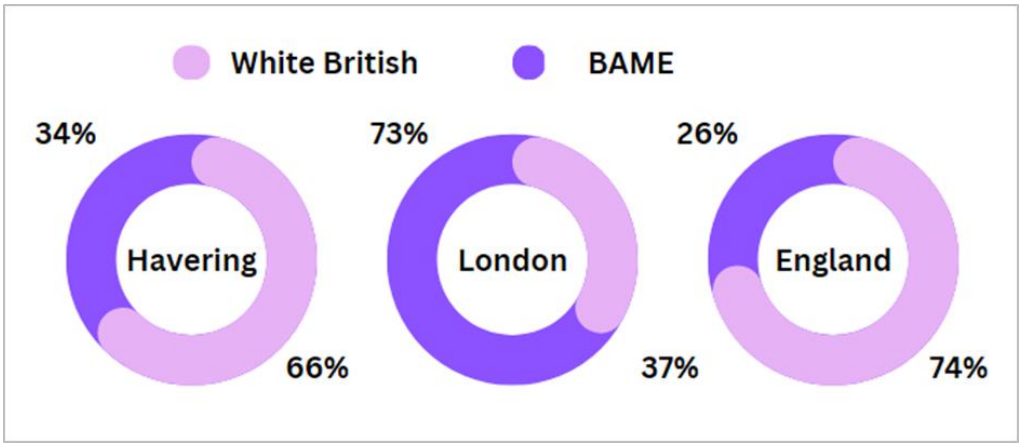
Havering's ethnic structure has significantly changed in the last 10 years. According to the 2021 census data, 66% of its residents were recorded as White British in the 2021 census as compared to 83% in 2011. However this remains higher than the London average but lower than the England average (see Table 9 and Figure 16).

Table 9: Number & Percentage White British (Gender & Persons)

Ethnicity	Male	Female	Total	Percentage
White British	84449	89783	174232	66%
Other White	10872	12210	23082	9%
Black	9979	11588	21567	8%
Asian	13799	14351	28150	11%
Mixed	4746	5001	9747	4%
Other	2539	2735	5274	2%
Total	126384	135668	262052	100%

Source: Census 2021

Figure 16: Havering 2021 Census Population, broken down by proportion of White British and BAME (Black and Minority Ethnic) groups

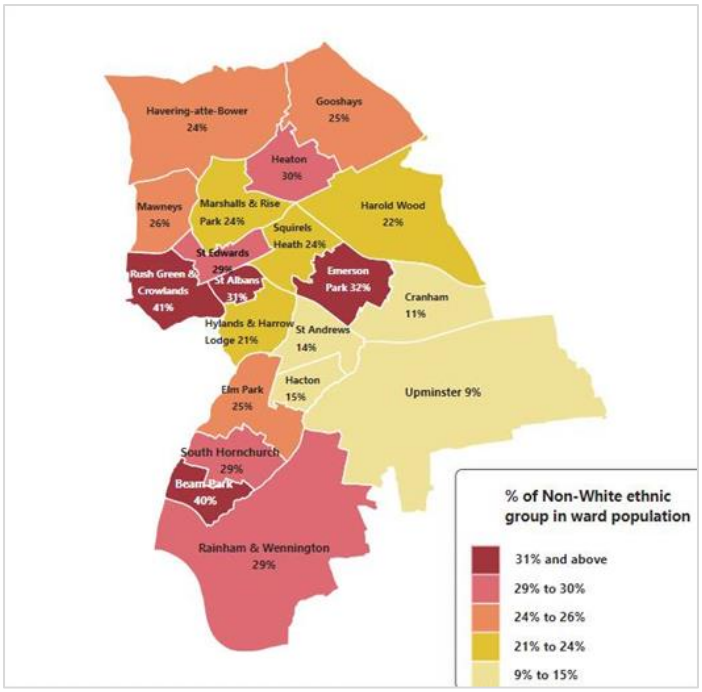


Source: Census 2021

Figure 17 presents the distribution of non-white population[10] across Havering wards.
Beam Park, Emerson Park, Heaton, Rush Green & Crowlands are the wards with the highest proportion of non-white categories.

[10] *Note that non-white population group excludes minority white ethnic groups*

Figure 17: The distribution of non-white population cross wards in Havering, 2021

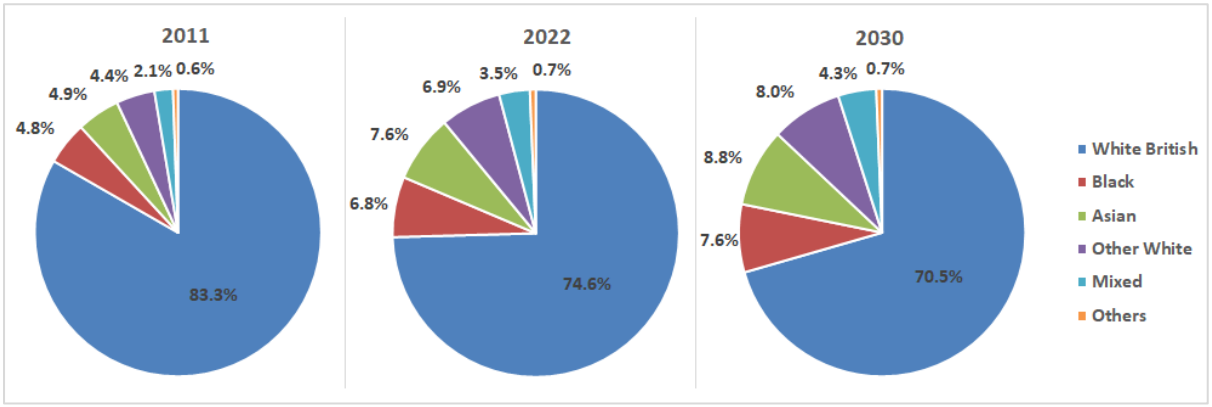


Source: Census 2021

Ethnic population projections

Ethnic diversity has increased in Havering since last census in 2011. Nonetheless, Havering remains more similar to England as a whole than London in terms of ethnic diversity with 74.6% estimated to be White British in 2022. This is expected to reduce to 70.5% by 2030 (Figure 18).

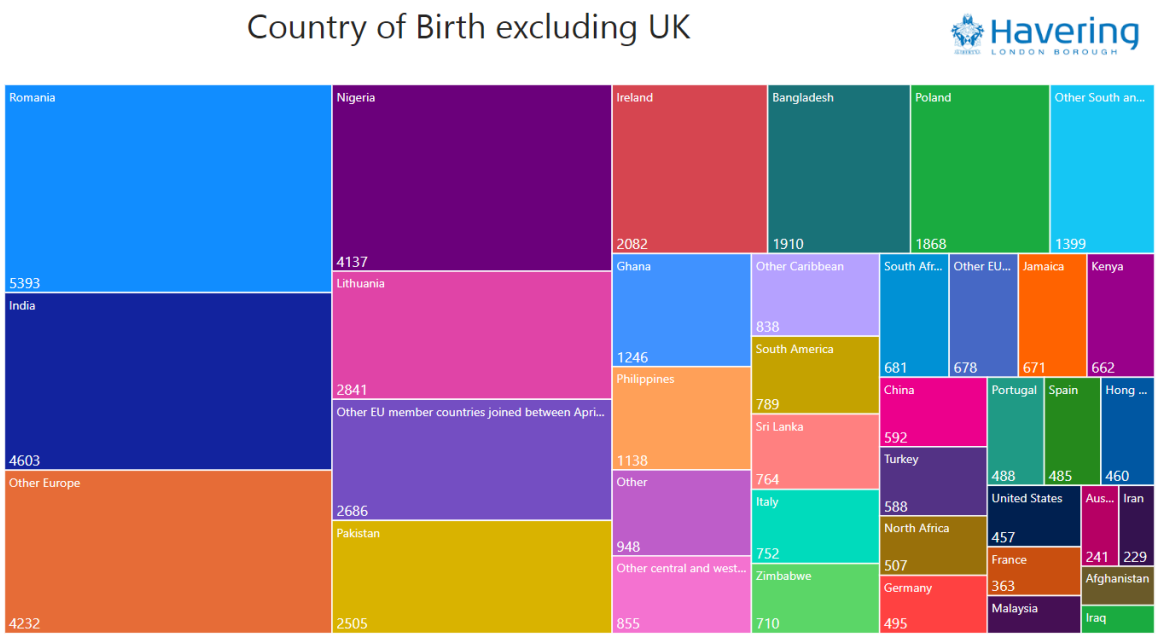
Figure 18: Havering ethnic population projections, 2011-2030



Data Source: GLA Ethnic Projections

According to the Census 2011 report, 81% of the residents in Havering were born in the United Kingdom (UK). A breakdown of the minority proportion of Havering residents born out of the UK (19%) is presented in Figure 19. It shows that most of the residents born outside of the UK were born in Romania and other European countries.

Figure 19: Count and proportion of UK born and non-UK born Havering residents and their countries and regions of origin, 2021



Source: Census 2021

5.2 Main Languages

According to Census 2021 data, the most spoken language in Havering is English (90%) followed by other European languages (4%). The most spoken non-European language is Panjabi (0.6%).

Table 10: Main Languages spoken in Havering

Main Language	Number	Percentage
English (English or Welsh if in Wales)	227,346	90.1%
Other European language (EU): Any other European languages	10,198	4.0%
South Asian language: Panjabi	1,393	0.6%
Other European language (EU): Polish	1,320	0.5%
South Asian language: Any other South Asian languages	1,178	0.5%
South Asian language: Bengali (with Sylheti and Chatgaya)	1,131	0.4%
South Asian language: Urdu	1,081	0.4%
European languages (non-EU)	1,001	0.4%
African languages	912	0.4%
East Asian language: Any other East Asian languages	769	0.3%
Portuguese	730	0.3%
Russian	719	0.3%
East Asian language: Mandarin, Cantonese and other Chinese languages	707	0.3%
South Asian language: Tamil	669	0.3%
Turkish	603	0.2%
South Asian language: Gujarati	599	0.2%
Spanish	537	0.2%
West or Central Asian languages	447	0.2%
Arabic	371	0.1%
French	326	0.1%
All usual residents aged 3 and over	**252,281**	

Source: Census 2021

According to School Census 2023 data, the first language for most children in Havering is English (74%) followed by Romanian (4%). The highest percentage among non-European languages is Urdu (2%).

Table 11: Top 10 First Language for Children in Havering Schools

First Language	Number	Percentage
English	31,567	74.4%
Romanian	1,740	4.1%
Urdu	866	2.0%
Lithuanian	720	1.7%
Bengali	625	1.5%
Polish	494	1.2%
Albanian	441	1.0%
Yoruba	404	1.0%
Punjabi	368	0.9%
Russian	352	0.8%

Data Source: School Census, 2023

5.3 Traveller population

There were 192 caravans occupied by travellers in Havering as at January 2023, an increase by 34 from the previous year (158) (see Table 12). Only 30 were on authorised sites while 57 were tolerated. [11] The total number of caravans has been consistent over the last two years and the number with permanent planning permission is increasing.

Table 12: Count of Traveller Caravans in Havering, Last Seven Counts, January 2020 to January 2023

			2020		2021		2022		2023
			Jan	Jul	Jan	Jul	Jan	Jul	Jan
Authorised sites (with planning permission)	Socially Rented Caravans		0	No data	No data	0	0	0	0
	Private Caravans	Temporary Planning Permission	122	No data	No data	122	121	0	0
		Permanent Planning Permission	25	No data	No data	25	22	22	30
		All Private Caravans	147	No data	No data	147	143	22	30
Unauthorised sites (without planning permission)	No. of Caravans on Sites on Travellers' own land	"Tolerated"	0	No data	No data	0	0	54	57
		"Not tolerated"	0	No data	No data	15	15	116	105
	No. of Caravans on Sites on land not owned by Travellers	"Tolerated"	0	No data	No data	0	0	0	0
		"Not tolerated"	0	No data	No data	0	0	0	0
Total All Caravans			**147**	**No data**	**No data**	**162**	**158**	**192**	**192**

Data Source: Department for Communities and Local Government (DCLG)

5.4 Sexual Orientation

According to the ONS Census 2021, the majority of Havering residents aged 16 and above (91%) identify as straight or heterosexual. In total, 2% identify with one of the LGB+ orientations ("Gay or Lesbian", "Bisexual" or "Other sexual orientation") (Table 13).

Table 13: Detailed breakdown of sexual orientation in Havering for residents aged 16 and over, 2021

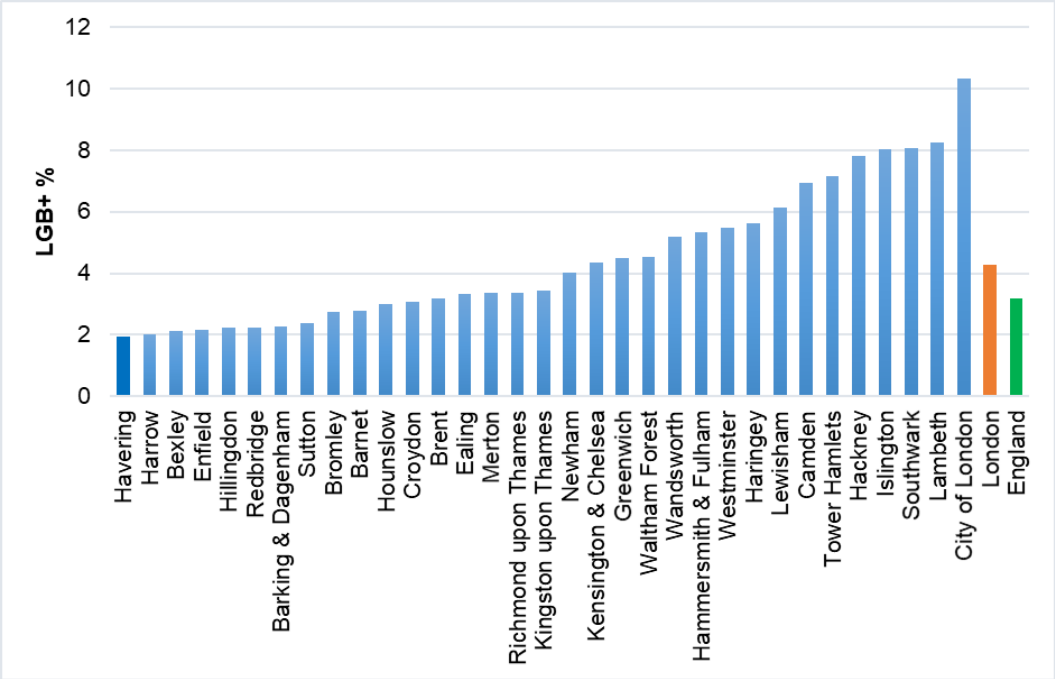
Sexual Orientation	Number	Percentage
Straight or Heterosexual	191,007	91.1%
Gay or Lesbian	1,993	0.95%
Bisexual	1,540	0.73%
Pansexual	436	0.21%
Asexual	56	0.03%
Queer	21	0.01%
All other sexual orientations	46	0.02%
Not answered	14,631	7.0%
Total	**209,730**	**100%**

Source: Office for National Statistics (ONS), Census 2021; Produced by: Havering PHI

[11] A 'tolerated' site is one where the local authority has decided not to seek the removal of the encampment, and where the encampment has been, or is likely to be, allowed to remain for an indefinite period of months or years

Havering has the lowest proportion of residents aged 16 and over in London who identify as LGB+ orientation ("Gay or Lesbian", "Bisexual" or "Other sexual orientation") (Figure 27).

Figure 20: Percentage of LGB+ residents, London boroughs and England, 2021



Source: Office for National Statistics (ONS), Census 2021; Produced by: Havering PHI

5.5 Gender Identity

According to the ONS Census 2021, the majority of Havering residents aged 16 and above have retained their gender identity as registered at birth. In total, less than 1% identify with gender identity being different from the one registered at birth (Table 14).

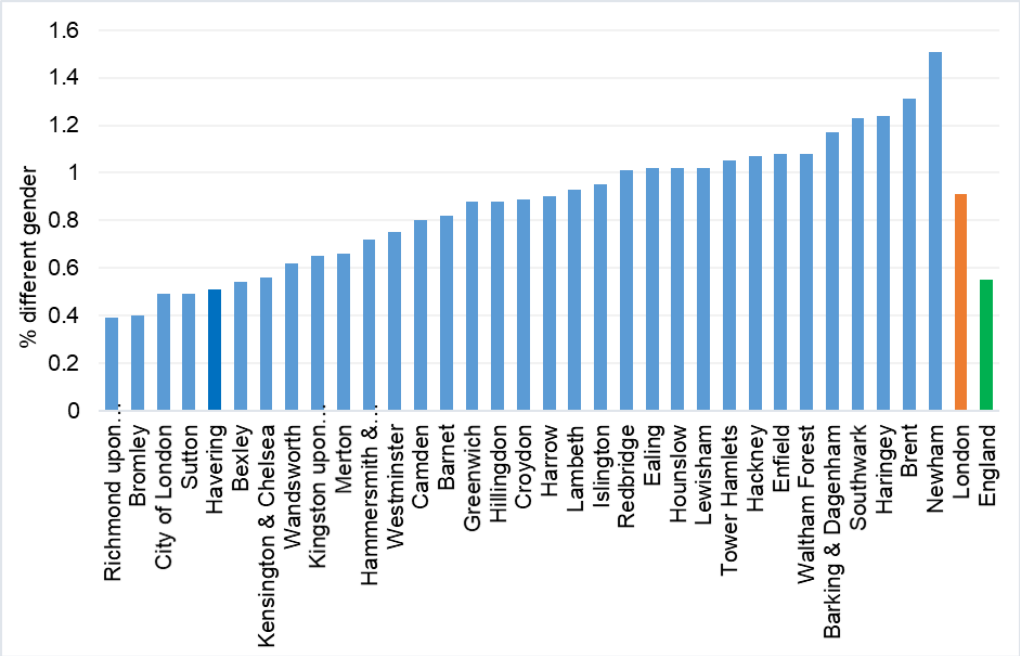
Table 14: Detailed breakdown of gender identity in Havering for residents aged 16 and over, 2021

Gender Identity	Number	Percentage
Gender identity the same as sex registered at birth	196,462	93.7%
Gender identity different from sex registered at birth but no specific identity given	528	0.25%
Trans woman	228	0.11%
Trans man	212	0.10%
Non-binary	60	0.03%
All other gender identities	39	0.02%
Not answered	12,201	5.8%
Total	**209,730**	**100%**

Source: Office for National Statistics (ONS), Census 2021; Produced by: Havering PHI

Within London, Havering has the 5th lowest proportion of residents aged 16 and over reporting that the gender that they identify with now is different to their sex registered at birth.

Figure 21: Percentage of people that identify as a different sex to that registered at birth, Havering, London boroughs and England, 2021



Source: Office for National Statistics (ONS), Census 2021; Produced by: Havering PHI

5.6 Religion

According to the ONS Census 2021, just over a half (52%) identify as Christians. This is a significant reduction from 65.6% in 2011. No religion was the second most common response, with 30.6% identifying in this category, up from 22.6% in 2011. Other religions accounted for 11.7% of the total Havering population, which is an increase from 5.1% in 2011.

Table 15: Number and percentage of the population by religion in Havering, London and England, 2021.

Religion	Havering		London		England	
	number	%	number	%	number	%
Christian	136,765	52.2	3,577,681	40.7	26,167,899	46.3
Buddhist	1,092	0.4	77,425	0.9	262,433	0.5
Hindu	6,454	2.5	453,034	5.1	1,020,533	1.8
Jewish	1,305	0.5	145,466	1.7	269,283	0.5
Muslim	16,135	6.2	1,318,754	15.0	3,801,186	6.7
Sikh	4,498	1.7	144,543	1.6	520,092	0.9
No religion	80,235	30.6	2,380,405	27.1	20,715,667	36.7
Other religion	1,056	0.4	86,755	1.0	332,406	0.6
Religion not stated	14,512	5.5	615,662	7.0	3,400,548	6.0
All Usual Residents	262,052	100	8,799,725	100	56,490,047	100

Source: ONS Census 2021

5.7 Recommendations

- *The local authority, NHS and other partners should continue to work together in supporting the needs of the increasing young and working age population by facilitating access to essential resources that may include childcare, school places, relevant health services and employment opportunities.*

- *The local authority, NHS and other partners should continue to work together in supporting the growing population of older people to remain as healthy and independent as possible for as long as possible and to ensure they receive the highest quality care when they need it.*

- *The local authority, NHS and partners should consider the implications of the growing population of persons with protected characteristics which include ethnicity, sexual orientation, gender identity and religion in their policies and plans in order to meet specific health and wellbeing needs of these groups and protect them from experiencing inequalities related to access and experience of essential support and services.*

6. Health Outcomes

6. Health Outcomes

6.1 Life expectancy at birth

As is the case nationally, life expectancy at birth in Havering has increased steadily over recent decades but the rate of improvement has slowed markedly since 2000 (Figure 22). Life expectancy continued to increase, albeit slowly, until 2020.

The most recent data available at borough level, aggregated for the period 2018-2020, shows that life expectancy in Havering actually reduced for both men (by 0.4yrs to 79.7yrs) and women (by 0.6yrs to 83.5yrs) (Figure 22). However, it remains similar to national averages, which also experienced a similar downturn, most likely as a result of the Covid-19 pandemic.

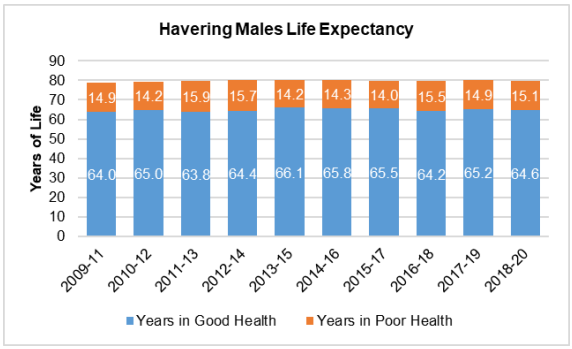
Figure 22: Life expectancy at birth (years), by gender, Havering compared to London and England, 3-year rolling periods, 2001-03 to 2018-20

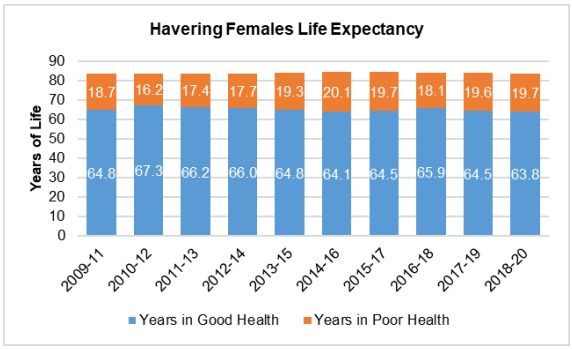
Source: Office for Health Improvement & Disparities - Fingertips

The impact of the pandemic is only partially captured in this period and a further reduction in life expectancy is likely when data for 2021 are included in borough level estimates.

The pandemic is also likely to leave a legacy of persistent ill-health and disability. This additional burden of ill-health will further emphasise the trend established before the pandemic whereby a significant proportion of life expectancy (19% for men and 23% for women) is impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services.

Figures 23 & 24: Havering Life expectancy 2009-11 to 2018-20

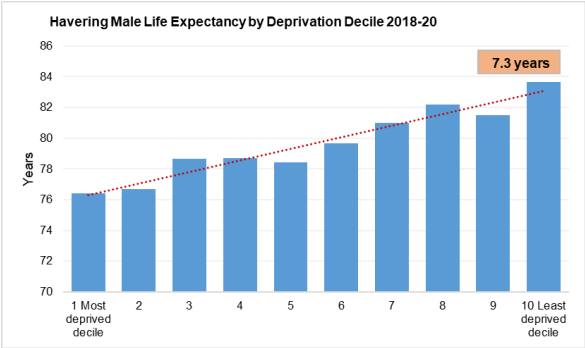


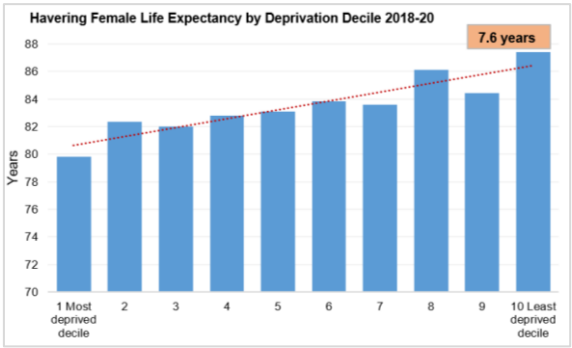


Source: Office for Health Improvement & Disparities - Fingertips

Residents living in the most disadvantaged decile of the borough have a significantly lower life expectancy (7.3 years for males and 7.6 years for females) than peers in the least deprived decile (Figures 17 & 18). The inequality in life expectancy for both men and women widened as compared to 2017-19 (0.4 for men and 0.6 for women).

Figures 25 & 26. Havering Life expectancy at birth by Deprivation, 2018-20





Source: Office for Health Improvement & Disparities - Fingertips

As well as lower life expectancy, national evidence shows people living in disadvantage have proportionally less healthy life expectancy than less disadvantaged peers.[12]

6.2 Life expectancy at 65

The latest data (2018-20) shows the life expectancy at age 65 for males in Havering is 18.2 years. This is shorter than the life expectancy for males in both London (19.2 years) and England (18.7 years).

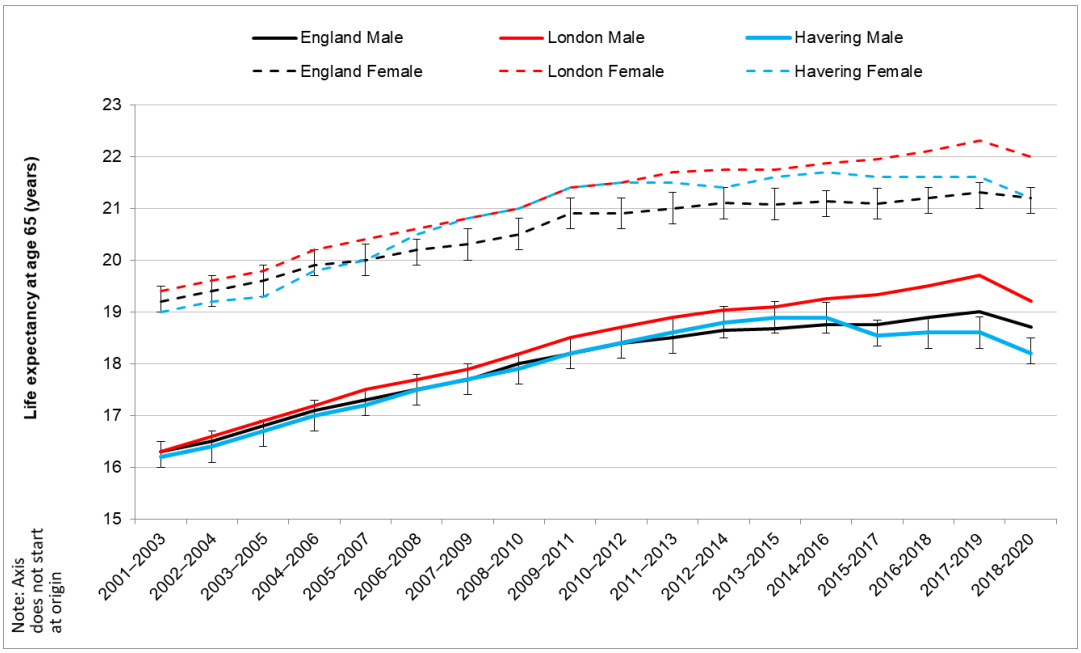
Over the last ten-year period (of 3-year rolling periods – from 2008-10 to 2018-20), the increase in life expectancy at age 65 for males in Havering has been minimal as compared to the London and England averages (see Figure 27).

The life expectancy at age 65 for females in Havering is 21.2 years, 3 years longer than for males; this is similar to England but significantly lower than London (22 years).

[12] Life expectancy and healthy life expectancy at birth by deprivation - The Health Foundation

Over the last ten-year period (of 3-year rolling periods – from 2008-10 to 2018-20), the increase in life expectancy at age 65 for females in Havering has been minimal as compared to the London average (Figure 27).

Figure 27: Life expectancy at age 65 (years), by gender, Havering compared to London and England, 3-year rolling periods, 2001-03 to 2018-20

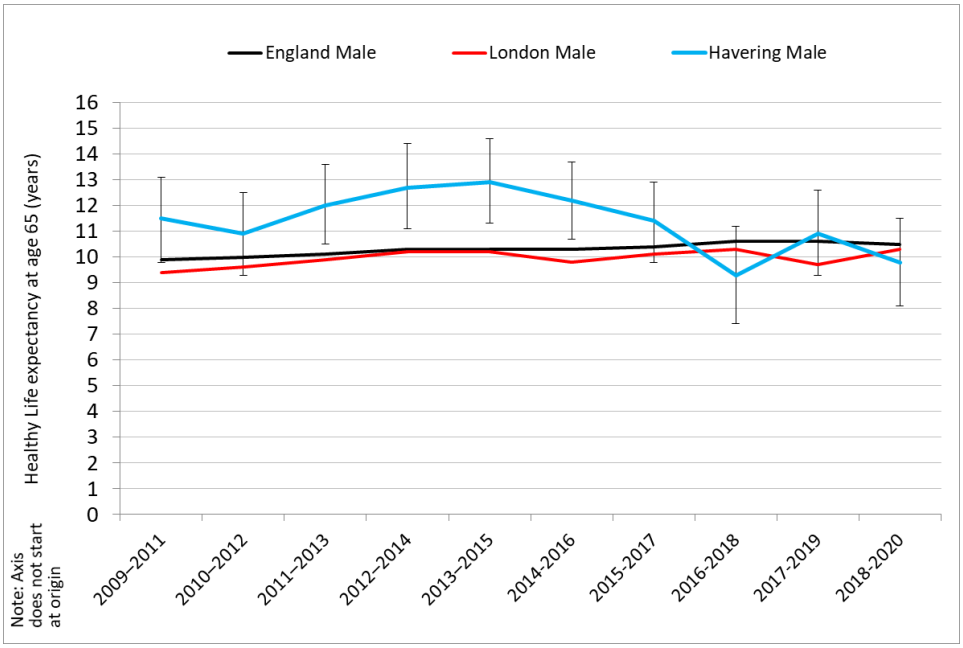


Source: Office for Health Improvement & Disparities - Fingertips

6.3 Healthy Life expectancy at 65

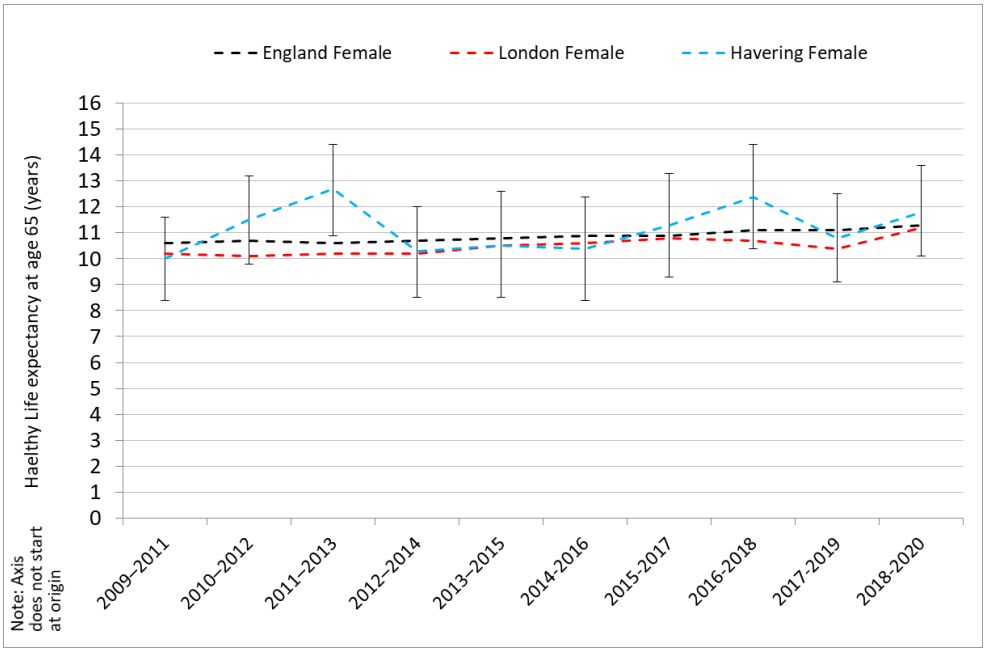
The latest data for the period 2018-20 shows males in Havering have a healthy life expectancy of 9.8 years at 65 as compared to females who have a higher expectancy of 11.8 years. The differences between Havering and the London and England averages are not statistically significant. The changes over the last 10 years have also not been statistically significant.

Figure 28: Healthy Life expectancy at age 65 (years), males, Havering compared to London and England, 3-year rolling periods, 2009-11 to 2018-20



Source: Office for Health Improvement & Disparities - Fingertips

Figure 29: Healthy Life expectancy at age 65 (years), females, Havering compared to London and England, 3-year rolling periods, 2009-11 to 2018-20



Source: Office for Health Improvement & Disparities - Fingertips

6.4 Health Status

In Havering an estimated 219,777 residents had 'good' or 'very good' health in 2021. This is an age-standardised proportion (ASP) [13] of 83.0%, which is higher than London (81.9%) and England (81.7%) (See figure 30 below).

Figure 30: ASP (%) reported health of the population

Source: Office for National Statistics (ONS), Census 2021; Produced by: Havering PHI

[13] Age-standardised proportions (ASPs) account for different age structures in populations and are more appropriate than crude percentages. ASPs allow for comparison between populations over time and across geographies.

The neighbourhoods (MSOA[14]) in Havering that had the highest crude proportion (%) of residents reporting 'good' or 'very good' health were Upminster North & Cranham West, Upminster South & Corbets Tey, and Ardleigh Green (*see figure 31 - darker shades represent areas with a higher proportion of residents reporting good or very good health*). The neighbourhoods in Havering that had the highest crude proportion (%) of residents who reported 'bad' or 'very bad' health were Harold Hill East, Dagnam Park & Noak Hill and Havering-atte-Bower & Chase Cross (*see figure 32 – darker shades represent areas with a higher proportion of residents reporting bad or very bad health*).

Figure 31: Crude % of residents by neighbourhood (MSOA) that reported 'good' or 'very good' health

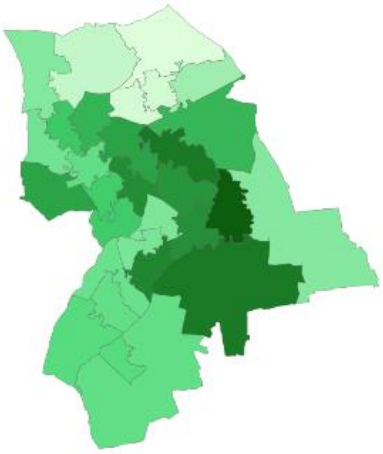
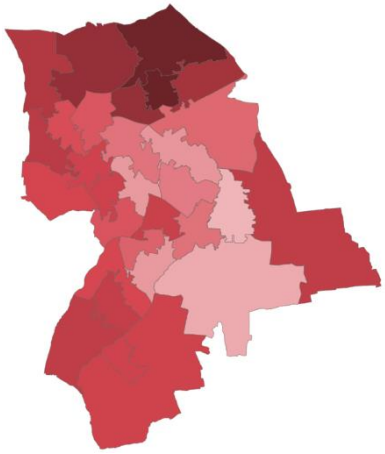


Figure 32: Crude % of residents by Havering neighbourhood



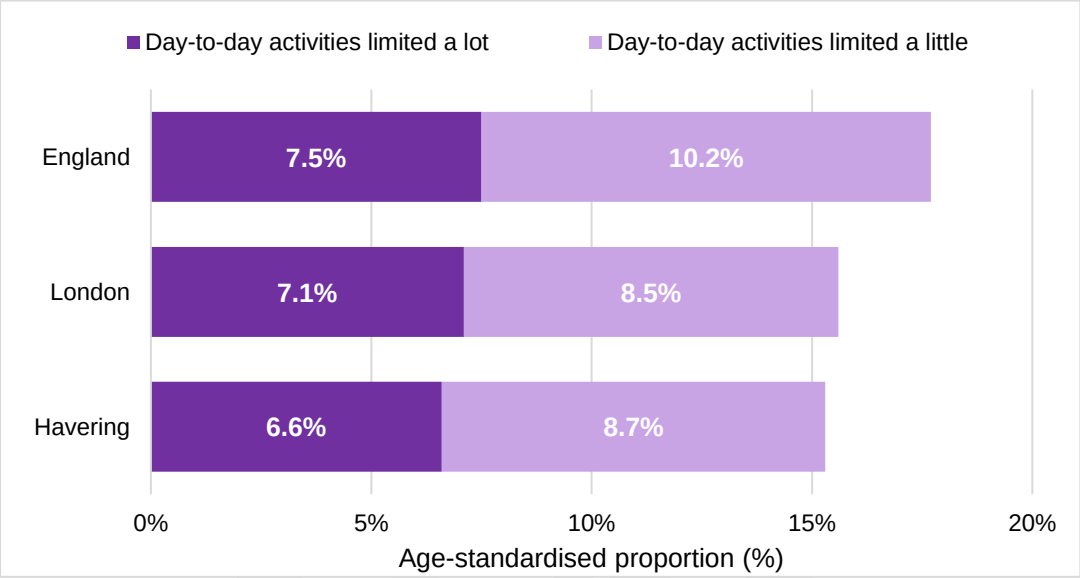
Source: Office for National Statistics, (ONS), Census 2021; Produced by: Havering PHI

[14] MSOA (Middle Layer Super Output Areas) are a geographic hierarchy designed to improve the reporting of small area statistics. The minimum population of an MSOA is 5,000 and on average is 7,200

6.5 People with Disabilities

In Havering an estimated 38,449 residents reported having a disability[15] in 2021. This is an Age standardised proportion (ASP) of 15.3%, which is slightly lower than London (15.6%) and lower than England (17.7%). 6.6% reported that their day-to-day activities were limited a lot and 8.7% reported their day-to-day activities were limited a little, due to a disability (see figure 33 below).

Figure 33: ASP (%) of population with a disability

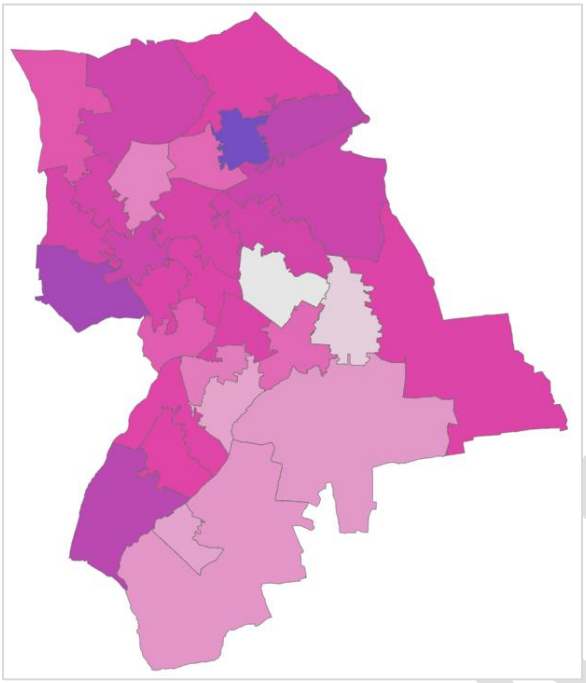


Source: Office for National Statistics (ONS), Census 2021; Produced by: Havering PHI

29,742 households in Havering had at least one person with a disability. Of these households, 6,181 had two or more members with a disability. The neighbourhoods in Havering that have the highest number of households where at least one member is disabled were Hornchurch Marshes, Rush Green and Harold Hill East. The lowest were Emerson Park, Upminster North & Cranham West and Hacton (*see figure 34 below - darker shades represent areas with a higher number of households where at least one person has a disability*). There are nearly three (2.7) times more households with a disabled person in the highest ranked neighbourhood (Harold Hill East – 1,605) compared to the lowest (Emerson Park – 596).

[15] People who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses are considered disabled. This definition of a disabled person meets the harmonised standard for measuring disability and is in line with the Equality Act (2010).

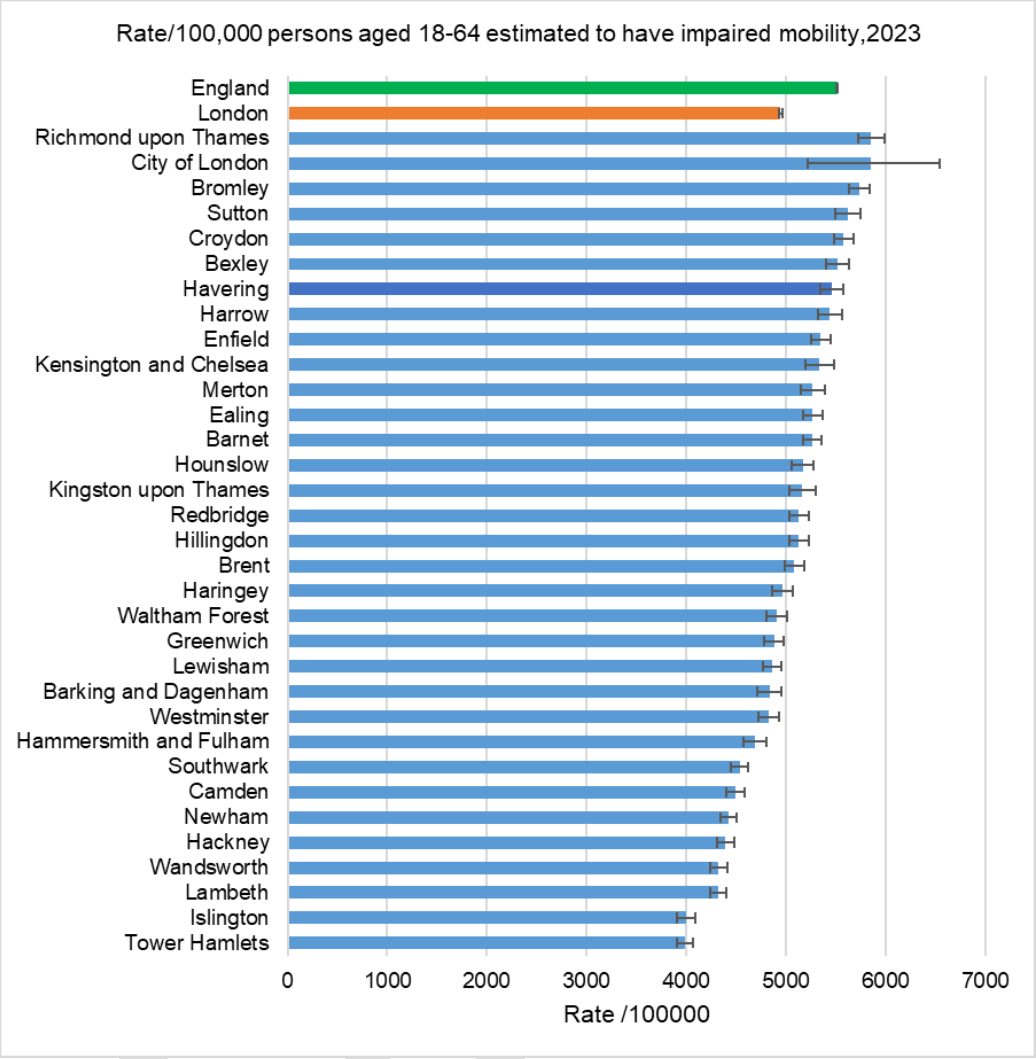
Figure 34: Number of households where at least one person has a disability by Havering neighbourhood (MSOA)



Source: Office for National Statistics (ONS), Census 2021; Produced by: Havering PHI

According to the ONS/PANSI projections, the estimated number of people in Havering aged 18-64 with impaired mobility is 8653, a rate of 5463 per 100,000 population. This rate is significantly higher than the London average (4945) but similar to England's (5515) (see Figure 35).

Figure 35: Population aged 18-64 estimated to have impaired mobility, rate /100,000 in Havering and other London boroughs, London and England, 2023.



Data Source: ONS Projecting Adult Needs and Service Information System (PANSI, 2022)

Table 16 shows that Havering is expected see an increase in persons aged 18-64 with mobility problems of 1.6% by 2035, higher than London (0.9%) and England (-2.2%).

Table 16: Population projections for persons aged 18-64 with impaired mobility in Havering, 2023 - 2035

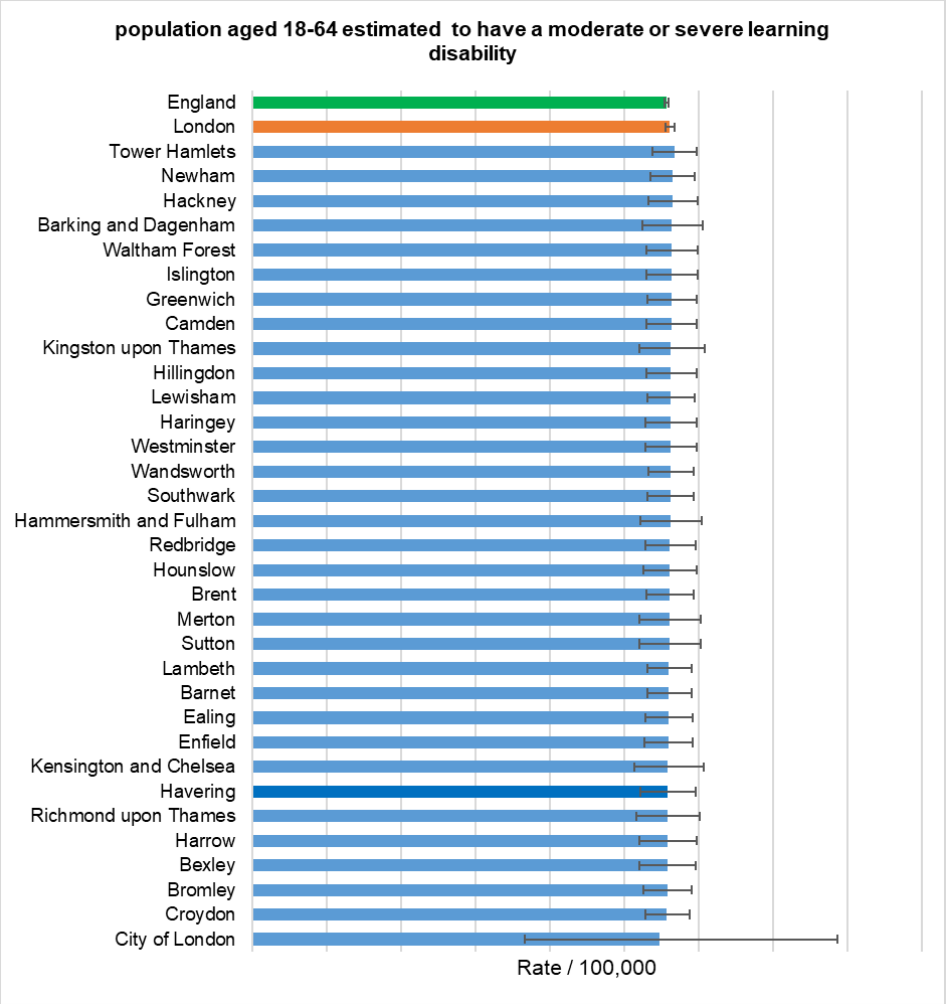
Year	2023	2025		2030		2035	
Number &%	Number	Number	% change	Number	% change	Number	% change
Havering	8653	8770	1.4	8845	0.9	8985	1.6
London	294378	298964	1.6	303356	1.5	306059	0.9
England	1889192	1910483	1.1	1898163	-0.6	1856653	-2.2

Data Source: Projecting Adult Needs and Service Information System (PANSI, 2022)

11.5.1 Population aged 18-64 estimated to have a moderate or severe learning disability

It is estimated that the number of people in Havering aged 18-64 with moderate or severe learning disability is 884 (Table 17), a rate of 5463 per 100,000 population. This rate is similar to the London and England averages (See Figure 37).

Figure 37: Population aged 18-64 estimated to have a moderate or severe learning disability, 2023



Data Source: Projecting Adult Needs and Service Information System (PANSI, 2022)

Table 17 shows that Havering is expected see an increase in persons aged 18-64 with moderate or severe learning disability of 2.8% by 2035, higher than the London and England average changes.

Table 17: Population projections for persons aged 18-64 with moderate or severe learning disability in Havering, 2023 – 2035

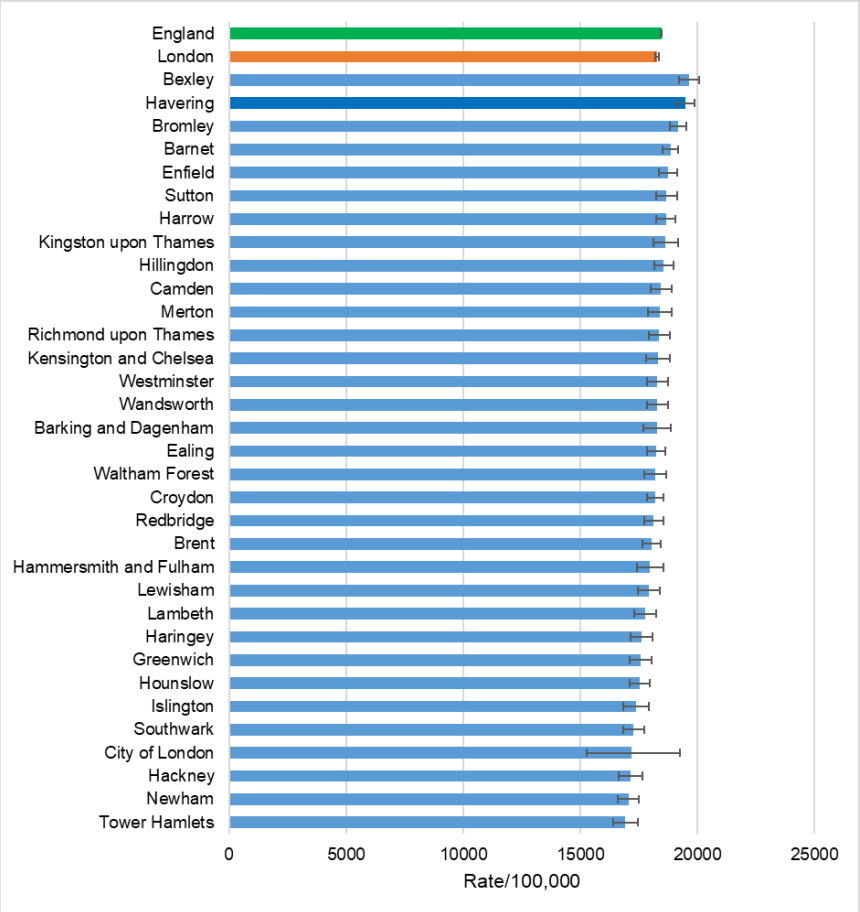
Year	2023	2025		2030		2035	
Number &%	Number	Number	% change	Number	% change	Number	% change
Havering	884	895	1.2	920	2.8	946	2.8
London	33411	33588	0.5	33996	1.2	34350	1.0
England	190725	191772	0.5	194194	1.3	195698	0.8

Data Source: Projecting Adult Needs and Service Information System (PANSI, 2022)

11.5.2 Population aged 65 and over unable to manage at least one activity on their own

The estimated number of people in Havering aged 65 and over unable to manage at least one activity on their own is 9,408 (table 15), a rate of 19,478 per 100,000 population (equivalent to 1 in 5). This rate is the highest in London (alongside Bexley) and significantly higher than the London and England averages (See Figure 25).

Figure 38: Population aged 65 + unable to manage at least one activity on their own, 2023



Data Source: Projecting Older People Population Information (POPPI, 2022)

Table 18 shows that Havering is expected see an increase in persons aged 65 and over unable to manage at least one activity on their own of 8.6% by 2035 but lower than the London and England average changes.

Table 18: Population projections for persons aged 65 and over unable to manage at least one activity on their own, 2023 – 2035

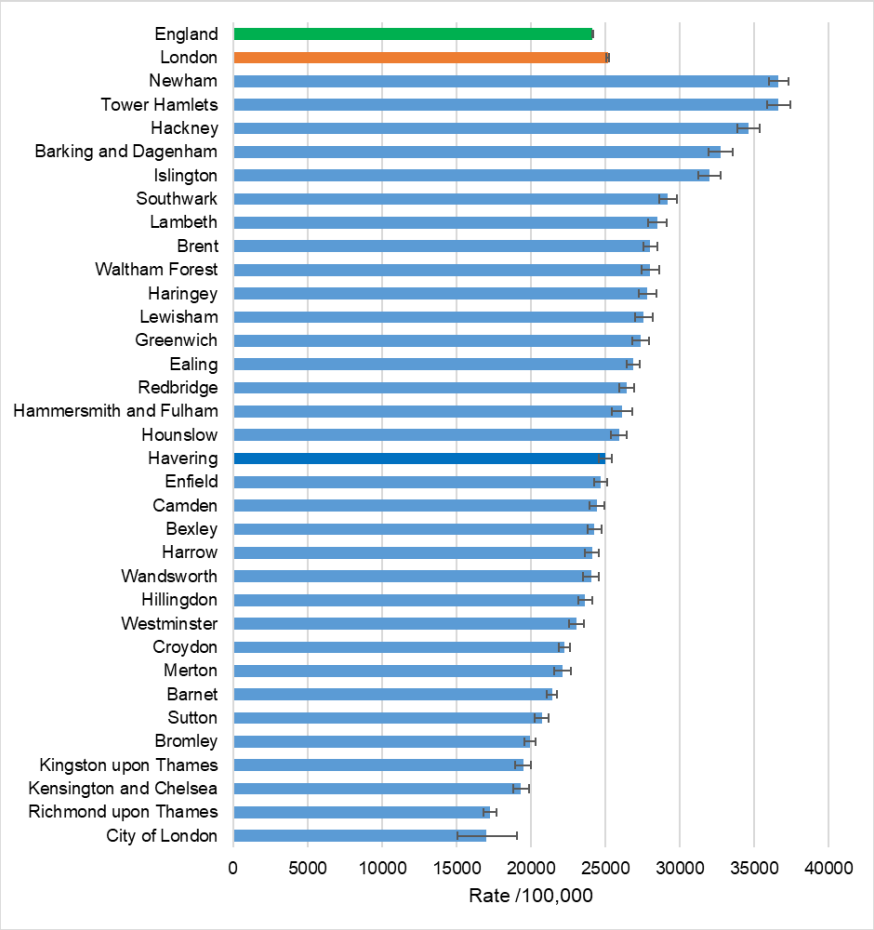
Year	2023	2025		2030		2035	
Number &%	Number	Number	% change	Number	% change	Number	% change
Havering	9408	9555	1.6	10192	6.7	11070	8.6
London	215661	225430	4.5	254818	13.0	289865	13.8
England	2039239	2120599	4.0	2372114	11.9	2643889	11.5

Data Source: Projecting Older People Population Information (POPPI, 2022)

11.5.3 Population aged 65 and over with a limiting long term illness whose day-to-day activities are limited a lot

The estimated number of people in Havering aged 65 and over with a limiting long term illness whose day-to-day activities are limited a lot is 12,081 (table 19), a rate of 25012 per 100,000 population (1 in 4). This rate is significantly higher than the England average but similar to the London average

Figure 39: Population aged 65 and over with a limiting long term illness whose day-to-day activities are limited a lot, 2023



Data Source: Projecting Older People Population Information (POPPI, 2022)

Table 19 shows that Havering is expected see an increase in persons aged 65 and over with a limiting long term illness whose day-to-day activities are limited a lot of 8.6% by 2035, lower than the London and England average changes.

Table 19: Population projections for persons aged 65 and over with a limiting long term illness whose day-to-day activities are limited a lot, 2023 - 2035

Year	2023	2025		2030		2035	
Number &%	Number	Number	% change	Number	% change	Number	% change
Havering	12081	12288	1.7	13081	6.5	14201	8.6
London	296788	311189	4.9	351468	12.9	397724	13.2
England	2664927	2773647	4.1	3070761	10.7	3390179	10.4

Data Source: Projecting Older People Population Information (POPPI, 2022)

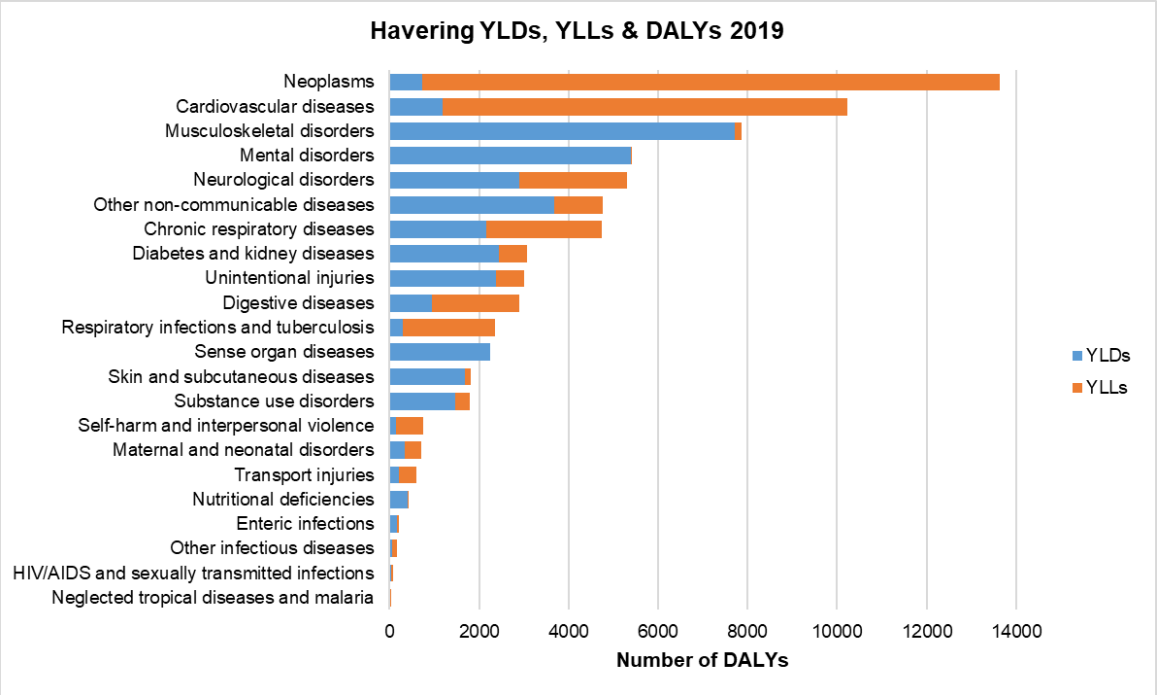
6.6 Premature Mortality

Life expectancy and other measures based on death rates highlight diseases that result in early death. Considerable harm to health is also caused by diseases that primarily result in prolonged illness and disability.

DALYs (Disability Adjusted Life Years)[16] are a means of combining years of life lost (YLLs) due to premature death and the years of healthy life lost due to disability (YLDs) into a single measure of harm to population health (Fig. 40).

Pre-pandemic, neoplasms (cancers) and cardiovascular diseases (e.g. heart attack and stroke) caused the greatest loss of good health as measured in DALYs, largely due to premature mortality. Musculoskeletal conditions and mental health disorders caused the next greatest loss of DALYS but as a result of years of healthy life lost to disability.

Figure 40. Havering YLDs, YLLs & DALYs, 2019



Data Source: Global Burden of Disease, 2019

6.7 Recommendations

- *All partners should be encouraged to adopt a Health in All Policies approach that takes into consideration health and wellbeing impacts in decision-making, including on the social determinants of health to maximise the wellbeing of residents and the overall healthy life expectancy.*

[16] Disability-adjusted life years (DALYs) (who.int)

- *The local authority, NHS and partners should consider the implications of the growing population of persons with disability in Havering in their policies and plans in order to meet specific health and wellbeing needs of these groups and protect them from experiencing inequalities related access and experience of essential support and services.*

- *Strengthen social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options as well as an effective signposting function and bring together NHS, council and CVS stakeholders*.

- *All partners within the integrated care system must give prevention and treatment equal priority if they are to succeed in improving health, narrow inequalities and provide high quality, affordable health and social care services.*

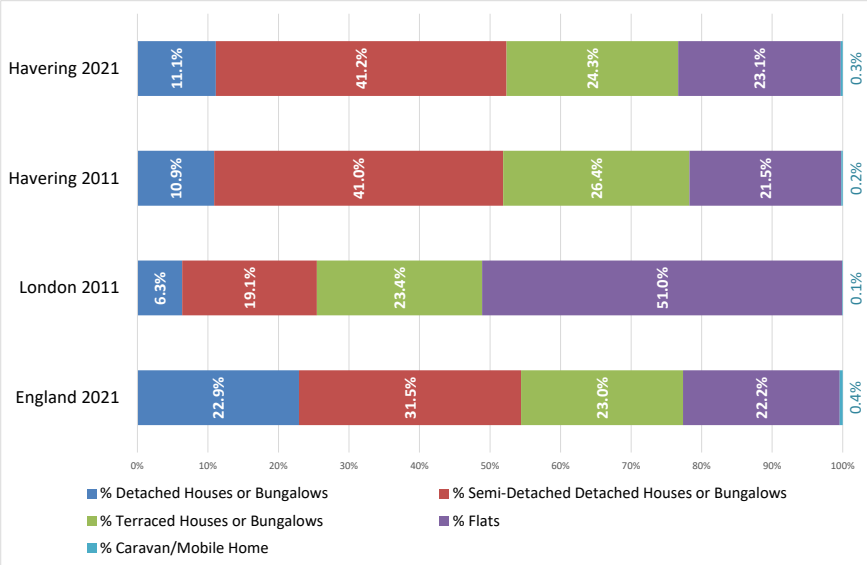
7. Household Profile

7. Household profile

7.1 Accommodation type

According to the ONS Census 2021, there are 101,277 households in Havering, a 4% increase (4,078) since 2011 (from 97,199). Out of these, 77,648 of households live in houses or bungalows (76.7%), an increase of 1,566 since 2011. Although the number of households living in houses has increased in number, as a percentage they have decreased since 2011 (78.3%), but is still higher than London (45.9%) but similar to England (77.4%).

Figure 41: Comparing Havering Accommodation Types to London and England in 2021 and 2011



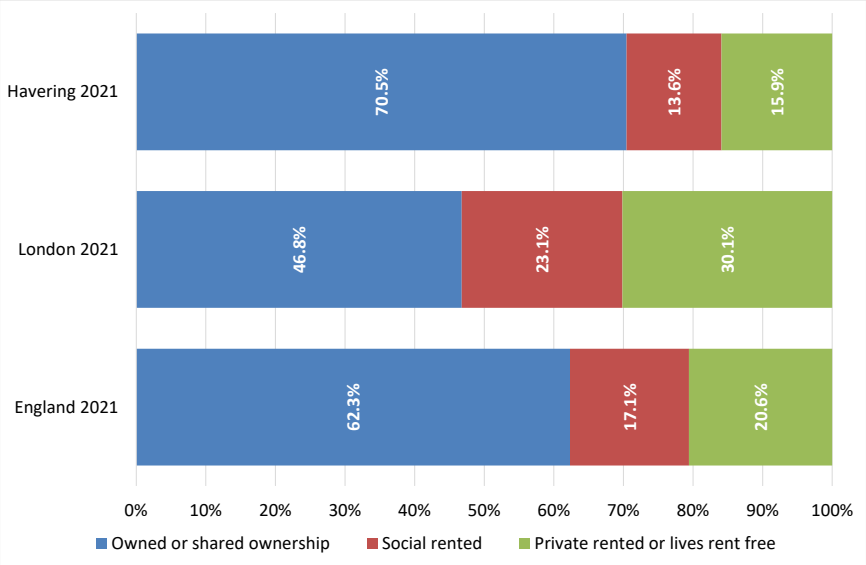
Source: Office for National Statistics (ONS), Census 2021: Produced by Housing Performance

7.2 Tenure

Tenure is classified in terms of whether a household rents or owns the accommodation that it occupies. Census data shows that Havering has the highest proportion of households that own their accommodation[17] across all London boroughs, at 70.5% (71,355). This is higher than England (62.3%) and London (46.8%), but is a slight decrease from 74.4% (72,284) in 2011. This decrease has also been apparent for England (64.1% in 2011) and London (49.5% in 2011).

[17] Households that own their accommodation either outright or with a mortgage, loan or in shared ownership

Figure 42: Comparing Havering Tenure Types to London and England in 2021 and 2011

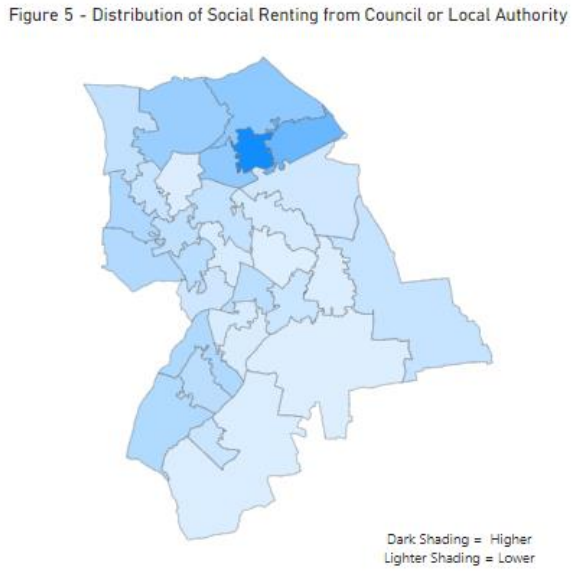


Source: Office for National Statistics (ONS), Census 2021: Produced by Housing Performance

The local area with the greatest increase in home ownership in Havering was Harold Park & Harold Wood (10.8%). Hylands (11.3%) saw a higher percentage change of those who owned their home outright. The area with the greatest decrease was in Romford South (-6.7%).

As a consequence, this has caused an increase in the proportion of households that rent their accommodation, from 24.8% (24,136) in 2011 to 29.5% (29,826) in 2021. Within Havering, the area seeing the greatest increase in households renting is Rush Green, rising from 1,205 in 2011 to 2,269 in 2021, an increase of 87.5%. The area within Havering with the highest proportion of socially rented properties from council or local authority was Harold Hill East (18.2%). (See Figure 43).

Figure 43: Distribution of Social Renting from council or Local Authority within Havering in 2021

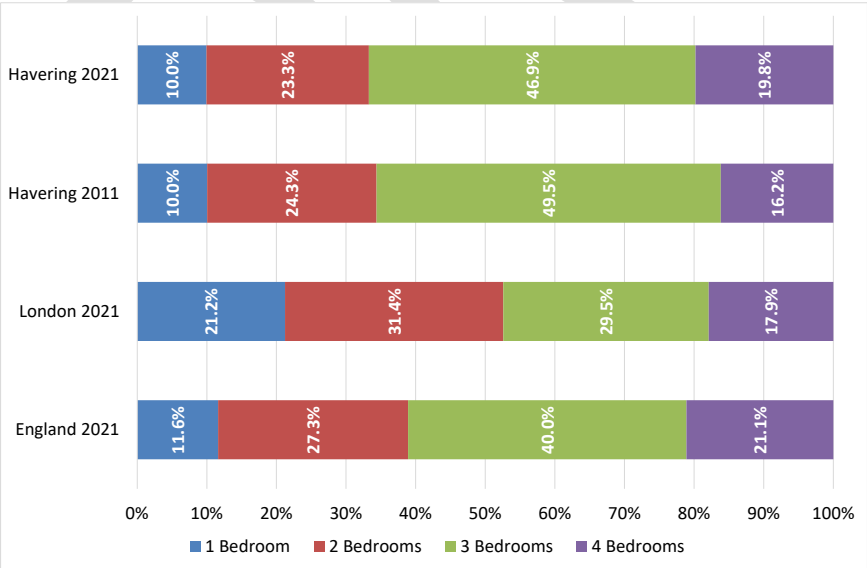


Source: Office for National Statistics (ONS), Census 2021; Produced by Housing Performance

7.3 Rooms, bedrooms, and occupancy rating

Just under half of all Havering's households have three bedrooms (46.9% of the 101,277 households). This is the highest percentage across all of the London boroughs and is higher than London (29.5%) and England (40%).

Figure 44: Comparing Havering Number of Bedrooms to London and England in 2021 and 2011



Source: Office for National Statistics (ONS), Census 2021; Produced by Housing Performance

Within Havering, Central Romford has the highest percentage of one bedroom (30.4%) and two bedroom (39.4%) properties. South Hornchurch has the highest percentage of three bedroom properties (63.9%) and Emerson Park has the highest percentage of four bedroom properties (59.6%).

7.4 Overcrowding and Under-Occupancy

Occupancy rating provides a measure of whether a household's accommodation is overcrowded (too few rooms/bedrooms for the number of people living at the address) or under-occupied (more rooms/bedrooms than people living at the address).

England and local authorities in London have shown an average decrease in household overcrowding based on rooms per household size over the last decade. However, Havering has seen a slight increase (0.5%) in the number of households who are overcrowded (7.4% (7,166) in 2011 to 7.9% (8,050) in 2021). Barking & Dagenham (0.3%) are the only other London borough to see an increase.

6.0% of households (6,125) in Havering as a whole, have fewer bedrooms than required, compared to 4.0% (3,901) in 2011. This means that the number of households over occupying bedrooms has increased by 57.0% since 2011.

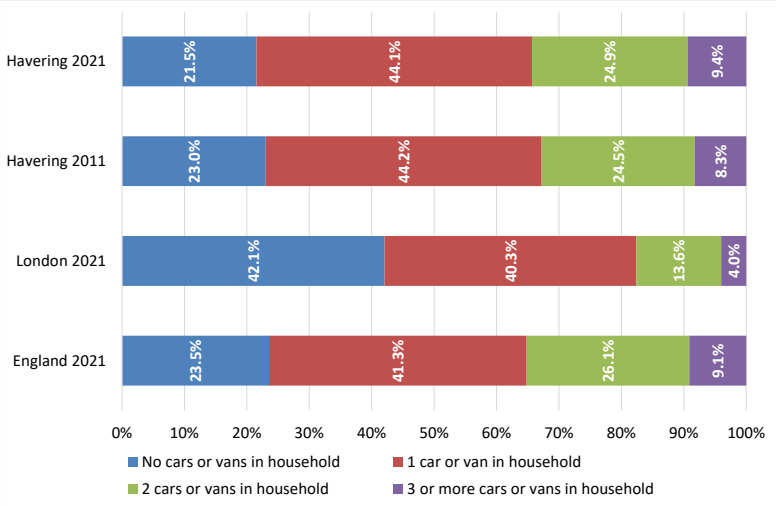
28.0% (28,368) of households in Havering had the required number of bedrooms, with the remaining 65.9% (66,784) of households having more bedrooms than required (a decline from 69.2% in 2011). This is below England (68.8%) but above London (48.9%) in 2021.

The proportion of households that had more bedrooms than required (under occupancy) within Havering was highest in Upminster South & Corbets Tey, with Harold Hill East having the highest rates of bedroom overcrowding in Havering.

7.5 Car or Van Availability

Havering has the lowest percentage of households with no cars or vans (21.5%) across all London boroughs, and the highest percentage of households that have 2 or more cars. The neighbourhood with the most households that have three or more cars is Emerson Park, contributing 23.7% of the 9.4% total.

Figure 45: Comparing Havering Number of Cars in Households to London and England in 2021 and 2011



Source: Office for National Statistics (ONS), Census 2021; Produced by Housing Performance

7.6 Mosaic Groups

Mosaic is a product built by Experian to help understand what types of people live in the UK. Table 26 presents the number and percentage of households in each Mosaic group while table 27 provides further details of the top five groups which account for 66% of the households in the borough.

Table 20: Mosaic Groups and number of households in Havering, 2023

Mosaic Group	Number of Households	%
Senior Security	16101	15.0
Aspring Homemakers	15500	14.4
Domestic Success	15470	14.4
Suburban Stability	11882	11.1
Urban Cohesion	9841	9.2
Rental Hubs	9796	9.1
Prestige Positions	9104	8.5
Family Basics	7075	6.6
Vintage Value	4444	4.1
Municipal Tenants	3991	3.7
Modest Traditions	2108	2.0
Transient Renters	1277	1.2
Country Living	437	0.4
City Prosperity	382	0.4
Rural Reality	88	0.1
Total	**107496**	**100**

Data Source: Experian's Mosaic Public Sector 2023; Produced by Public Health Intelligence

Table 21: Top 5 Household Mosaic groups in Havering, 2023

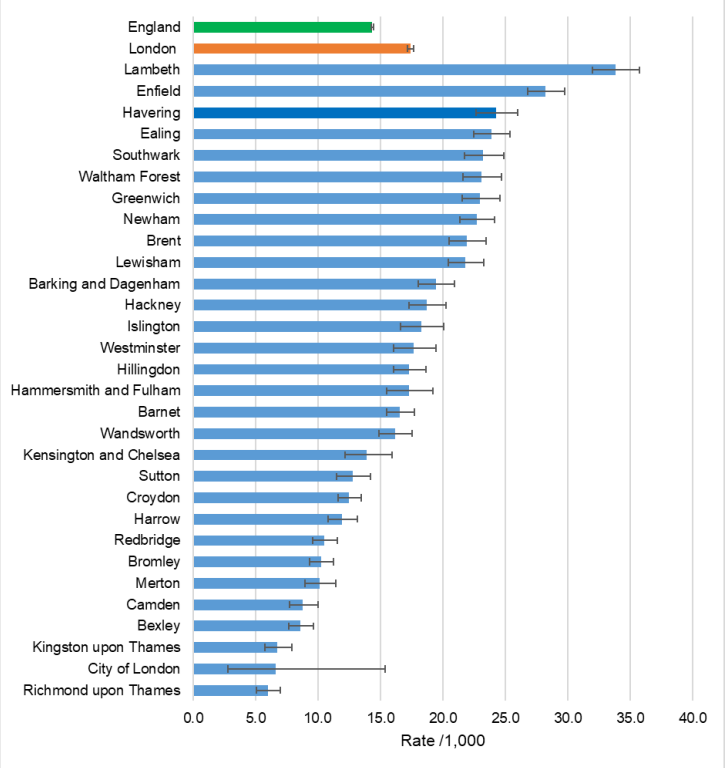
Group – Name	Typical Profile Picture	One Line Description	Key Features
F – Senior Security		Elderly people with assets who are enjoying a comfortable retirement	• Elderly singles and couples • Homeowners • Comfortable homes • Additional pensions above state • Don't like new technology • Low mileage drivers
H – Aspiring Homemakers		Younger households settling down in housing priced within their means	• Younger households • Full-time employment • Private suburbs • Affordable housing costs • Starter salaries • Buy and sell on eBay
D – Domestic Success		Thriving families who are busy bringing up children and following careers	• Families with children • Upmarket suburban homes • Owned with a mortgage • 3 or 4 bedrooms • High Internet use • Own new technology
E – Suburban Stability		Mature suburban owners living settled lives in mid-range housing	• Older families • Some adult children at home • Suburban mid-range homes • 3 bedrooms • Have lived at same address some years • Research on Internet
I - Urban Cohesion		Residents of settled urban communities with a strong sense of identity	• Settled extended families • City suburbs • Multicultural • Own 3 bedroom homes • Sense of community • Younger generation love technology

Data Source: Experian's Mosaic Public Sector 2023; Produced by Public Health Intelligence

7.7 Homelessness

There are 774 homeless households with dependent children owed a duty under the Homelessness Reduction Act[18] in Havering. The Havering's rate (24.3 per 1,000 households) is among the highest in London boroughs and significantly higher than London (17.4 per 1,000) and England (14.4 per 1,000) averages. Homelessness is associated with severe poverty and is a social determinant of health. It often results from a combination of events such as relationship breakdown, debt, adverse experiences in childhood and through ill health.[19]

Figure 46: Number of homeless households with dependent children owed a duty under the Homelessness Reduction Act per 1,000 household in Havering, 2021



Source: OHID

[18] The Homelessness Reduction Act (HRA) introduced new homelessness duties which meant significantly more households are being provided with a statutory service by local housing authorities than before the Act came into force in April 2018. The HRA introduced new prevention and relief duties, that are owed to all eligible households who are homeless or threatened with becoming homeless, including those single adult households who do not have 'priority need' under the legislation.
(https://www.legislation.gov.uk/ukpga/2017/13/contents/enacted).

[19] Homelessness is associated with poor health, education and social outcomes, particularly for children. (The Impact of Homelessness on Health, LGA 2017, https://www.local.gov.uk/impact-health-homelessness-guide-local-authorities)

7.8 Social isolation

According to Census 2021, about 12.7% (12,838) of the population aged 66 years and above are living in one-person households. This is the second highest proportion after Bexley in London[20]. Older people living alone can be an indicator of social isolation and may require more support from health and social care services.

Table 22: One-person household: Aged 66 years and over, Havering, London & England, 2021

Area	Number	%
Bromley	17443	12.8
Havering	12838	12.7
Bexley	11968	12.6
Richmond upon Thames	10039	12.4
Kensington and Chelsea	7750	11.6
Sutton	9497	11.5
Camden	9718	10.5
Kingston upon Thames	6894	10.5
Barnet	15208	10.2
Hillingdon	11143	10.2
Enfield	12251	10.1
Harrow	9050	10.1
City of London	494	10
Westminster	9498	10
Croydon	14652	9.6
Redbridge	9669	9.3
Merton	7507	9.2
Hammersmith and Fulham	7351	9
Ealing	11837	8.9
Hounslow	9176	8.9
Haringey	8958	8.5
Greenwich	9581	8.4
Brent	9712	8.2
Barking and Dagenham	5991	8.1
Waltham Forest	8254	8
Islington	7636	7.9
Wandsworth	10880	7.9
Lewisham	9365	7.7
Southwark	9507	7.3
Hackney	7489	7.1
Lambeth	9531	7.1
Newham	6377	5.5
Tower Hamlets	5786	4.8
London	**313049**	**9.1**
England	**3001789**	**12.8**

Source: ONS Census 2021

[20] *Census 2021 (Household Composition by Age), Office for National Statistics (ONS)*

Table 23: Population aged 65 and over in Havering predicted to live alone, 2023 - 2040

	2023	2025	2030	2035	2040
Total population aged 65-74 predicted to live alone	5,758	5,916	6,611	7,030	6,943
Total population aged 75 and over predicted to live alone	10,350	10,516	10,840	11,638	12,815
Total	**16,108**	**16,432**	**17,451**	**18,668**	**19,758**

Source: ONS / POPPI 2022

7.9 Recommendations

- *The local authority and partners need to prioritise addressing the issue of homelessness and overcrowding by including more affordable houses in their housing plans as well as identifying and utilising under-occupied homes.*

- *The local authority needs to engage with other local partners to address the issue of loneliness and social isolation as these are multi-faceted issues and effective responses should be delivered in cross authority partnerships including the voluntary and community sectors.*

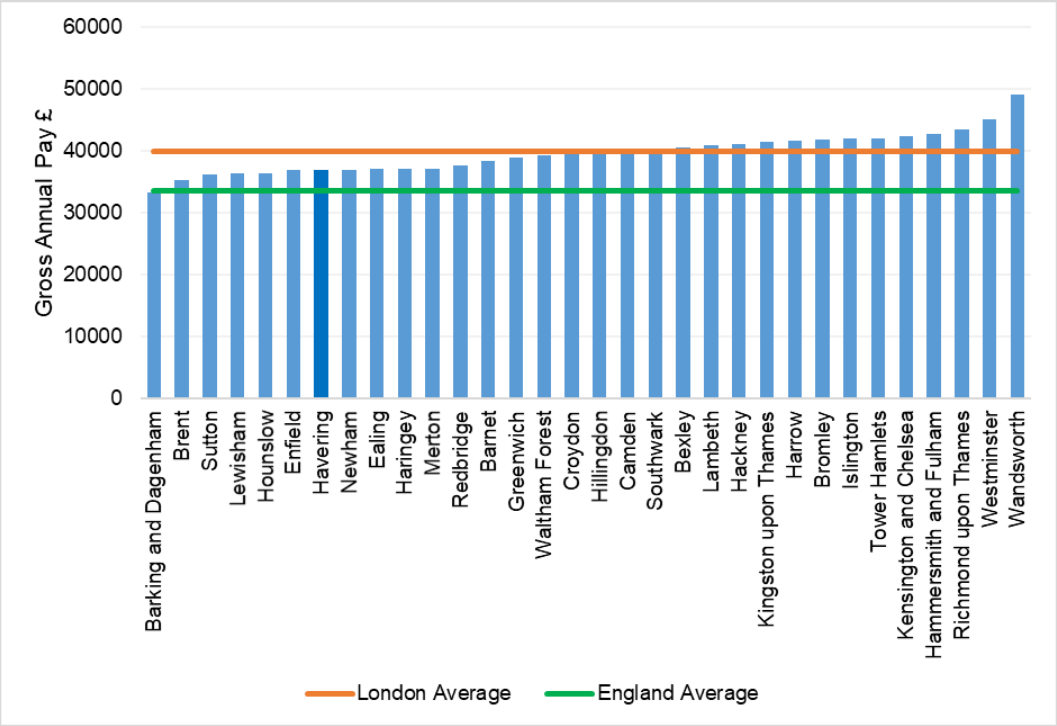
8. Economic Profile

8. Economic Profile

8.1 Income

The average gross annual household income in Havering for full time workers (£36873) is lower than the London average (£39800) but higher than the England average (£33,582). It is in the lowest third of all London boroughs.

Figure 47: Gross annual income for all full time workers in Havering, London boroughs, London and England, 2022



Source: ONS, annual survey of hours and earnings - resident analysis, 2022

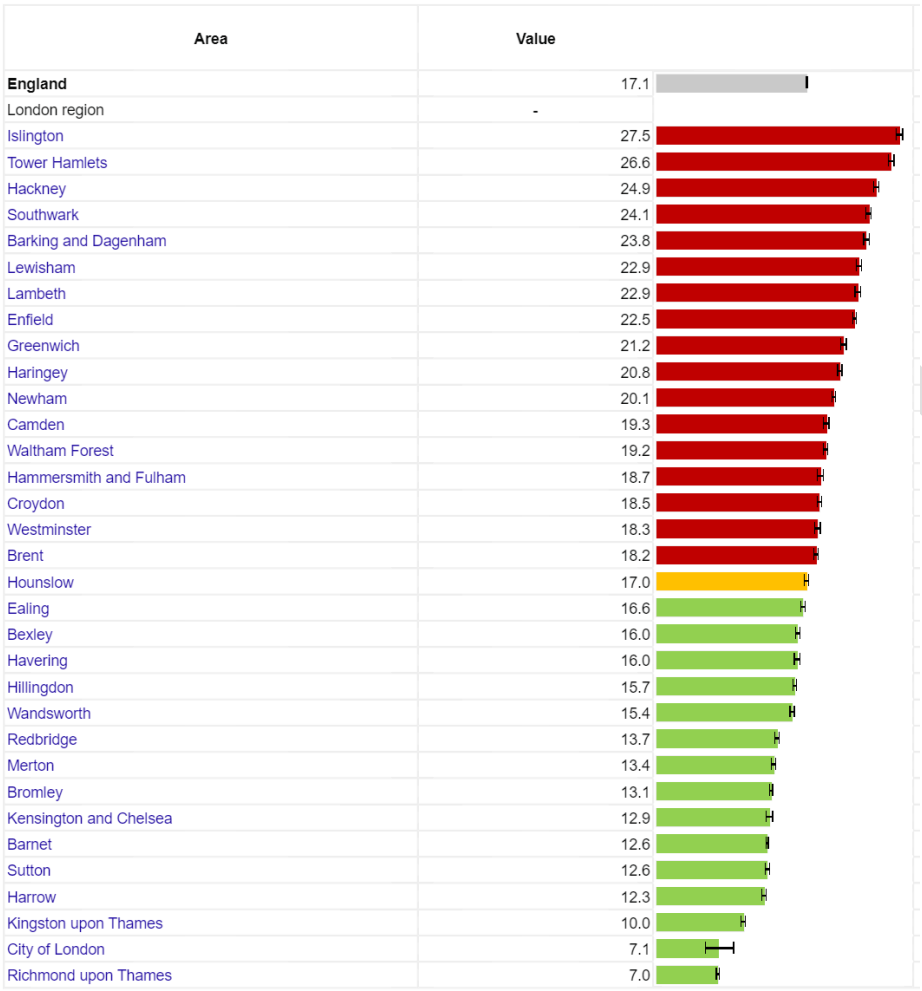
8.2 Income deprivation affecting children (IDACI)

Over 7,000 children are estimated to be living in poverty in Havering. However, Havering is among the London boroughs with the lowest proportion of children living in poverty (16%). This rate is also significantly lower than the England average (17%) (Figure 48). Within Havering Figure 49 shows a high proportion of children living in poverty are located in the North and South in areas considered as relatively more deprived.

Growing up in poverty damages children's health and well-being, adversely affecting their future health and life chances as adults. Ensuring a good environment in childhood, especially early childhood, is important. A considerable body of evidence

links adverse childhood circumstances to poor child health outcomes and future adult ill health.

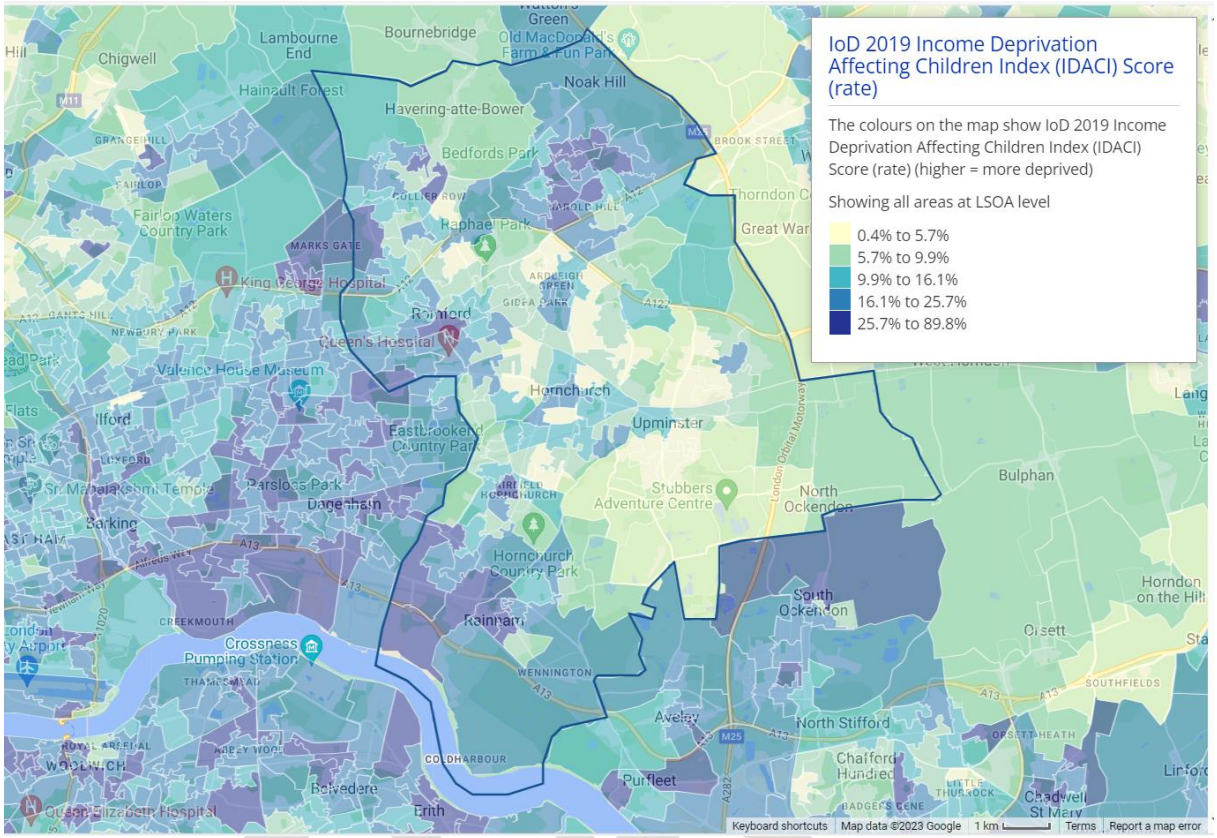
Figure 48: Income deprivation affecting children (IDACI), Havering, London & England, 2019



Area	Value
England	17.1
London region	-
Islington	27.5
Tower Hamlets	26.6
Hackney	24.9
Southwark	24.1
Barking and Dagenham	23.8
Lewisham	22.9
Lambeth	22.9
Enfield	22.5
Greenwich	21.2
Haringey	20.8
Newham	20.1
Camden	19.3
Waltham Forest	19.2
Hammersmith and Fulham	18.7
Croydon	18.5
Westminster	18.3
Brent	18.2
Hounslow	17.0
Ealing	16.6
Bexley	16.0
Havering	16.0
Hillingdon	15.7
Wandsworth	15.4
Redbridge	13.7
Merton	13.4
Bromley	13.1
Kensington and Chelsea	12.9
Barnet	12.6
Sutton	12.6
Harrow	12.3
Kingston upon Thames	10.0
City of London	7.1
Richmond upon Thames	7.0

Source: Office for Health Improvement & Disparities - Fingertips

Figure 49: Income deprivation affecting children (IDACI), by Havering LSOA's, 2019

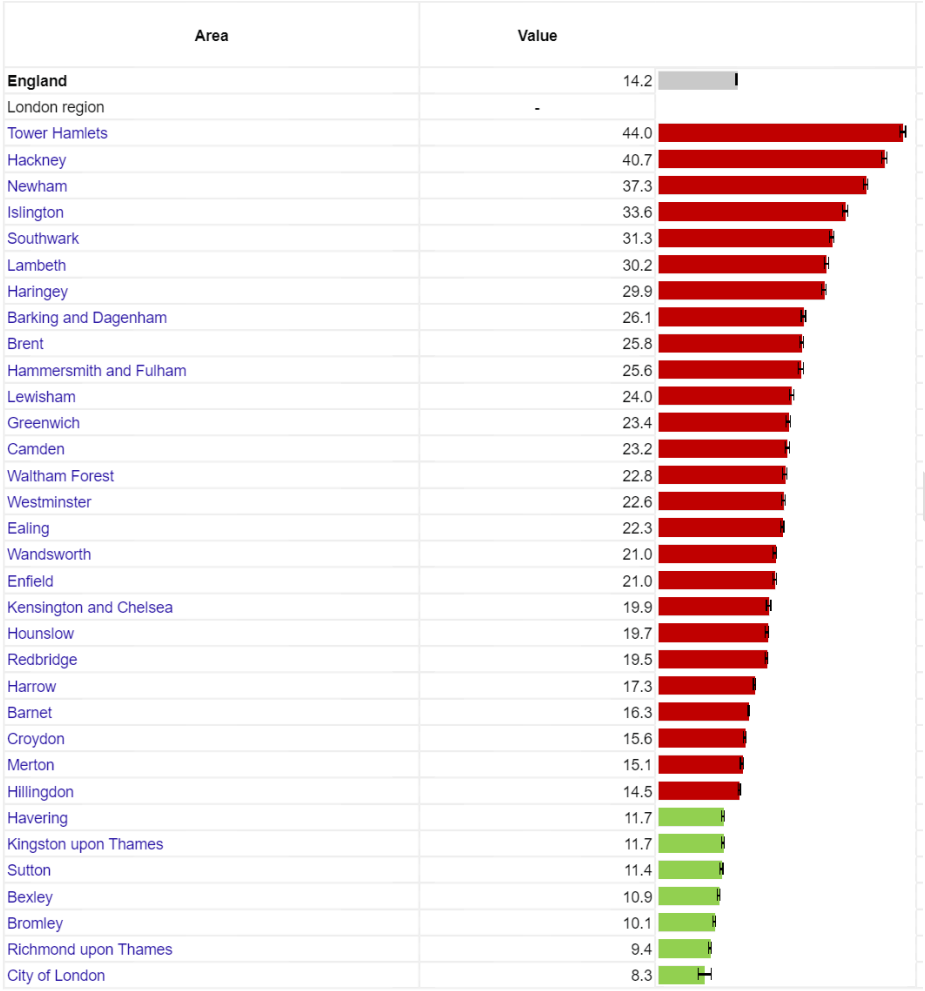


Source: Havering Local Insight

8.3 Income deprivation affecting older people (IDAOPI)

Nearly 7,000 older people are estimated to be leaving in poverty in Havering. However, Havering is among the London boroughs with the lowest proportion of older people living in poverty (11.7%). This rate is also significantly lower than the England average (14.2%) (Figure 50). Within Havering Figure – shows a high proportion of older people living in poverty are located in the North and other areas considered as relatively more deprived. Although there are no national targets, there is need to tackle poverty and promote greater independence and well-being in later life. People living in more deprived areas have a greater need for health services.

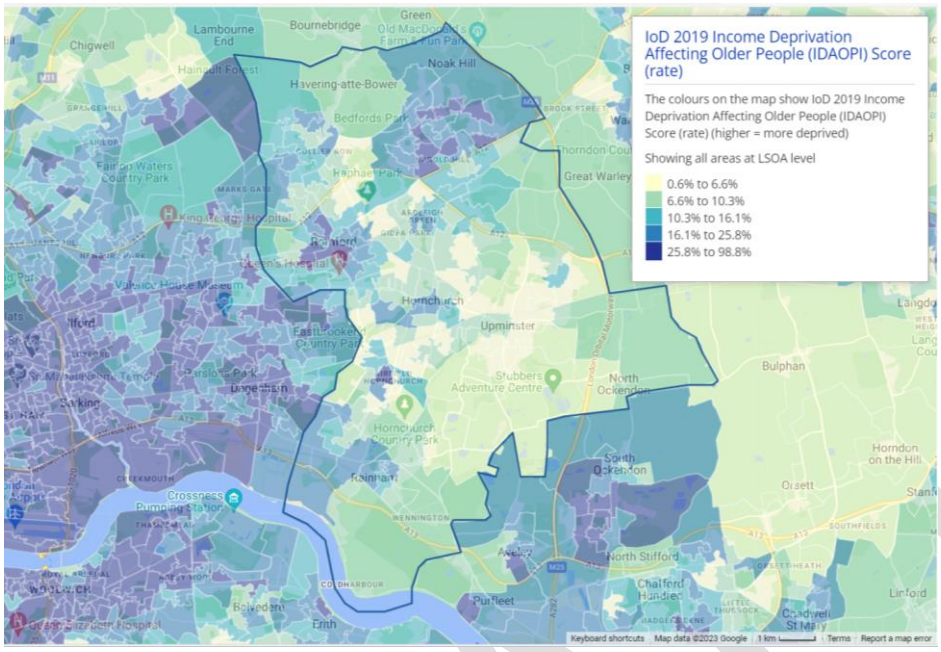
Figure 50: Older people in poverty, income deprivation affecting older people Index (IDAOPI), Havering, London & England, 2019



Area	Value
England	14.2
London region	-
Tower Hamlets	44.0
Hackney	40.7
Newham	37.3
Islington	33.6
Southwark	31.3
Lambeth	30.2
Haringey	29.9
Barking and Dagenham	26.1
Brent	25.8
Hammersmith and Fulham	25.6
Lewisham	24.0
Greenwich	23.4
Camden	23.2
Waltham Forest	22.8
Westminster	22.6
Ealing	22.3
Wandsworth	21.0
Enfield	21.0
Kensington and Chelsea	19.9
Hounslow	19.7
Redbridge	19.5
Harrow	17.3
Barnet	16.3
Croydon	15.6
Merton	15.1
Hillingdon	14.5
Havering	11.7
Kingston upon Thames	11.7
Sutton	11.4
Bexley	10.9
Bromley	10.1
Richmond upon Thames	9.4
City of London	8.3

Source: Office for Health Improvement & Disparities - Fingertips

Figure 51: Older people in poverty, income deprivation affecting older people Index (IDAOPI) by Havering LSOA's, 2019

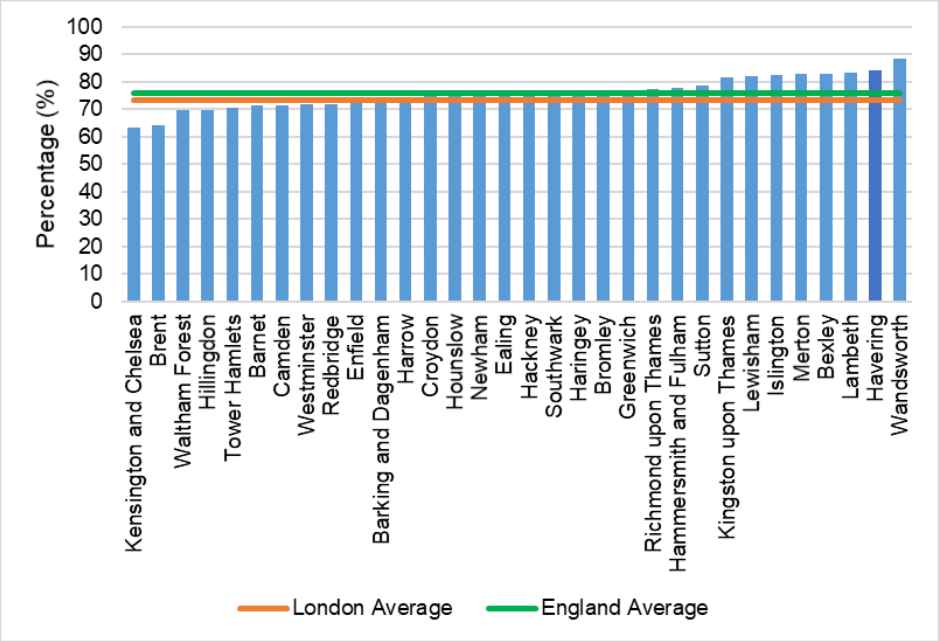


Source: Havering Local Insight

8.4 Employment and unemployment

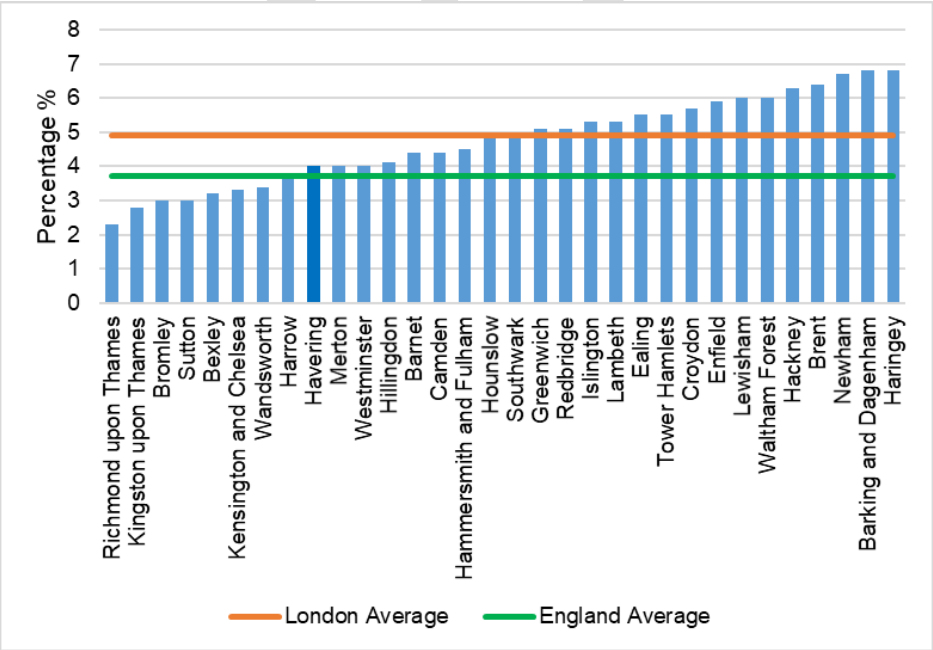
The overall employment rate in Havering (84%) is higher than the London (74%) and England (76%) averages (See Figure 52). Conversely, the proportion of working age residents in Havering claiming out-of-work benefits (4%) is lower than London (5%) but similar to the England average (4%) (Figure 53).

Figure 52: Proportion of working age residents in employment, Havering, London & England, August 2023



Source: Nomis

Figure 53: Proportion of working age residents claiming out-of-work benefits in London Boroughs, August 2023



Source: Nomis

8.5 Occupation

Havering has lower percentage of persons aged 16 over in employment in the managerial and professional qualifications (31.9%) as compared to London (40.4%) and England (33.2%).

Table 24: Havering all usual residents aged 16 years and over in employment

Occupation (current)	Havering		London		England	
	number	%	number	%	number	%
1. Managers, directors and senior officials	15,438	12.4	634,405	14.6	3,403,916	12.9
2. Professional occupations	24,339	19.5	1,123,398	25.8	5,356,649	20.3
3. Associate professional and technical occupations	16,717	13.4	668,876	15.3	3,499,749	13.3
4. Administrative and secretarial occupations	16,701	13.4	370,335	8.5	2,446,565	9.3
5. Skilled trades occupations	14,375	11.5	328,042	7.5	2,683,139	10.2
6. Caring, leisure and other service occupations	10,294	8.2	336,092	7.7	2,447,148	9.3
7. Sales and customer service occupations	8,162	6.5	276,860	6.3	1,972,553	7.5
8. Process, plant and machine operatives	8,058	6.5	219,351	5.0	1,832,666	6.9
9. Elementary occupations	10,697	8.6	402,718	9.2	2,762,829	10.5
Total:	**124,781**	**100.0**	**4,360,077**	**100.0**	**26,405,214**	**100.0**

Source: Nomis

8.6 Recommendations

- *Notwithstanding the fact that the London borough of Havering as a whole has average levels of disadvantage, there are significant inequalities within the borough, including health inequalities. Health and social care professionals in consultation with patients / residents should consider the extent to which problems with employment, poverty, housing etc. are the underlying cause and / or exacerbate a presenting health issue and therefore might benefit from social prescribing in addition to or instead of the tradition medical response.*

- *Local authority and partners need to work collectively to improve overall educational attainment, address any inequalities in educational outcomes for young people, support them to develop leadership skills and pursue professional careers.*

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Update on the progress of Havering Substance Misuse Strategy
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Anthony Wakhisi, Public Health Principal

The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy

☒	The wider determinants of health • Increase employment of people with health problems or disabilities • Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do. • Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.
☒	Lifestyles and behaviours • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☒	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.
☒	Local health and social care services • Development of integrated health, housing and social care services at locality level.
☒	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and **end of life** • **Long term conditions** • **Children and young people** • **Mental health** • Planned Care Cancer **Primary Care** **Accident and Emergency Delivery Board** Transforming Care Programme Board

Havering
LONDON BOROUGH

SUMMARY

On behalf of the Combating drugs partnership (CDP), I will be presenting the final draft of the Havering substance misuse strategy. The following are the key highlights:

The draft strategy was out for consultation between 18th September and 5th November 2023. Over this period we received feedback from 39 online participants, engaged with 2 service user groups and several stakeholders.

The final draft incorporating feedback from the consultation was presented on 11th December to CDP and endorsed for onward approval process.

A full report of the consultation and response is included as appendix to the strategy document. Also included is a an equality health impact assessment report.

RECOMMENDATIONS

Members of the Health and Wellbeing Board are asked to

- consider the presentation content,
- comment on the strategy document, suggesting any amendments to the strategy as necessary, and
- agree that a final draft strategy that takes into account consultation responses be received by the Health and Wellbeing Board or the Chair for a final sign off onward submission for approval by the cabinet meeting in March 2024

REPORT DETAIL

A final draft of the On behalf of Havering Substance Misuse Strategy 2023 has been completed and is now ready for approval. This strategy was produced jointly with all key stakeholders and has been produced in response to the national and to replace the existing local strategy which expired in 2019.

Havering had a similar strategy called “Drug and Alcohol Harm Reduction Strategy 2016- 19,” the revision of which was delayed due to the COVID-19 pandemic. In addition, a new 10- year national drugs strategy called ‘From harm to hope: A 10-year drugs plan to cut crime and save lives’ was published by the government in December 2021. The national strategy was accompanied by a supplementary grant to increase capacity in local treatment system. The grant requires local partnerships to produce a new strategy. Thus Havering CDP drafted this strategy in response to the national drugs strategy thereby renewing the previous Havering strategy.

Our strategy covers all substances which have the potential for abuse and addiction, except tobacco. It treats addiction as a chronic (long-term) health condition and requires all relevant local agencies to work together to provide effective long-term support. It aims to tackle the stigma around addiction to

encourage individuals and families who are affected to get support, and to minimise community violence towards those with substance-misuse problems.

The draft strategy describes some key findings from the needs assessment; for example, it is estimated that 1 in 5 adults (around 41,000 people) in Havering drink excessive amount of alcohol and 14,000 16 to 74-year-olds use illicit drugs. Two workshops with local and regional partners and people with lived experience followed by direct communication with delivery partners informed the set of actions in the strategy.

Substance misuse and addiction affect more than just the person with dependency problems – they can affect the family and wider community in many ways. Substance misuse can lead to criminal behaviour including domestic violence, assaults, antisocial behaviour, theft and burglaries, sexual exploitation, slavery and gang violence. This is why the partners in Havering will work together to:

- break drug supply chains;
- deliver a world-class treatment and recovery system;
- achieve a generational shift in the demand for drugs; and
- reduce risk and harm to individuals, families and communities.

A plan to address these four key areas was developed through working with all key stakeholders such as the National Health Service (NHS), drug and alcohol treatment services, voluntary care sector, schools, Police, trading standards, licensing, Department for Work and Pensions (DWP), children services, adult services etc. To achieve our intended outcomes of reducing drug use and drug-related crime, harm and deaths, Havering CDP will monitor using national and local outcomes frameworks.

This strategy will be implemented over a five-year period commencing from the date of publication and will be reviewed at least annually by the Havering Combating Drugs Partnership and amendments made where necessary.

Feedback from the consultation and engagement with service users has been incorporated into the final draft and the Equality Health impact Assessment report is also included. Havering Combating Drugs Partnership has signed off the final and allowed submission to Health and Wellbeing Board, Place-based Partnership and Cabinet for noting and approval.

IMPLICATIONS AND RISKS

No specific implications and risks are identified as a result of agreeing the local strategic approach. Any decisions relating to the implementation of the Havering Strategy will be subject to the relevant governance arrangements of the individual agencies participating in the Health and Wellbeing Board. Havering CDP will have to continue to meet regularly and monitor the delivery of the strategy.

The risk of not publishing a new local strategy will be reputation as this is required through the national strategy and grant.

Havering
LONDON BOROUGH

BACKGROUND PAPERS

The Havering Substance Misuse Strategy final draft.

Executive summary of Havering Combating Substance Misuse Strategy 2023-2028: https://consultation.havering.gov.uk/public-health/havering-combating-substance-misuse-strategy/supporting_documents/Havering%20CSM%20Strategy%20ExcSum%20Consult%20Draft%201.pdf

From harm to hope: A 10-year drugs plan to cut crime and save lives (29/4/2022) https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

Havering drug and alcohol harm reduction strategy 2016-19 https://democracy.havering.gov.uk/documents/s18103/Item%2012%20-%209b%202016%20D%20A%20Harm%20Reduction%20Strategy%20DRAFT%20v0%202.pdf

Consultation Draft of Havering Combating Substance Misuse Strategy 2023-2028 https://consultation.havering.gov.uk/public-health/havering-combating-substance-misuse-strategy/user_uploads/haveringcsm-strategy-_-sep2023_v0.6.pdf

Frequently asked questions regarding the strategy and consultation: https://consultation.havering.gov.uk/public-health/havering-combating-substance-misuse-strategy/supporting_documents/Havering%20CSM%20Strategy%20FAQs.pdf

Havering Combating Substance Misuse Strategy 2023 - 2028

Final Draft for HWB Approval v1.0

December 2023

Document Control

Include document details, version history, approval history, and equality analysis record.

Document details

Name	Havering Combating Substance Misuse Strategy
Version number	V1.0
Status	Final Draft for HWB Approval
Author	Havering CDP Working Group
Lead Officer	Tha Han, Consultant in Public Health
Approved by	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Scheduled review date	December 2028

Version history

Version	Change	Date	Dissemination
V0.1	First Draft	23/12/2022	Havering CDP Working Group
V0.2	Draft 2	05/07/2023	Havering CDP Working Group
V0.3	Draft 3	11/07/2023	Havering CDP Working Group
V0.4	Draft 4	13/07/2023	Havering Combating Drugs Partnership
V0.5	Draft 5	31/08/2023	Havering CDP Core Working Group
V0.6	Draft 6	18/09/2023	Public Consultation
V0.6	Draft 7	05/12/2023	Havering CDP Approval

V1.0	Draft 7	13/12/2023	HWB Approval

Equality & Health Impact Assessment Record

1	**Title of activity**	Havering Combating Substance Misuse Strategy		
2	**Type of activity**	Multi-agency Strategy		
3	**Scope of activity**	This is a five year local strategy that aims at working with all partners to: • Break drug supply chains by disrupting the ability of gangs to supply drugs and seizing their cash, bringing perpetrators to justice, safeguarding and supporting victims • Deliver a world-class treatment and recovery system, including; improving access to support by tackling stigma, delivering efficient and effective treatment and recovery system based on a multi-disciplinary multi-agency integrated approach. • Achieve a generational shift in the demand for drugs, including; preventing substance misuse and addiction. Supporting research, service audit, and evaluation. • Reduce risk and harm to individuals, families and communities, including; reducing harm related to substance misuse and safeguarding the vulnerable from abuse and harm. Ensuring care and support for other family members (a Think Family approach)		
4a	**Are you changing, introducing a new, or removing a service, policy, strategy or function?**	Yes	If the answer to <u>any</u> of these questions is **'YES'**, Please continue to question **5**.	If the answer to <u>all</u> of the questions (4a, 4b & 4c) is **'NO'**, please go to question **6**.
4b	**Does this activity have the potential to impact (either positively or negatively) upon people (9 protected characteristics)?**	Yes		

4c	**Does the activity have the potential to impact (either positively or negatively) upon any factors which determine people's health and wellbeing?**	Yes		
5	**If you answered YES:**	**Please complete the EqHIA in Section 2 of this document.** Please see Appendix 1 for Guidance. The equality health impact assessment has been completed and will be included in the final report once approved		
6	**If you answered NO: (***Please provide a clear and robust explanation on why your activity does not require an EqHIA. This is essential in case the activity is challenged under the Equality Act 2010.)* *Please keep this checklist for your audit trail.*			

Date	Completed by	Review date
15/11/2023	**Anthony Wakhisi**	**December 2028**

Table of Contents

Foreword

[To be included in Final Report]

Mark Ansell

Signature:

Director of Public Health, London Borough of Havering

Senior Responsible Officer (SRO), Havering Combating Drugs Partnership

Councillor Gillian Ford

Signature:

Cabinet Lead Member for Adults & Health, London Borough of Havering

List of abbreviations

Abbreviation	Meaning
AA	Alcoholics Anonymous
ASB	Anti-Social Behaviour
ATR	Alcohol Treatment Requirement
BAP	Behaviour and Attendance Partnership
BAU	Business as usual
BBV	Blood Borne Viruses
BCU	Basic Command Unit
BHC	Before Housing Costs
BHRUT	Barking, Havering & Redbridge University Trust
CAMHS	Children and adolescent mental health services
CCG	Clinical Commissioning Group
CEPN	Community Education Provider Networks
CDP	Combating Drugs Partnership
CDPB	Havering Combatting Drugs Partnership Board
CGL	Change Grow Live
CI	Confidence Interval
CLDT	Community Learning Disability Team
CJS	Criminal Justice System
CMT	Corporate Management Team
CPOMS	Child Protection Online Management System
CSB	Community Safety Board
CSCA	Country Signing Certificate Authority
CSC	Children Social Care
CST	Complex Safeguarding Teams
D&A	Drugs and Alcohol
DCLG	Department for Communities and Local Government
DHSC	Department of Health and Social Care
DIP	Drug Intervention Programme
DOMES	Diagnostic and Outcome Measure Executive Summary
DPO	Data Protection Officer
DRR	Drug Rehabilitation Requirement
DSL	Designated Safeguarding Lead
DV	Domestic Violence
DWP	Department for Work and Pensions
ESOL	English for Speakers of Other Languages
EUPD	Emotionally unstable personality disorder
FTEs	First-Time Entrants
GLA	Greater London Authority
GP	General Practitioner
HA	Havering Association
HRVA	Hazard, Risk and Vulnerability Analysis
HASP	Health and Safety Plan

Abbreviation	Meaning
HCV	Hepatitis C virus
HES	Hospital Episode Statistics
HJTF	Havering Joint Taskforce
HIV	Human Immunodeficiency Virus
HMPPS	His Majesty Prison and Probation Service
HSAB	Havering Safeguarding Adults Board
HSCB	Health and Social Care Board
HSCP	Havering Safeguarding Children's Partnership
HSL	Healthy Schools London
HSSW	Home school support workers
HWB	Health and Wellbeing Board
ICB	Integrated Care Board
ICS	Integrated Care System
IDVA	Independent domestic violence advocate
IMD	Index of Multiple Deprivation
IOM	Integrated Offender Management
ISA	International Standards on Auditing
JCU	Joint Commissioning Unit
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAPE	Local Alcohol Profiles for England
LBH	London Borough of Havering
LFB	London Fire Brigade
LGA	Local Government Association
LGBTQ	Lesbian, Gay, Bi-sexual, Transgender, Queer/Questioning
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LSD	Lysergic acid Diethylamide
LSOA	Lower Super Output Areas
LTC	Long-term conditions
MARAC	Multi-Agency Risk Assessment Conference
MACE	Multi Agency Child Exploitation Meeting
MASH	Multi-Agency Safeguarding Hub
MDMA	Methyl enedioxy methamphetamine
MH	Mental Health
MOPAC	Mayor's Office for Policing and Crime
MOJ	Ministry of Justice
MPS	Metropolitan Police Service
NA	Needs Assessment
NCC	National Collaborating Centres
NDTMS	National Drug Treatment Monitoring System
NEL	North East London
NELFT	North East London Foundation Trust
NHS	National Health Service

Abbreviation	Meaning
NIDA	National Institute on Drug Abuse
NRM	National Referral Mechanism
NTA	National Treatment Agency for Substance Misuse
OCU	Opiate and Crack users
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PBP	Place Based Partnership
PCC	Police Crime Commissioner
PCN	Primary Care Networks
PH	Public Health
PHE	Public Health England
PHI	Public Health Intelligence
PSHE	Personal, Social, Health, and Economic education
PWID	Persons Who Inject Drugs
PYLL	Potential Years of Life Lost
SGV	Sexual and Gender-based Violence
SPOC	Single Point of Contact
SRO	Senior Responsible Officer
TBA	To be announced
TBC	To be confirmed
TOPS	Treatment Outcome Profile
TOR	Terms of Reference
TTCG	Tactical Tasking and Coordination Group
UK	United Kingdom
VAWG	Violence Against Women and Girls
VCS	Voluntary Community Sector
VOLT	Victims, Offenders, Locations and Trends
WAY	What About Youth
YJB	Youth Justice Board
YJS	Youth Justice Service
YP	Young People

Executive Summary

The use and abuse of alcohol and psychoactive substances is a worldwide public health issue with harms extending from the level of the individual to the family, community, and society. The UK is among the countries in Europe most affected by drugs and demand for them across the population is very high: over three million adults reported using drugs in England and Wales in the last year (2021).

Drug use drives crime, damages people's health, puts children and families at risk and reduces productivity – it impacts all, with the most deprived areas facing the greatest burden. According to the UK Government estimates, drugs misuse costs society nearly £20 billion a year. Nearly 3,000 people tragically lose their lives through drug misuse related deaths in England & Wales each year.

In Havering, statistics show substance misuse remains a priority issue that requires a sustained integrated approach to tackle. Latest data show an increase of annual substance misuse related crime incidents. Cases have nearly tripled since 2016 from 388 to 1,084 in 2022. In 2022, 938 possession of drugs crimes and 146 drug trafficking crimes were reported in Havering.

Alcohol-related mortality among males has also been rising in the last three years with the latest data (2020) showing alcohol-related mortality in Havering (57/100,000) was higher than the London average (51/100,000). In 2020/21 there were a total of 528 Havering adults in drug treatment services. The number has not changed significantly in the last 5 years indicating there still many people who require treatment but are not accessing it.

In 2020/21, 82% of known dependent drinkers did not get in contact with alcohol treatment services. And it is estimated that there are more than two thirds (67%) opiate and /or crack users aged 15-64 in Havering not in treatment. Of concern also is that out of a total of 364 new adult presentations to treatment for substance misuse during 2019/20, 77 (21%) were parents or adults living with children.

This strategy has been drafted in response to the UK 10 year drugs strategy, 'From harm to hope: A 10-year drugs plan to cut crime and save lives' published in December 2021. The national strategy sets out how the government will combat illegal drug use, cut off the supply of drugs by criminal gangs and give people with a drug addiction a route to a productive and drug-free life, deliver a world-class treatment and recovery system and change attitudes in society around the perceived acceptability of illegal drug use. It has three overarching priorities, namely:

- Breaking drug supply chains
- Delivering a world-class treatment and recovery system
- Achieving a generational shift in the demand for drugs

Implementation of the plan is supported by allocation of a supplementary grant (circa £300K for each of three years for Havering) and local partnership guidance. The grant will be used to strengthen the capacity of local treatment service that offers a full range of evidence-based interventions.

The Havering Combating Drugs Partnership (Havering CDP) was fully formed in Aug 2022 to lead the local response set out in this strategy which is consistent with the national plan; informed by a detailed local needs assessment and builds on many existing activities and policies across a range of areas including enforcement, treatment, recovery and prevention to the benefit of local residents.

The scope of Havering's strategy includes all substances of abuse and addiction potential other than tobacco. It treats addiction as a chronic health condition and requires all relevant local agencies to work together to provide effective long-term support. It seeks to tackle stigma regarding addiction to encourage individuals and families affected to seek support; and to minimise community violence towards those with substance misuse problems.

The strategy acknowledges that although addiction problems can be seen across all communities, some communities and population groups including veterans, rough sleepers, the LGBTQ+ community and the children of people with addiction problems are disproportionately affected, requiring greater support and bespoke solutions.

There is a well-established range of specialist treatment services in Havering but investment is relatively low as the Public Health Grant received by the Council is itself low. Hence there is still greater need for innovative and cost effective approaches that engage the widest possible partnership to:

- Increase the proportion of people in treatment for drug and/ or alcohol dependency, which although similar to the national average has remained unchanged of the last five years.

- Support the cohort of residents with the most complex needs including poor physical and mental health, homelessness, unemployment and contact with the criminal justice system who require a holistic response to address their drug addictions, reduce harm and support recovery.

- Support parents with drug misuse problems to minimise the harm to children including the heightened risk that they themselves will in turn experience similar problems

The impacts of substance misuse and resultant addiction are multigenerational and multidimensional and go beyond the relatively small cohort with dependency problems. Substance misuse drives criminal behaviour, from domestic violence, antisocial behaviour and acquisition crime to sexual exploitation, slavery and gang violence. Hence, the partners in Havering will work together to:

- Break drug supply chains
- Deliver a world-class treatment and recovery system

- Achieve a generational shift in the demand for drugs
- Reduce risk and harm to individuals, families and communities

A delivery plan to address these four key areas was developed through engagement with all key stakeholders. The table below summarises the components of the agreed delivery plan. A more detailed plan is available in appendix 2.

Priority	Why	How	Who
Breaking drug supply chains	• Supplying illicit drugs is not only a crime in itself, but the operating model involves exploitation and slavery.	• Collect and share intelligence • Collaborate to disrupt county lines and modern day slavery • Follow the money • Target retail and middle market • Limit alcohol outlets where necessary • Community vigilance, street policing • Survey emerging markets e.g. vapes	• Metropolitan Police • Community Safety • Trading standards, Licensing Committee • Residents • NHS • Social care
Delivering a world-class treatment and recovery system	• Addiction is a chronic condition with remission, relapse and recovery stages. • Tough enforcement action must be coupled with a high-quality treatment and recovery system to break the cycle of addiction. • Reducing stigma is key to improve both access to and	• Monitor the impact of the treatment system • Close working with Mental Health & Integrated work with all partners (NHS Trusts, GPs, Community Pharmacies, Housing, Social Care, Voluntary Sector etc.) • Information and advice for the public on treatment access and self-care • Data sharing • Coordination with prisons, detentions	• Members of the Havering Combatting Drugs Partnership • CGL (Provider) • NELFT • Voluntary care sector • LBH Comms • Community pharmacies working with CGL • All front line services • Housing • DWP • VCS

Priority	Why	How	Who
	success of treatment. • Building confidence in services by the individuals to seek support and treatment	and probation to ensure treatment • Needle exchange, supervised consumption • Tackling stigma • Culturally sensitive access for marginalised communities	
Achieving a generational shift in the demand for drugs and alcohol misuse	• Some children are more at risk than others due to the genetic predisposition and environmental exposure • 21% of services users were living with their children.	• Information, Awareness and Staff Training • School-based prevention and early intervention to reduce the chances of them using abusing alcohol, drugs and other substances • Supporting young people and families most at risk of substance misuse or criminal exploitation • Review and regulate alcohol retail sector • Links to treatment system and breaking the supply chain • Collect and share intelligence	• Education (including schools) • Children services • Public Health • Met Police • Youth Justice • Licensing • LBH Comms
Reducing risk and harm to individuals, families and communities	• Substance (drug and alcohol) misuse are involved in antisocial behaviour, domestic violence, exploitation,	• Information and advice for the public on harm and risk reduction, and where to seek help • Multidisciplinary multiagency support to those at	• CGL • NELFT • Safeguarding Boards: HSAB and HSCP • Social services

Priority	Why	How	Who
	violent crime and acquisition crime. • 21% (5282 people) of those using illicit drugs in Havering are young people aged 16-24 • Blood-borne virus infection risk is highest among injection drug users	higher risk or those who suffered from harm of drugs and alcohol misuse. • Cross-disciplinary staff training • Improved opportunities for volunteering, employment and fixed accommodation • Needle exchange, supervised consumption • Research, audit and surveillance • Awareness and training around neurodiversity • Reducing risk and harm to communities	• Community safety e.g., domestic violence • DWP • Public Health • LBH Comms • Community pharmacies working with CGL • Trading standards and public protection • LFB

Our vision is that through partnership working in prevention and supporting individuals and communities, through tackling the supply chain and reducing demand, we will further reduce substance misuse in Havering and safeguard the users, families, and communities from the harms of addiction, including providing useful and timely information and advice.

In order to achieve the ultimate strategic outcomes of reducing drug use, crime, harms and deaths, there is need to be clear about where we are, where we are going and how to get there. To help local partnerships monitor achievement of these outcomes, the government recently (May 2023) published the National Combating Drugs Outcomes Framework.[1]

The framework sets our three strategic outcomes of reducing drug use, reducing drug-related crime, and reducing drug-related deaths and harm. Also included are intermediate outcomes of reducing drug supply, increasing engagement in treatment and improving recovery outcomes. The document further outlines a set of additional

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1158290/National_Combating_Drugs_Outcomes_Framework_-_Supporting_metrics_and_technical_guidance_PDF__1_.pdf

22 supporting measures which allow partnerships to monitor progress towards the outcomes, with two key aims:

- More timely, interim, and/or proxy measures, which can tell us about direction of travel towards the strategic and intermediate outcomes

- A wider picture of the system allowing us to monitor the health of the whole system and to see unexpected trends or provide early warning.

The single set of outcomes and metrics outlined in this strategy is aimed at all partners getting involved in delivering the 5-year drugs strategy. It emphasises shared accountability for all outcomes to avoid the problem of individual organisations being pulled in different directions by competing outcomes and targets. The Havering CDP board will organise and monitor its work around progress towards the outlined outcomes, ensuring local partners are accountable to central government, each other and local residents.

Monitoring and consideration of different demographics and protected characteristics will be a key part of this work. The drugs strategy commits to promoting equality and meeting the needs of all communities, particularly those who have often not received an effective service in the past, including people from ethnic minority backgrounds and women.

The Havering SRO represents the whole CDP through holding overarching responsibility for local delivery of the strategy. The SRO on behalf of the CDP will report and be accountable to the central government and will monitor local delivery against the outlined metrics as defined in the national and local outcomes framework. The measures will be monitored in the context of the whole system, with an awareness that the direction of travel may change over the course of the strategy. In the short term, we could expect initial increases in some metrics, due to more planned activity and services better meeting demand, but in the longer term these might decrease due to effective activity and reduction in the underlying problematic issues.

This strategy will be implemented over a five-year period from the date of publication and will be reviewed at least annually and amendments made as necessary.

1 Introduction

1.1 Purpose

The use and abuse of alcohol and psychoactive substances is a worldwide public health issue with harms extending from the level of the individual to the family, community, and society. Recent data published by the United Nations[2] put the global estimate of people who inject drugs in 2021 at 13.2 million, 18 per cent higher than previously estimated. Globally, over 296 million people used drugs in 2021, an increase of 23 per cent over the previous decade. The number of people who suffer from drug use disorders, meanwhile, has skyrocketed to 39.5 million, a 45 per cent increase over 10 years. The UK is among the countries in Europe most affected by drugs and demand for them across the population is very high: over three million adults reported using drugs in England and Wales in the last year and one in three 15-year-olds said they took drugs in 2018, up from one in four in 2014.[3]

People use substances including alcohol and drugs for a variety of reasons:[4]

- to relax, for enjoyment
- to be part of a group
- experiment out of a sense of curiosity
- rebellion
- to avoid physical and/or psychological pain
- to cope with problems
- to relieve stress

Some people are more vulnerable to initial use and addiction due to environmental and genetic factors. Drug and alcohol dependence often co-exists with other health disparities, like poor mental health and homelessness, so the local partners need to make sure the physical and mental health needs of people with drug addictions are addressed, to reduce harm and support recovery.[5] Moreover, most people who drink alcohol and/or use legal or illegal drugs do not become dependent on any of these substances. Addictions to cocaine, opiates, caffeine, alcohol, and tobacco are moderate to highly heritable.[6] In most people with addiction, their opioid receptors, dopamine transporters, cannabinoid receptor, and nicotinic receptors respond differently to opiates, stimulants, cannabinoids, and nicotine respectively from the general population in expressing a sense of reward. Environmental factors such as stress can interact with genes to exhibit drug addiction. In drug addiction especially with alcohol and opioids, not only there is psychological attachment to the substance our body develops physiological dependence, which makes treatment necessary.

Therefore, it is crucial that the drug market is disrupted so vulnerable people are not exposed to substances, or exploited and targeted; an evidence-based, world-class

[2] World Drug Report 2023 - Special Points of Interests (unodc.org)
[3] Drug misuse in England and Wales: year ending March 2020 (Office for National Statistics).
[4] Why do people use alcohol and other drugs? - Alcohol and Drug Foundation (adf.org.au)
[5] From harm to hope: a 10-year drugs plan to cut crime and save lives (publishing.service.gov.uk)
[6] The genetics of addiction—a translational perspective | Translational Psychiatry (nature.com)

treatment system is there to manage addiction; information, advice and relevant support are there to eliminate the demand, and a supporting system is there to reduce the risk and prevent the harm of substance misuse and addition to the individuals, families and the community.

In addition to health impacts, drug use drives crime, damages people's health, puts children and families at risk and reduces productivity – it impacts all of the country, with the most deprived areas facing the greatest burden. According to the UK Government estimates, drugs misuse costs society nearly £20 billion a year. Nearly 3,000 people tragically lose their lives through drug misuse related deaths in England & Wales each year.[7]

Alcohol is a factor in many drug-related deaths alongside drugs including heroin and methadone. In the night-time economy, drugs such as cocaine and MDMA are frequently used alongside alcohol. Moreover, specialist treatment and recovery services tend to be integrated for alcohol and other drugs. Therefore, local partnerships are asked to ensure that their plans sufficiently address alcohol dependence and wider alcohol-related harms. This should include considering the multiple complex needs of people who use alcohol as well as other drugs, and including alcohol in relevant activity and performance monitoring, considering deaths, hospital admissions and treatment for alcohol as well as other drugs.

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and £21 billion annually for society as a whole Neighbourhoods blighted by the presence of illegal drugs cannot prosper or provide the happy, healthy environment that people deserve.

1.2 National Strategy

In December 2021, the UK government published a new 10-year drugs strategy, 'From Harm to Hope', backed by record levels of funding of over £3 billion to be spent from 2022 to 2025 on addressing the substance misuse problem. The national strategy sets out how the government will combat illegal drug use; cut off the supply of drugs by criminal gangs, give people with a drug addiction a route to a productive and drug-free life, deliver a world-class treatment and recovery system and change attitudes in society around the perceived acceptability of illegal drug use. It has three overarching priorities, namely:

- breaking drug supply chains
- delivering a world-class treatment and recovery system
- achieving a generational shift in the demand for drugs

For ease and brevity, the strategy document will use the term 'substance' to collectively describe alcohol, illegal drugs, psychoactive substances, over the counter drugs and prescription only medicines. However 'substance misusers' do not form one

[7] From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)

homogenous group. Therefore, where there are specific aspects of alcohol or drugs to be considered, more precise terminology will be used, e.g. alcohol misuse, drug use, problematic use of over the counter drugs and prescription only medicines.

1.3 Local Strategy

The national strategy is supported by provision of a supplementary grant and guidance for local authorities on how to establish partnerships for defined areas. Havering received nearly £300,000 in 2022/23 which will be repeated for two further years. The grant will be used to strengthen the capacity of local treatment service that offers a full range of evidence-based interventions.[8]

Guidance for implementation of the national strategy at local level was published on 15 June 2022. Local areas are expected to define their geographical footprint which should be at least Lower Tier Local Authority, identify a Senior Responsible Officer (SRO) to chair a partnership board and lead the local strategy. The partnership board should bring together the different individuals and organisations with responsibility for delivering the strategic priorities of the drug strategy – breaking supply, treatment and recovery and reducing demand.

The Havering Combating Drugs Partnership (CDP) was established in August 2022 to lead on the implementation of the national drugs strategy at local level. Below is the list of member organisations and representatives:

Table 2: Member organisations/representatives of the Havering Combating Drugs Partnership, 2023

• LB Havering Public Health • LB Havering Elected member representatives for adults and children services • LB Havering Public Involvement Lead & Communities • Community Safety Partnership and Crime Prevention • Police and Crime Commissioner • Metropolitan Police • Probation Service Representative • Integrated Offender Management and Serious Group Violence • CGL • NELFT • BHRUT A&E • Healthwatch	• LB Havering Housing • Jobcentre Plus / DWP • LB Havering Adult Social Care • LB Havering Children Services • LB Havering Early Help • Schools and Education • Safeguarding Board • NHS NEL ICB • Local Pharmaceutical Committee • GP Representative • Voluntary Care Sector • Youth Justice Board • Service User with Lived Experience • Independent Domestic Violence Advocate • LB Havering Licensing Team • LB Havering Communications

[8] Guidance for local delivery partners (publishing.service.gov.uk)

Management team of the Havering CDP (Unpaid roles)

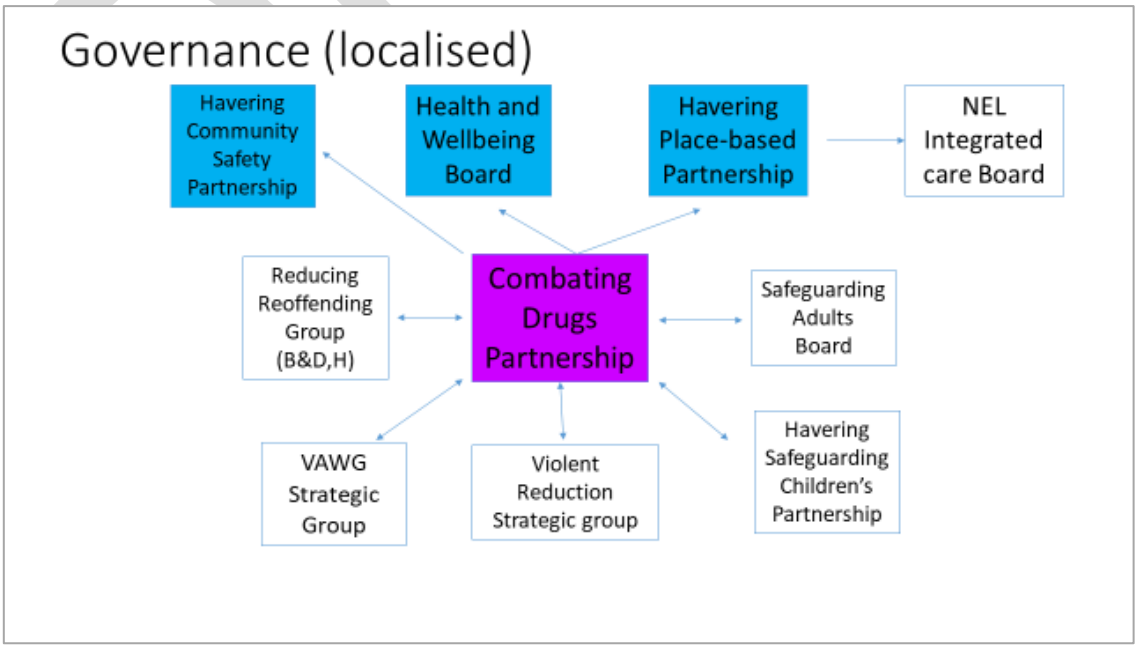
- SRO and Chair
- Partnership Lead
- Strategy Development Lead.
- Commissioner Lead
- Programme Manager
- Data Lead

In Havering, NEL sub-region and London, there are many synergistic plans and strategies that interact with combating substance misuse strategy. These include:

- Community Safety Plan, 2022-2025
- Community Safety Strategic Assessment, 2022
- Integrated Offender Management (IOM), pan-London Framework, 2022
- Serious Group Violence and Knife Crime Strategy, 2017-2021 (new version expected by January 2024).
- Violence Against Women and Girls (VAWG) Strategy, 2019-2022
- Knife Crime and Violence Reduction Action Plan, 2022
- The London Reducing Reoffending Strategy, 2022-2025

Due to the cross-cutting nature of substance misuse and co-existing circumstances including health issues, the partnership will report to or work with Health and Wellbeing Board, Havering Place-based Partnership Board, Havering Community Safety Partnership and Safeguarding Boards. The partnership governance can be seen as below.

Figure 1: The combating drugs partnership governance structure



The partnership will be putting in place structures and processes through which we should work together to reduce drug-related harm, and to implement co-ordinated actions across a range of areas including enforcement, treatment, recovery and prevention.

A key task of the local partnership board has been to facilitate a joint needs assessment through the review of local drug data and evidence and using this to agree a local drugs strategy and action plan, including developing data recording and sharing mechanisms. This new strategy will replace Havering Drug and Alcohol Harm Reduction Strategy 2016-19, the review of which was delayed due to the COVID-19 pandemic.

Drug and alcohol addiction, homelessness, and contact with the criminal justice system are often experienced in combination. It is important to break a vicious cycle of harm to individual users, their families, and communities. Therefore, locally, we added another priority which is **to reduce the harm to individuals with substance misuse, their families, and their communities** through multiagency partnership efforts to safeguard all those vulnerable, to reduce the risk, and to prevent the harm from substance misuse.

2 Where We Are Now

To enable understanding of our current status as regards substance misuse in Havering and current interventions and also to facilitate the development of the Havering local strategy, a joint needs assessment was carried out by the CDP between May and December 2022. This involved collation and analysis of relevant local data from treatment services and published data on prevalence, treatment and recovery from resources such as OHID Fingertips, National Drug Treatment Monitoring System (NDTMS), Metropolitan Police Service Crime Dashboard and London SafeStats. The needs assessment also drew from other relevant partnership pieces of work, such as the Local Drugs Market Profiles, Community Safety Strategic Assessments and the Havering Joint Strategic Needs Assessment (JSNA). Below is a summary of key findings from the needs assessment reported according to the four priority areas.

2.1 Breaking Drug Supply Chains

This priority area aims at levelling up neighbourhoods by ridding them of drugs, making them safe and secure places and enabling all areas to prosper and grow. This can only be achieved by prioritising cutting off the drug supply that is causing the most harm. Given the scale of the threat and the rise of the violent county lines distribution model, breaking drug supply chains and 'rolling up' county lines should be a priority for everyone, the police and all law enforcement partners.

Currently in Havering, the Met Police and relevant members of the Community Safety Partnership (CSP) share intelligence reports including VOLT intelligence, information on operations to enable the Multi-agency Safeguarding Hub (MASH), ASB and rescue and response referrals. Community Safety Partnership effectively apply the Crime and Disorder Act through its members. Youth Justice Board (YJB) and MASH use National Referral Mechanism (NRM) to identify young people involved in County lines and also monitor exploitation data. CSP also publishes Serious Violence Duty and Strategic Assessment annually. There are also a suite of activities around community vigilance, street policing and enforcement such as Neighbourhood Watch, Ward panel meetings with the Met, Community Safety Roadshows, Operation Yamhill, Drugs Dog operations, diversionary mentoring and enforcement drones.

2.1.1 Key findings from needs assessment

County Lines

There is no data on county line closures at local level.

At national level **3,588** county lines have been closed **since 2019**.

Substance misuse related crime

Number of annual **substance misuse related crimes** in Havering have nearly **tripled** since 2016 from **388 to 1,084** in 2022.

10,209 people have been **arrested** by police via the county lines programme

In 2022, **938 possession of drugs crimes** were reported in Havering.

5,727 referred for **safeguarding** via the county lines programme.

In 2022, **146 drug trafficking crimes** were reported in Havering, an **increase by 63%** compared to the previous year.

2.2 Delivering a World-Class Treatment & Recovery System

Tough enforcement action must be coupled with a high-quality treatment and recovery system to break the cycle of addiction. We must tackle the stigma to addiction and must treat **addiction as a chronic health condition**, and where people who need it are provided with long-term support. NHS and the local substance misuse provider are working together to ensure effective pathways and better integration, including improving the skills of the workforce in relation to drugs and alcohol.

The Havering council drug and alcohol service is delivered by Change Grow Live (CGL), a health and social care charity with services across England, Scotland and Wales. They offer support to young people, adults, those in the criminal justice system and anyone looking to live a healthier happy life. The government has recently (February 2023) provided a supplementary grant to all local authorities across England to improve drug and alcohol addiction treatment and recovery.[9] The funding will enable local authorities to:

- recruit more staff to work with people with drug and alcohol problems

[9] £421 million to boost drug and alcohol treatment across England - GOV.UK (www.gov.uk)

- support more prison leavers into treatment and recovery services
- invest in enhancing the quality of treatment they provide - in turn helping make streets safer by getting people out of the addictions which are known to drive offending

The Havering local plan to utilise the supplementary grant is led by the combating drugs partnership board. Local services are delivered via a highly trained and motivated workforce offering a full range of evidence-based interventions.

2.2.1 Key findings from the needs assessment

Treatment Services

In 2020/21 there were a total of **528 Havering adults in drug treatment services**.

The number has not changed significantly in the last 5 years.

Adult patients living with children

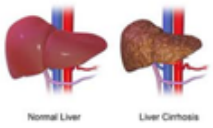
Havering had a total of **364 new adult presentations to treatment** for substance misuse during 2019/20. Of those, **77 (21%) were parents or adults living with children.**

Currently there are more than **400 patients** (**75 under CAMHS**) in mental health care who have **co-existing substance misuse problems.**

Hospital Admissions

In 2020/21, **632 people in Havering** were admitted in hospital with **alcohol related mental and behavioural disorders.**

In 2020/21, **82% (1,844) of known dependent drinkers** did not get in contact with alcohol treatment services.



In 2020/21, **226 people** in Havering were admitted in hospital with **alcoholic liver disease.**

It is estimated that **67%** of **opiate** and /or **crack users** aged 15-64 in Havering **are not in treatment**.

In 2020, **6.3% (16 people**) **of opiate users**, **35% (84) of non-opiate users** and **40% (100) of alcohol users** successfully completed treatment.

Alcohol related deaths

Alcohol-related mortality among males has been **rising in the last three years.** The latest data (2020), shows alcohol-related mortality in Havering **(57/100,000)** is higher than the London average (51/100,000).

2.3 Achieving a Generational Shift in the Demand for Drugs

A downward shift in the demand for drugs and alcohol addiction can be achieved by:

- ensuring there are local pathways to identify and change the behaviour of people involved in activities that cause drug- and alcohol- related harm
- delivering school-based prevention and early intervention – ensuring that all pupils receive a co-ordinated and coherent programme of evidence-based interventions to reduce the chances of them using / abusing alcohol, drugs and other substances
- supporting young people and families most at risk of substance misuse or criminal exploitation – co-ordinating early, targeted support to reduce harm within families that is sensitive to all the needs of the person or family and seeks to address the root causes of risk

In addition, raising awareness among young people and adopting a risk reduction approach within higher-risk communities and families are crucial steps to reduce the demand for drugs. There is information for young people and their families and carers on **FRANK** at www.talktofrank.com. FRANK also lists sources of help and advice, including local services.

The harms of the substances should be **communicated** across the population and high risk groups. This is because not many people know about the harms of both newer substances of abuse such as nitrous oxide (laughing gas) and more well-known ones such as opioids, cocaine, alcohol and cannabis.
NICE guidance 64 (NG64) recommends skills training be offered to children and young people and their carers or families, ensure it helps children and young people develop a range of personal and social skills, such as:

- listening
- conflict resolution
- refusal
- identifying and managing stress
- making decisions
- coping with criticism
- dealing with feelings of exclusion
- making healthy behaviour choices
- dealing with feelings of exclusion (especially for care leavers and look-after-children).

NG64 also recommends providing information in different formats, including web-based information (such as digital and social media) and printed information in the following settings where groups who use drugs or are at risk of using drugs may attend:

- nightclubs or festivals
- sexual health services and primary care
- people in temporary accommodation, supported accommodation or hostels
- gyms (to target people who are taking performance-enhancing drugs)

Currently, vulnerable siblings and children are identified through Integrated Offender Management (IOM), Sexual and Gender-based Violence (SGV) and Domestic

Violence MARAC for early support to **break cycles of substance misuse and trauma**. In addition, here is a lot being done in school, e.g. PSHE/RSE alongside awareness training on substances, modern day slavery and pastoral support to understand what is going on at home. Schools and colleges involve parents, carers, children and young people in initiatives to reduce drug and alcohol use. CGL's Wize-up and hidden harm work engage with a range of key partners in Havering. Criminal Justice (Probation) and Youth Justice Services also ensure treatment and continuity of care.

2.3.1 Key findings from needs assessment

Drugs and alcohol misuse

Based on the Crime Survey for England, there are **14,032 people in Havering (7.6 %)** aged 16-74 using illicit drugs. The **highest proportion of users is of those aged 16-24 (21%)** equivalent to **5,282 young people.**

Criminal Justice System

In 2021, **a total of 2,287 people** in London entered the **Criminal Justice System (CJS) for a drug offence**. This represents **16.9% of all First-Time Entrants** (FTEs) in 2021.

It is estimated that **14.3% of adults in Havering** regularly **binge drink**. This equates to approximately **28,833 people. 1 in 5 (20.7%)** adults in Havering regularly drink excessively. This equates to approximately **41,738 people**.

Prescription Drugs

The **problematic use of prescription and over-the-counter medication** is becoming more widely recognised. The issue is also linked to self-harm and cheating in sports. The exact size of the problem is largely unknown due to lack of reliable data.

2.4 Reducing Risk and Harm to Individuals, Families and Communities

Both **genetic predisposition** and environment factors such as **poverty, easy access to drugs and alcohol, social isolation, past trauma, family business and work demand** increase the risk of taking drugs and alcohol or involvement in trafficking activities. On the other hand, substance use can lead to other **adverse consequences**, such as unemployment, homelessness and poverty, which create a cycle of dependency and loss. It is crucial that risk assessment tools are used to

identify and support young people so that they are supported to resist addiction and to become less vulnerable for exploitation.

There are also other **marginalised groups** (NICE NG64) who may be at higher risk of taking drugs such as refugees; people with disability or those who have mental and chronic physical illness, veterans, the unemployed, the homeless, LGBTQ+ persons, young people under care or former looked-after children and other stigmatised groups (e.g., sex workers, people with severe mental illness). Bespoke solutions are required to reduce the risk, to improve access to services and to sustain remission.

Physical activity or **social support** behaviours produce epigenetic changes that prevent the development of addiction and can have a beneficial role in treatment when used in combination with other interventions, such as cognitive behavioural therapy and, for some people, medications. In the example of a stressful situation such as the death of a significant other or loss of a job, if a person engages in physical activity this can reduce their stress-induced epigenetic changes, which will decrease the risk of developing addiction or stress-induced relapse. Alcohol and other substances can cause vitamin deficiency and multiple organ damage. It is important that substance misuse services support the users to adopt positive health behaviours including physical activity, social integration and balanced diet, and to receive physical and mental health advice when required.

As a good practice, trading standards team is routinely carrying out checks to prevent the under-age sale of alcohol which is a NICE Quality Standard 83 (QS83) for local authorities. Other good practices include unannounced visits, mystery shopping, working with the businesses not selling alcohol to those who are already intoxicated, safety campaigns, Night Marshalls, Friday night briefings, street triage and joint patrol with police. Havering Housing demand is also piloting Housing First initiative to enable treatment and recovery of the eligible homeless people, while also investing in additional drug worker in the treatment system. Community Safety team applies antisocial behaviour legislation to improve engagement with treatment services. All services including housing, social services and voluntary care services support service users with fire risk reduction. CGL has a safeguarding coordinator and all drug workers identify, assess and refer domestic abuse victims and perpetrators to relevant pathways.

2.4.1 Key findings from needs assessment

Substance misuse adults living with children

Havering had a total of **364 new adult presentations to treatment** for substance misuse during 2019/20. Of those, **77 (21%) were parents or adults living with children.**

There are **399 adults in Havering with alcohol dependence living with children**. **Only 80 are in treatment** indicating the **majority (80%) are unattended to** and therefore potentially **a threat to child safety**. This rate is higher than the national benchmark of unmet treatment need **(75%).**

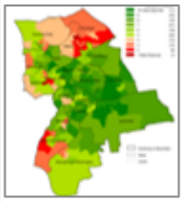
There are **189 adults** in Havering with **opiate dependence living with children. Only 59 are in treatment** indicating the **majority (69%) are unattended to** and therefore potentially **a threat to child safety.** This is lower than the national benchmark of unmet treatment need **(72%).**

Housing

The number of patients with housing problems starting treatment has been increasing in the last 4 years.

In 2020/21 a total of **105 patients had housing problems**. This is equivalent to **2 in 10 patients (21%)**.

Deprivation



The highest levels of alcohol and drug-related deaths in the UK occur in those areas of greatest neighbourhood deprivation. **Ten LSOAs (6.7%) in Havering are in decile 1 and 2** i.e. most and second most deprived LSOA's nationally. These deprived areas are in the **north and south of the borough and along its western boundary.**

Smoking

More than half of patients admitted for substance misuse treatment in Havering in 2022 were smokers.

Antisocial behaviour

The majority of substance misuse persons are involved in antisocial behaviour. **Romford Town, Gooshays, Brooklands and Heaton among Havering wards** had the highest number of reported incidents in 2021.

3 Where We Want To Be

3.1 Vision

Reduced drug and alcohol misuse in Havering alongside effective local services that support and safeguard users, families, and communities from the harms of addiction.

3.2 Aim & Objectives

Aim

The Havering strategy aims at working with all partners to:

- Break drug supply chains
    - Disrupting the ability of gangs to supply drugs and seizing their cash.
    - Bringing perpetrators to justice, safeguarding and supporting victims
    - Through collaboration with cross border operations and raising awareness around exploitation.
- Deliver a world-class treatment and recovery system, including
    - Improving access to support by tackling the stigma
    - Delivering efficient and effective treatment and recovery system based on a multi-disciplinary multi-agency integrated approach
- Achieve a generational shift in the demand for drugs, including
    - Preventing substance misuse and addiction
    - Supporting research, service audit, and evaluation
- Reduce risk and harm to individuals, families and communities, including
    - Reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm
    - Ensuring care and support for other family members (a Think Family approach)

Objectives

Specific objectives include:

- To support more young people to resist drug and alcohol misuse
- To reduce drug dealing activities
- To find county lines in North East London and ensure they are closed.
- Increase the number of people seeking advice, support and treatment
- Increase treatment and recovery capacity
- Ensure there is a treatment place for every offender with an addiction
- Ensure support for dual diagnoses- substance misuse, alcohol misuse, learning difficulty or mental health concerns
- Reduce number of substance misuse related hospital admissions
- Ensure physical and mental health conditions of individuals with substance misuse problems are managed by relevant services without waiting to complete substance misuse treatment
- Ensure more people achieve long-term recovery from substance dependency

- Ensure more people recovering from addiction are in sustained employment and in stable and secure housing
- Ensure more families are supported; fewer children taken into care
- Reduce mortality due to substance misuse

3.3 Local Strategic Outcomes

Expected outcomes from the implementation of the new strategy include:

- A greater collaboration among members in delivering services that will lead to improved multi-agency working arrangements including the formalisation of previous loose and informal arrangements
- Increased referrals from police, courts and probation into drug treatment
- Improved co-ordination of relevant local services leading to improved delivery of services including easier information sharing and access to information
- Involvement of service users and frontline professionals in the development of the local strategy and associated plans leading to a wider co-operation and ownership of local plans and services
- Service expansion to deliver new high-quality drug and alcohol treatment places
- More people recovering from addiction in sustained employment, stable and secure housing

3.4 National Outcomes

In order to achieve the ultimate strategic outcomes of reducing drug use, crime, harms and deaths, there is a need to be clear about where we are, where we are going and how to get there. To help local partnerships monitor achievement of these outcomes, the government recently (May 2023) published the National Combating Drugs Outcomes Framework.[10]

The framework sets our three strategic outcomes of reducing drug use, reducing drug-related crime, and reducing drug-related deaths and harm. Also included are intermediate outcomes of reducing drug supply, increasing engagement in treatment and improving recovery outcomes. The document further outlines a set of additional 22 supporting measures which allow partnerships to monitor progress towards the outcomes, with two key aims:

- More timely, interim, and/or proxy measures, which can tell us about direction of travel towards the strategic and intermediate outcomes

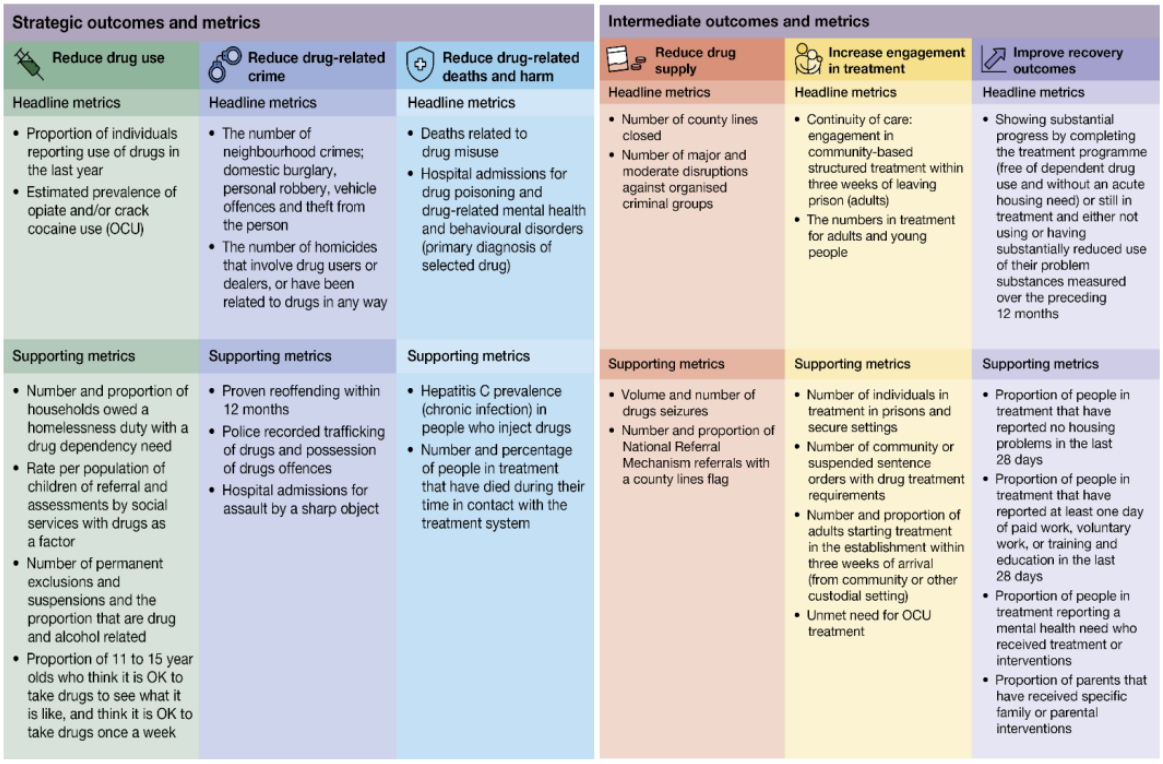
- A wider picture of the system allowing us to monitor the health of the whole system and to see unexpected trends or provide early warning.

10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1158290/National_Combating_Drugs_Outcomes_Framework_-_Supporting_metrics_and_technical_guidance_PDF__1_.pdf

The supporting measures are summarised in Figure 1 below. CDPs are expected to organise and monitor their work around progress towards these outcomes. All relevant local partners should contribute to all outcomes, and are accountable to central government, each other and local residents. For example, reduction of drug-related crime relies on increases in quality drug treatment and recovery, so it is crucial that local partners work together to increase referrals into treatment from the criminal justice system. We can only deliver this joined-up effort in reducing drug use and supply if each part of the system plays their role.

A new local outcomes framework dashboard is to be published by end of 2023 by OHID using data from NDTMS. This tool will provide local areas with key information to monitor local performance and activity against the aims of the local substance misuse. This will sit alongside a wider set of performance and data monitoring that emerged from our partner workshops held early in 2023.

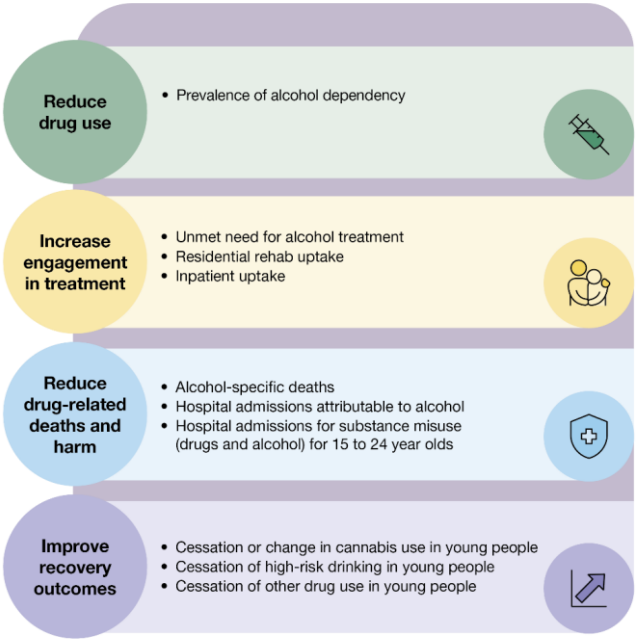
Figure 1: Full National Combating Drugs Outcomes Framework



Strategic outcomes and metrics			Intermediate outcomes and metrics		
Reduce drug use	**Reduce drug-related crime**	**Reduce drug-related deaths and harm**	**Reduce drug supply**	**Increase engagement in treatment**	**Improve recovery outcomes**
Headline metrics	Headline metrics	Headline metrics	Headline metrics	Headline metrics	Headline metrics
• Proportion of individuals reporting use of drugs in the last year • Estimated prevalence of opiate and/or crack cocaine use (OCU)	• The number of neighbourhood crimes; domestic burglary, personal robbery, vehicle offences and theft from the person • The number of homicides that involve drug users or dealers, or have been related to drugs in any way	• Deaths related to drug misuse • Hospital admissions for drug poisoning and drug-related mental health and behavioural disorders (primary diagnosis of selected drug)	• Number of county lines closed • Number of major and moderate disruptions against organised criminal groups	• Continuity of care: engagement in community-based structured treatment within three weeks of leaving prison (adults) • The numbers in treatment for adults and young people	• Showing substantial progress by completing the treatment programme (free of dependent drug use and without an acute housing need) or still in treatment and either not using or having substantially reduced use of their problem substances measured over the preceding 12 months
Supporting metrics	Supporting metrics	Supporting metrics	Supporting metrics	Supporting metrics	Supporting metrics
• Number and proportion of households owed a homelessness duty with a drug dependency need • Rate per population of children of referral and assessments by social services with drugs as a factor • Number of permanent exclusions and suspensions and the proportion that are drug and alcohol related • Proportion of 11 to 15 year olds who think it is OK to take drugs to see what it is like, and think it is OK to take drugs once a week	• Proven reoffending within 12 months • Police recorded trafficking of drugs and possession of drugs offences • Hospital admissions for assault by a sharp object	• Hepatitis C prevalence (chronic infection) in people who inject drugs • Number and percentage of people in treatment that have died during their time in contact with the treatment system	• Volume and number of drugs seizures • Number and proportion of National Referral Mechanism referrals with a county lines flag	• Number of individuals in treatment in prisons and secure settings • Number of community or suspended sentence orders with drug treatment requirements • Number and proportion of adults starting treatment in the establishment within three weeks of arrival (from community or other custodial setting) • Unmet need for OCU treatment	• Proportion of people in treatment that have reported no housing problems in the last 28 days • Proportion of people in treatment that have reported at least one day of paid work, voluntary work, or training and education in the last 28 days • Proportion of people in treatment reporting a mental health need who received treatment or interventions • Proportion of parents that have received specific family or parental interventions

In addition to the metrics in Figure 1 that will be used for monitoring the overall performance of the strategy nationally and locally across-central Government, OHID will be monitoring the treatment and recovery system both nationally and locally in greater detail with the additional outcomes metrics outlined in Figure 2. These metrics are also important for use by CDPs to monitor local treatment and recovery systems and will be included in local-facing reports produced by OHID.

Figure 2: OHID local outcomes framework: additional metrics


Reduce drug use
• Prevalence of alcohol dependency
Increase engagement in treatment
• Unmet need for alcohol treatment
• Residential rehab uptake
• Inpatient uptake
Reduce drug-related deaths and harm
• Alcohol-specific deaths
• Hospital admissions attributable to alcohol
• Hospital admissions for substance misuse (drugs and alcohol) for 15 to 24 year olds
Improve recovery outcomes
• Cessation or change in cannabis use in young people
• Cessation of high-risk drinking in young people
• Cessation of other drug use in young people

4 How We Will Get There: Key Actions

Two major workshops were organised by the Havering CDP to develop a delivery plan with actions that will ensure identified needs from the needs assessment are addressed and also that indicators from the national and local outcomes frameworks are incorporated to facilitate monitoring of progress. This was followed by direct engagement with individual lead organisations and officers resulting in a detailed delivery plan for each theme that outlines priority areas, actions, resources, timescales, strategic delivery and planning groups, lead organisations and officers and metrics for monitoring progress. A high level summary of key actions that will enable us achieve the strategy objectives and outcomes are presented below by theme. For the detailed delivery plan see appendix 2.

4.1 Breaking Supply Chains

- There are no gangs in Havering but we recognise that modern gangs are closely tied with the local drug trade so we will collect and share intelligence.
- **Working with regional tier** policing to share intelligence and jointly tackle trafficking into and around the UK.
- A **multi-agency approach** to intelligence sharing and development of interventions which: disrupts the supply of drugs and eliminates the exploitation of children and vulnerable people in drug trafficking and money laundry
- **Mapping** offenders, emerging groups and gangs linked to drug supply and exploitation
- Cultivating VOLT intelligence for the partnership – victims, offenders, locations and trends.
- Targeting street dealing with council **enforcement** assets
- Denial of criminal assets, taking cash, crypto-currency and other assets from the hands of criminals involved in drug trafficking and supply
- Reducing the opportunities for **money laundering**
- Identifying and taking action against **middle-tier offenders** and drug supply networks in our neighbourhoods – at every tier of policing.
- Protecting and redirecting young people through **diversionary mentoring**
- Surveillance of **emerging markets** e.g. vapes, xanax, lean
- Gathering intelligence and investigating substances of abuse in vapes by trading standards and community safety
- **Street policing**
- Detection and tackling of '**Cuckooing**' which is a tactic where drug dealers use violence and coercion to occupy a property and use it as a base for dealing
- Licensing committee and trading standards work together with local intelligence to limit the number **of alcohol retailers** where alcohol related health and social burden is high.

4.2 Delivering a World-Class Treatment & Recovery System

- Tackling **stigma** to addiction and treatment of addiction as a chronic health condition, and providing long-term support where necessary.
- Delivering **world-class** treatment and recovery services – strengthening local authority commissioned substance misuse services for both adults and young people, and improving quality, capacity and outcomes
- Improving **clinical pathways** and joint care for co-existing mental health and physical health conditions
- Improving **coordination and partnership** working across sectors, especially between NHS mental health services, substance misuse services, GPs, community pharmacies, social services, education, and housing to ensure holistic care and a higher chance of treatment success
- Strengthening the **professional workforce** – developing and delivering a comprehensive substance misuse workforce strategy
- Local services will be delivered via a highly trained and motivated workforce offering a full range of **evidence-based interventions**
- Ensuring better **integration** of services – making sure that people's physical and mental health needs are addressed to reduce harm and support recovery, and joining up activity to maximise impact across criminal justice, treatment, broader health and social care, and recovery
- Improving access to **accommodation** alongside treatment – access to quality treatment for everyone sleeping rough, and better support for accessing and maintaining secure and safe housing
- Improving **employment** opportunities – linking employment support and peer support to Jobcentre Plus services
- Increasing referrals into treatment in the **criminal justice system** – specialist drug workers delivering improved outreach and support treatment requirements as part of community sentences so offenders engage in drug treatment
- Keeping people engaged in treatment after **release from prison** – improving engagement of people before they leave prison and ensuring better continuity of care in the community
- Putting the individual at the centre of everything we do, and by underpinning services with extensive and robust evidence to save lives, reduce harm and crime, and **stop the 'revolving door'** in and out of prison.
- Continuously improving **information and advice** to promote self-help when possible and to seek advice when required.
- Engaging with service users to **understand factors** that contribute to both treatment success and attrition
- Addressing existing **inequalities** in substance misuse prevalence, access of treatment, **culturally sensitivity** and treatment outcomes
- Holding regular local multi-agency panels to identify, agree and embed learning from drug-related deaths in order to improve local response and **reduce deaths**.
- Working with other services to provide testing, safe injecting equipment and vaccination against **infections** including Hepatitis B.

4.3 Achieving a Generational Shift in the Demand for Drugs and Excessive Alcohol

- Ensuring there are local pathways to **identify and change the behaviour** of people involved in activities that cause drug- and alcohol- related harm
- **Supporting young people and families most at risk** of substance misuse or criminal exploitation – co-ordinating early, targeted support to reduce harm within families that is sensitive to all the needs of the person or family and seeks to address the root causes of risk
- Reinforcing knowledge and **positive behaviour around healthy lifestyles** during key transitions
- Delivering **school-based prevention and early intervention** – ensuring that all pupils receive a co-ordinated and coherent programme of evidence-based interventions to reduce the chances of them using and abusing alcohol, drugs and other substances
- **Clear messaging** to young people of **the realities** of drug use, county lines, and a life on the road (low wages, violent punishments, constant threat from rivals)
- Identifying siblings and children of substance users through IOM, SGV and DV MARAC for early support to break cycles
- Increased awareness among current and potential drug users:
    - Public information that recreational drug use enables a slave trade
    - Banning orders by pubs and clubs for users, in order to clean the night-time economy and reduce the local market
    - Proactive police action against drug users (stop and search, test on arrest)
    - Stricter action against those identified as buying drugs, and those buying drugs from individuals under 18
- Interagency working strategy is required to provide support to **marginalised members of the community** by addressing predisposing factors associated with social exclusion, rejection and severe mental health problems.
- Strengthen **community pharmacies** in their work on preventing prescription drug misuse.
- Review and limit the growth of number of alcohol retailers within legal powers

4.4 Reducing Risk and Harm to Individuals, Families and Communities

- Tackling stigma and improving **peer support** and health-seeking behaviour
- **Ensuring mental health access** of young people, victims of abuse, veterans, vulnerable communities and those who misuse drugs and alcohol is assured when they need it.
- Partnership work to reduce the level of risk to **the families** exposed to substance misuse and to reduce the harm through proportionate health and care support
- **Evaluating and researching** the service needs and outcomes, the cost-effectiveness of the approaches, and partnership working success factors

- **Collecting and analysing data regularly** from community safety, safeguarding, coroners and death registry to monitor drug-related violence, abuse, neglect and homicides
- **Cross-disciplinary training** in identification, signposting and first response to those with substance misuse and other co-existing needs such as mental health, physical help, employment support, social care etc.
- **Improving access to information** and awareness among young people and risk reduction approach with the higher risk communities and families to reduce demand for drugs
- Raising awareness of **foetal alcohol syndrome, sudden infant deaths** etc.
- **Needle exchange programme** and supervised consumption at community pharmacies
- Community Safety and Development Team and the MPS both routinely carrying out **unannounced swabbing** of licensed premises and other locations such as colleges, leisure facilities and shopping centres, to detect the presence of drugs.
- Council Licensing Officers regularly checking outside of office hours if premises are complying with their licences and to gain **compliance** with the legislation.
- Using of orders to tackle problem premises and create safer communities
- Working with LFB to identify people at risk of causing **fire** in their home due to alcohol or drug misuse
- Effectively **identifying and signposting** those with substance misuse problems including alcohol to other important existing programmes and services such as NHS Health Check, stop smoking, antenatal care etc.

5 Performance Measures

Measures will be based on the national and local outcomes framework as provided by the central government. The supplementary grant also has specific treatment priorities that need to be achieved in the next three years (See Table 3). These are summarised in section 5.1 by specific strategic and intermediate outcomes and where available includes the current status /baseline statistics for each indicator.

5.1 Supplementary Grant

Table 3: Supplementary Grant: Agreed increase in treatment and residential rehab capacity

Measure / Indicator	Baseline	Year 1: 2022-23	Year 2: 2023-24	Year 3: 2024-25
Treatment				
Total No of Adults in structured treatment	912	912	992	1075
Opiate Users	276	276	300	330
Non-opiate Users (combined non-opiate only and non-opiates and alcohol)	341	341	372	395
Alcohol Users	295	295	320	350
Young people in treatment	41	45	55	65
Adults with substance misuse problems who engage successfully in community based treatment following release from prison/ secure estate	35%	45%	55%	60%
Residential Rehab				
Proportion of adults in rehab as a proportion of all adults in treatment	1.2% (baseline average - 9)	11	13	15

5.2 Performance Measures: The National and Local Outcomes Framework

5.2.1 Strategic Outcome: Reducing drug use

Measure	Metric	Baseline Statistics	Source
Proportion of individuals using drugs in the last year	Proportion of individuals reporting use of drugs in the last year: 16 to 24 years, 16 to 59 years. Monitored by drug type (all, cannabis, cocaine), personal characteristics (gender, ethnicity, others as required)	Based on the Crime Survey for England, there are **14,032 people (7.6 %) aged 16-74** using illicit drugs. The highest proportion of users is of those aged **16-24 (21%) equivalent to 5,282 people** in Havering (See NA for detailed breakdown)	Crime Survey for England and Wales, Office for National Statistics
Proportion of individuals using drugs in the last year	Proportion of pupils aged 11 to 15 who took drugs in the last year. Monitored by drug type, personal characteristics (gender, ethnicity)	Example: Cannabis: Havering (4%), London (5%), England (4.6%)	Smoking, drinking and drug use among young people in England. Office for National Statistics
Prevalence of opiate and crack use	Estimated total number and prevalence rate of opiate and/or crack cocaine use at local authority, regional and England only. Monitored by drug type and age.	Havering 858 (5.4/1,000), London (9.3), England (8.9%)	Estimates of the prevalence of opiate use and/or crack cocaine use Office for National Statistics
Additional supporting measure: Prevalence of alcohol dependency	The estimated number of adults with an alcohol dependency.	Available only for England (1.4%) can model for Havering	Alcohol dependence prevalence in England Office for National Statistics
Additional Supporting Measure: Homeless with a drug dependency need	Number and proportion of households owed a Homelessness duty with a drug dependency need. Monitored by local authority	In 2020/21 a total of 105 patients had housing problems. This is equivalent to 1 in 5 patients (21%)	Official statutory homelessness statistics The Department for Levelling Up, Housing and Communities
Additional Supporting Measure: Children in need with drugs as an assessed factor	Rate per 1,000 population of children of referrals and assessments by social services with drugs as a factor. This is in respect of a case where the child is not	To be considered for inclusion when available	Characteristics of children in need Department of Education

Measure	Metric	Baseline Statistics	Source
	previously known to the council, or where the case was previously open but is now closed. Monitored by parent, child, or other person, local authority		
Additional Supporting Measure: Permanent exclusions and suspensions – drug and alcohol related	Number of permanent exclusions and suspensions and the proportion that are drug and alcohol related. Monitored by local authority and proportion of pupil enrolments	To be considered for inclusion when available	Permanent exclusions and suspensions in England. Department of Education
Additional Supporting measure: Acceptability of drug use in children	Proportion of 11 to 15 year olds who think it is OK to try drugs to see what it is like, and the proportion who think it is OK to take drugs once a week. Monitored by drug type (all, cannabis, cocaine), age, gender.	To be considered for inclusion when available	Smoking, drinking and drug use among young people in England. Department of Education

5.2.2 Strategic outcome: Reducing drug-related crime

Measure	Metric	Baseline Statistics	Source
Drug-related homicide	Homicides that involve drug users or dealers or have been related to drugs in any way. An offence is 'drug related' if any of the following variables are positive: victim is an illegal drug user, victim is an illegal drug dealer, suspect is an illegal drug user, suspect is an illegal drug dealer, victim has taken a drug, suspect has taken a drug, suspect had motive to obtain drugs, suspect had motive to steal drug proceeds, or drug related.	Havering reported fewer homicides in the last 2 years (9 cases) compared to other London boroughs but nonetheless a significant number that appear to be on an upward trend	Homicide in England and Wales Office for National Statistics
Neighbourhood crime	Neighbourhood crime, made up of domestic burglary, personal robbery, vehicle offences and theft from the person.	In the last 12 months (ending October 2022) 1084 drug related crimes were reported in Havering.	Crime Survey for England and Wales Office for National Statistics

Measure	Metric	Baseline Statistics	Source
Additional Supporting measure: Proven reoffending	Proven reoffending within 12 months. Monitored by Adult/juvenile, all, index offences – drug and theft, local authority.	Havering (22.5%) England (25.4%)	Proven reoffending statistics Office for National Statistics
Additional Supporting measure: Trafficking and possession	Police recorded trafficking of drugs and possession of drugs offences. Monitored by adult/juvenile national and police force area.	In 2022, 146 drug trafficking crimes were reported in Havering, an increase by 63% compared to the previous year.	Crime Survey in England and Wales Office for National Statistics
Additional Supporting measure: Hospital admissions for assault by sharp object	Hospital admissions for assault by a sharp object. Monitored by age: 16 to 24, over 25, local authority.	Local data not available, to be included.	Monthly hospital admissions for assault by sharp object. NHS Digital

5.2.3 Strategic outcome: Reducing drug-related deaths and harm

Measure	Metric	Baseline Statistics	Source
Deaths from drug misuse	Deaths related to drug misuse. Monitored by English region, LA, date of death and date of registration	Local data not available, to be included.	Deaths related to drug poisoning, England and Wales. Office for National Statistics
Hospital admissions for drug misuse	Hospital admissions for drug poisoning and drug related mental health and behavioural disorders (primary diagnosis of selected drugs). Monitored by national, local authority, and age group (16 to 24, over 25).	The latest data (2020), shows alcohol-related mortality in Havering (57/100,000) is higher than the London average (51/100,000).	NHS Digital
Additional Supporting measure: Deaths in treatment	The number and percentage of people in treatment who have died during their time in contact with the treatment system. Monitored by local authority.	An average of 5 deaths in treatment annually have occurred in Havering in the last 3 years	OHID.
Additional Supporting measure: Alcohol-specific deaths	The rate per population of registered deaths where alcohol is the primary cause. Monitored by local authority.	The latest data (2017-19) shows Havering has a lower rate (5/100,000) than both London and England.	Local alcohol profiles for England, OHID

Measure	Metric	Baseline Statistics	Source
Additional Supporting measure: Hospital admissions attributable to alcohol	Admissions to hospital where the primary reason for admission was attributable to alcohol, and admissions to hospital where the primary reason for hospital admission or a secondary diagnosis was linked to alcohol. Monitored by local authority.	In 2020/21, 2862 people in Havering were admitted in hospital with alcohol related conditions.	Alcohol-related hospital admissions OHID
Additional Supporting measure: Hospital admissions for substance misuse (young people)	Admissions to hospital where the primary or secondary reason was due to substance misuse in those aged 15 to 24). Monitored by local authority	To be considered for inclusion when available	Public health profiles, OHID.
Additional Supporting measure: Hepatitis C prevalence in people who inject drugs	Hepatitis C prevalence (chronic infection) in people who inject drugs	In 2021, 36 patients in Havering attending treatment were diagnosed with Hepatitis C while 3 had HIV.	Unlinked anonymous monitoring survey of HIV and viral hepatitis among people who inject drugs

5.2.4 Intermediate outcome 1: Reducing drug supply

Measure	Metric	Baseline Statistics	Source
Number of county lines closed	Number of county lines closed through the County Lines Programme.	No local data available, to included when available	Home Office
Organised crime group disruptions	Number of moderate and major drug disruptions against organised criminals. Major: Significant disruptive impact on an organised crime group, individual or vulnerability, with significant or long-term impact on the threat. Moderate: As above but with noticeable and/or medium-term impact on the threat.	No local data available, to included when available	National Crime Agency
Number and volume of drug seizures	Number and volume of drugs seizures. Monitored by source of seizures (National Crime Agency, police forces, Regional Organised Crime Units, Border Force) and drug types (all, class A, other).	No local data available, to included when available	Home Office

Measure	Metric	Baseline Statistics	Source
	England and Wales. National Crime Agency seizures to capture UK, at sea and international seizures.		
Number and volume of drug seizures	Number of incidents of drug finds in prisons. Monitored by drug types (all, class A, other).	No local data available, to included when available	HMPPS annual digest
Additional Supporting measure: National Referral Mechanism referrals	National Referral Mechanism referrals (county lines flagged).	No local data available, to included when available	Modern slavery National Referral Mechanism. Home office

5.2.5 Intermediate outcome 2: Increasing engagement in drug treatment

Measure	Metric	Baseline Statistics	Source
Numbers in treatment	Numbers in treatment for adults and young people. Monitored by: protected characteristics, opiate and/or crack cocaine users (OCUs) and non-OCUs, and alcohol,	In 2020/21 there were a total of 528 adults in treatment services	Alcohol and drug treatment statistics: adults and young people. OHID
Prison continuity of care	Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	In 2020/21, only 14 adults with substance misuse treatment need successfully engaged in community-based structured treatment following release from prison.	Alcohol and drug treatment in secure settings. Ministry of Justice
Additional Supporting measure: Community sentence treatment requirements	Number of community or suspended sentence orders with drug treatment requirements	No local data available, to included when available	Offender management statistics Ministry of Justice

Measure	Metric	Baseline Statistics	Source
Additional Supporting measure: Unmet need for OCU treatment	Unmet need for OCU treatment, based on a comparison of the opiate and crack use prevalence and numbers in treatment measures	It is estimated that there are more than two thirds (67%) opiate and /or crack users aged 15-64 in Havering not in treatment.	OHID.
Additional Supporting measure: Unmet need for alcohol treatment	Unmet need for alcohol treatment, based on a comparison of the alcohol prevalence and numbers in treatment measures	It is estimated that there are 82% alcohol misusers in Havering who are not in treatment.	OHID
Additional Supporting measure: Number in prison treatment	Number of individuals in treatment in prisons and secure settings. Monitored by age (under 18, over 18).	To be considered for inclusion when available	Alcohol and drug treatment in secure settings. Ministry of Justice
Additional Supporting measure: Proportion starting treatment within three weeks of arrival	Number and proportion of adults starting treatment in the establishment within three weeks of arrival (from community or other custodial setting).	To be considered for inclusion when available	Alcohol and drug treatment in secure settings. Ministry of Justice
Additional Supporting measure: Residential rehab uptake	The number and percentage of adults in treatment accessing residential rehab provision during the year.	To be considered for inclusion when available	OHID.
Additional Supporting measure: Inpatient uptake	The number and percentage of adults in treatment accessing inpatient provision during the year.	To be considered for inclusion when available	OHID.

5.2.6 Intermediate outcome 3: Improving drug recovery outcomes

Measure	Metric	Baseline Statistics	Source
Treatment progress	Showing substantial progress by completing the treatment programme (free of dependent drug use and without an acute housing need) or still in treatment and either not using or having	To be considered for inclusion when available	OHID

Measure	Metric	Baseline Statistics	Source
	substantially reduced use of their problem substances, measured over the preceding 12 months.		
Supporting measure: Proportion in treatment in stable accommodation	The percentage of people in treatment who have reported no housing problems or issues in the last 28 days.	To be considered for inclusion when available	OHID.
Supporting measure: Proportion in treatment in paid work	The percentage of people in treatment who have reported at least one day of paid work in the last 28 days.	To be considered for inclusion when available	OHID
Supporting measure: Proportion in treatment in voluntary work	The percentage of people in treatment who have reported at least one day of voluntary work in the last 28 days	To be considered for inclusion when available	OHID.
Supporting measure: Proportion in treatment in training or education	The percentage of people in treatment who have reported at least one day in training or education in the last 28 days.	To be considered for inclusion when available	OHID.
Supporting measure: Mental health interventions and treatment provided (adults and young people)	Adults: the percentage of adults in treatment who reported a mental health need and received mental health treatment or interventions. Young people: the percentage of young people who had an unmet mental health need at treatment start who still have an unmet mental health need at treatment exit.	To be considered for inclusion when available	OHID
Supporting measure: Parental and family interventions delivered	The percentage of parents who have received specific family or parental interventions.	To be considered for inclusion when available	OHID

Measure	Metric	Baseline Statistics	Source
Additional supporting measure: Cessation or change in cannabis use in young people	Cessation: the percentage of young people who were using cannabis at treatment start who have stopped using at treatment exit. Change: the reduction in days of cannabis use of young people who were using cannabis at treatment start and are still using at treatment exit.	To be considered for inclusion when available	OHID.
Additional supporting measure: Cessation of high-risk drinking in young people	The percentage of young people who were drinking alcohol at a high-risk level at treatment start who have stopped drinking at a high-risk level at treatment exit. High-risk level drinking is defined as more than 140 units over 28 days.	To be considered for inclusion when available	OHID.
Supporting measure: Cessation of other drug use in young people	The percentage of young people who were using other drugs at treatment start and have stopped using other drugs at treatment exit. Other drugs refers to all drugs except cannabis, and does not include alcohol or nicotine.	To be considered for inclusion when available	OHID.

6 Whole-System Accountability

The drivers of drug use and drug-related harm are complex and cut across the responsibilities of a range of different organisations. The successful implementation of this 5-year strategy is dependent on the whole local partnership working together and sharing the responsibility for creating a safer, healthier and more productive society.

The single set of outcomes and metrics outlined in this strategy are aimed at all partners getting involved in delivering the 5-year drugs strategy. It emphasises shared accountability for all outcomes to avoid the problem of individual organisations being pulled in different directions by competing outcomes and targets.

The Havering CDP will organise and monitor its work around progress towards the outlined outcomes, ensuring local partners are accountable to central government, each other and local residents. The outcomes will run through all the CDP outputs, from needs assessment to action plans and regular progress reports. Further performance monitoring outcomes may be incorporated in future to address specific local needs.

Monitoring and consideration of different demographics and protected characteristics will be a key part of this work. The drugs strategy commits to promoting equality and meeting the needs of all communities, particularly those who have often not received an effective service in the past, including people from ethnic minority backgrounds and women.

The Havering SRO represents the whole CDP through holding overarching responsibility for local delivery of the strategy. Reporting and accountability into national government central government will monitor local delivery against the metrics outlined above. The measures will be monitored in the context of the whole system, with an awareness that the direction of travel may change over the course of the strategy. In the short term, we could expect initial increases in some metrics, due to more planned activity and services better meeting demand, but in the longer term these might decrease due to effective activity and reduction in the underlying problematic issues.

7 Timescales

This strategy will be implemented over a five-year period from the date of publication and will be reviewed at least annually and amendments made as necessary.

8 Related Documents

In drafting this strategy the following government reports and guidance have been key references. This was to ensure this local strategy is consistent with the national strategy and related policies. Our local needs assessment report has also been a key resource providing required baseline intelligence that has informed the development of the performance and monitoring system for the strategy.

- Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)
- From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)
- Guidance for local delivery partners (accessible version) - GOV.UK (www.gov.uk)
- Havering Combating Drugs Needs Assessment 2022

9 Consultation

As per the council regulations, this strategy was subjected to a public consultation for 6 weeks commencing October to November 2023. This involved uploading the draft strategy on the Havering Council's Consultation and Engagement Hub (Citizen Space) and a structured survey.[11] The consultation was promoted via the council social media platforms and newsletters. Direct engagement with key stakeholders and service users was carried out over the same period in form of focus group discussions and arranged plenary sessions. The summary report is included in appendix.

10 Authorisation and Communication

The final strategy document will be presented to the Combating Drugs Partnership, the Health and Wellbeing Board, Borough Place Based Partnership and signed off by the LB Havering Cabinet. The approved strategy will be published on the council website and a copy circulated to all partners.

11 Implementation and Monitoring

11.1 Action Plan

A detailed delivery plan is included in appendix 2.

11.2 Monitoring Actions and Performance

The Combating Drugs Partnership will be responsible for monitoring actions and performance using the delivery plan and list of outcomes derived from the national and local outcomes frameworks. Lead organisations and named officers have been identified for each performance area. They will update the partnership board on a quarterly basis on progress and receive appropriate feedback and support. An analytics working group will be created to develop a performance dashboard to facilitate monitoring and reporting of progress over time.

[11] London Borough of Havering Council - Citizen Space

11.3 Evaluation and Review

The strategy and related action plans will be reviewed annually by the Combating Drugs Partnership. Any changes or adjustments will require approval by the board.

11.4 Further Information

Partnership Lead for Havering Combating Drugs Partnership:
Tha.Han@havering.gov.uk

Appendix 1: Consultation and Engagement Report

Report will be included in final strategy document as it will incorporate feedback from CDP.

Havering Combating Substance Misuse Strategy 2023 – 2028: Consultation Report

Table of Contents

Executive Summary:

Citizen Space Survey

There were 38 respondents to the Citizen Space Survey. Respondents to the Citizen Space survey were from a range of backgrounds, with the majority representation from professionals with an interest in substance misuse (43%). 28% of respondents were Havering residents not using substances. 22% of respondents were Havering residents impacted by substance misuse personally, and 22% had been impacted by substance misuse through a family member.

A range of organisations and backgrounds of respondents were reported, and listed below:

- Havering council
- Mind in Havering, Barking & Dagenham
- CCC-FAITHVERSES
- NHS
- Myplace Harold Hill
- London South Bank University
- Nurse
- Former user of substance misuse in another borough, now living in Havering
- Ex-police officer

The majority of respondents were heterosexual/straight (84%) and white British (68%) – 39% identified male, and 50% identified female.

Ages of respondents varied from 18-84 years – with the peak age bracket at 55-64 (24%).

A range of Havering wards were represented, but some professional respondents lived outside of Havering, contributing to a high “Not Answered” rate (21%). 29% of respondents reported a long term health issue or disability status.

The majority of respondents have agreed with the strategy, it’s priorities and suggested actions. Substance misuse is recognised by all respondents as a serious issue in society and within Havering. Among those in agreement, is an appreciation for the strategy’s focus on the wider determinants of substance misuse and dependence/addiction; with priorities focused on harm reduction and having world leading treatment and recovery programmes. The systems approach and partnership working is recognised as effective by a majority of respondents, and an encouraging step to tackling substance misuse within Havering.

There is agreement across respondents that education of young people is vital in order to prevent starting to use substances in the first place, with an emphasis on exposure to the consequences of substance misuse and addiction.

Themes across the survey from a minority of respondents are that the strategy is ambiguous with unclear actions that need more detail for respondents to feel confident that they would be positive. A further concern is that there are too many organisations involved in the partnership for effective and efficient decision making to occur.

However, the majority of respondents agreed all organisations were included, but a similar number were unable to tell or didn't know. Suggested organisations to join were:

- Voluntary sector, for a non-statutory voice/perspective
- Alcohol industry
- Religious/spiritual institutions – due to the active support offered by them to those using substances
- A general public representative – particularly from the perspective of families
- Local Medical Council – recognition that NEL ICB was included as a partner, but unclear how Primary Care/GPs were represented
- Drinkware

There was concern of how we could ensure we are engaging effectively, including with those less able to engage. Respondents shared their uncertainty about how this could be monitored and evaluated within the strategy. A proportion of respondents (14%) expressed that we should take an individual focused and whole population approach, not prioritising any specific group within the cohort of those affected by substance misuse.

Financial concerns and a lack of resource across the partnership organisations were highlighted throughout the responses to the survey, and were a cause of concern for a large proportion of respondents as to whether the strategy was realistically achievable. A lack of faith was expressed that effective action is ever undertaken. Specifically highlighted were the:

- NHS, and concern of its capacity to deliver on effective care for those affected by substance misuse
- Police and trading standards, to be able to deliver on local enforcement and disrupting the supply chain
- Council's current financial situation, and whether it will be able to fund services and actions
- The education sector, and capacity to engage with young people

A minority of respondents (5%) expressed concern that council and public money should not be spent on substance misuse, as they perceived it as self-inflicted.

A lack of focus on spiritual/religious institutions in the strategy was highlighted within the survey, as well as these institutions current involvement and capacity to assist in the issues around substance misuse.

Focus Groups

Within the focus groups, the lived experiences of those who have misused substances were captured - highlighting the challenges that they face, where best practice exists,

and what they think would lead to improvements. The focus groups were run in two sessions, with four former rough sleepers, and eight substance misuse service users.

In terms of challenges, there is a perceived lack of knowledge and awareness in staff, across services working with substance misusers, of the needs and available support. In line with this are experienced delays in early intervention services, stigma and Access to Recovery (ATR) and Drug Rehabilitation Requirements (DRR). Barriers to Housing, Primary Care and Mental Health services were also highlighted.

Feedback highlighted that the lack of awareness amongst staff led to truncated care, and a lack of a joined up approach. Mental Health services were highlighted as a specific issue, as a need to be sober was a barrier to access the service, penalising those having dual diagnosis.

Current good practice was highlighted at Farringdon House, in the form of multiple outreach services (with information on how to access), literacy/numeracy support, peer support and a positive social environment.

When asked what would be helpful, cross-sector training on addiction, stigma, the services available and how to refer were highlighted. Multiple points on how to improve services and enforcement included easier access, better integration and personal connections – as well as through training.

New forms of campaigning and communication through social media and by using less formal written communication were suggested. This would be alongside a better visibility of services available. Peer support and buddying were emphasized, alongside improvement in the available housing/hostel support (including segregation of those with a history of violence).

A community and person centered approach were valued, with youth centers highlighted as important in prevention.

Introduction:

Havering is refreshing its substance misuse strategy (covering alcohol and drugs). This is in response to the UK's national 10-year drugs strategy (From harm to hope: A 10-year drugs plan to cut crime and save lives), which highlighted three overarching priorities:

- Breaking drug supple chains.
- Delivering a world-class treatment and recovery system.
- Achieving a generational shift in the demand for drugs (to make fewer people want to use drugs.)

The Combating Drugs Partnership (CDP) group was formed to create the strategy and organise the actions to be taken based on it. It has formed the substance misuse strategy and actions around these key priorities, whilst including a fourth priority of "reduce risk and harm to individuals, families and communities".

A public consultation has been done in line with statutory requirements, to ensure residents and service providers not directly involved with the creation of the strategy have input before it is published. This consultation was conducted through an online survey, with additional insights from focus groups with those with lived experience.

The results of the consultation are discussed below, and the themes highlighted are described. A response will be formed to the concerns raised, and the feedback from the focus groups, with the strategy being updated as needed.

Methodology:

The public consultation was run through Citizen Space – an online survey platform used by the London Borough of Havering. It was run online from 18/09/2023 to 05/11/2023; with four additional hard copy answers being uploaded manually.

Questions were created by Havering's Substance Misuse Working Group, and approved by the Combating Drugs Partnership (see Appendix for full set of questions and answer options). A whitespace section was included for respondents to expand on why they made their choice, or to give further information, for all questions except those asking about demographics (questions 11-16).

Two focus groups were conducted to have direct engagement with those with lived experience to contribute their thoughts in more detail. One focus group was through Change Grow Live (CGL) (a service provider to substance misusers) and another through Havering's Housing service.

Citizen Space generated the quantitative results from the survey, creating charts and tables detailing the number of respondents. These were re-formatted to remove absolute counts and suppress values to prevent identification of respondents.

Themes from answers to the whitespace part of the questions were captured and written out for each question, and then overall themes were captured in the executive summary.

Two focus groups were conducted. Themes from the focus group were captured under the categories of "The Main Challenges", "Current Good Practice", and "What Would Be Helpful".

Results:

Citizen Space Consultation:

The Citizen Space software has auto-generated a quantitative summary of responses. This section of the report will demonstrate the response counts to each question and then share the themes highlighted in responses to the whitespace section, summarising themes for each question.

39 responses were received to the Citizen Space survey. On review of the whitespace answers, one response was judged to have been submitted twice. Exact free-typed responses were submitted within three minutes of each other, but with some answers being different in the multiple-choice part. The conclusion drawn was that one respondent had submitted twice, as they wished to change their responses, creating a duplicate response. To avoid bias and unfair weighting, the earlier response has been discarded, with the auto-generated charts and tables adjusted for this.

It is taken that the total number of respondents to this survey is 38.

https://consultation.havering.gov.uk/public-health/havering-combating-substance-misuse-strategy

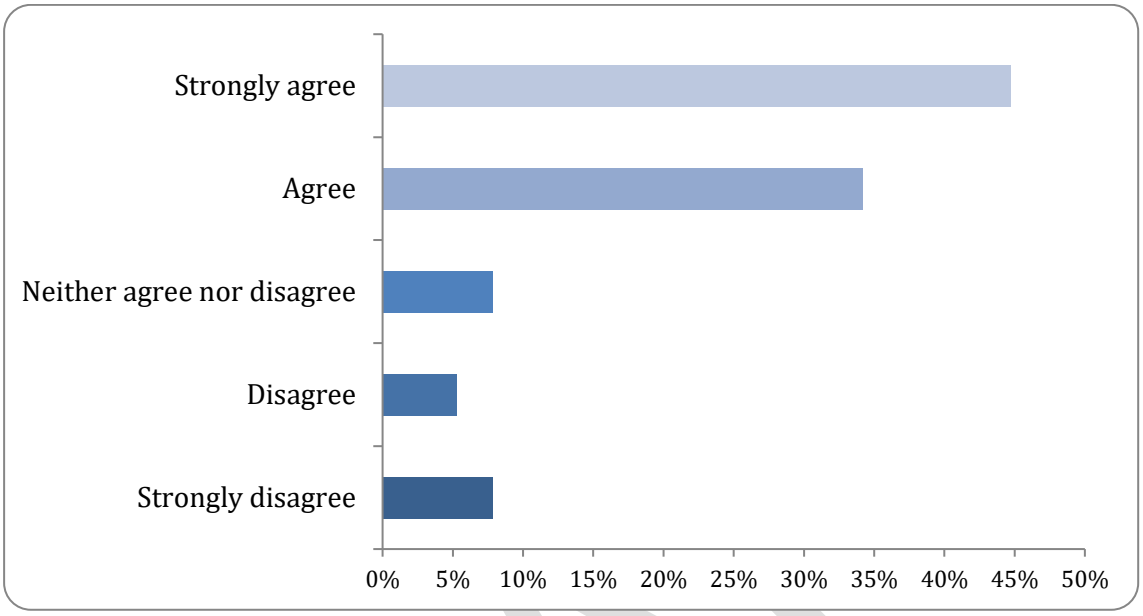
This report was created on Tuesday 07 November 2023 at 09:52
The activity ran from 18/09/2023 to 05/11/2023
Responses to this survey: 39

Figure 1 – Details of Combating Substance Misuse Consultation Auto-Report from Citizen Space

Questions:

1: How far do you agree with the scope of the substance misuse strategy in Havering?

100% of respondents answered this part of the question.



Option	Percent
Strongly agree	44.74%
Agree	34.21%
Neither agree nor disagree	7.89%
Disagree	5.26%
Strongly disagree	7.89%
Not Answered	0.00%

Themes in those who strongly agree:

- Addiction is recognised as a serious problem in society
- Impacts not only on users but those around them, including children
- Encouraging to see it focus not only on substances, but on the behaviours/circumstances leading to it, the harm caused and need for treatment/support of those affected
- Legal and illegal substances are both an issue

Themes in those who agree:

- Continue themes from strongly agree, but adds:
- Crime is funded by addiction, and substance misuse is a factor in anti-social behaviour/healthcare costs

- More focus on transition to adulthood, particularly in dual diagnosis

Themes in those who are neither agree nor disagree:

- Strategy seems ambiguous and actions are unclear
- There should be more focus on spiritual interventions

Themes in those who disagree:

- Too much emphasis on enforcement, that it ts not effective in stopping addiction, and there is not enough detail on actions for recovery
- Addressing tobacco use should have been included in this strategy

Themes in those who strongly disagree:

- Concern that the council cannot afford the strategy actions.
- We should pay to treat self-inflicted problems

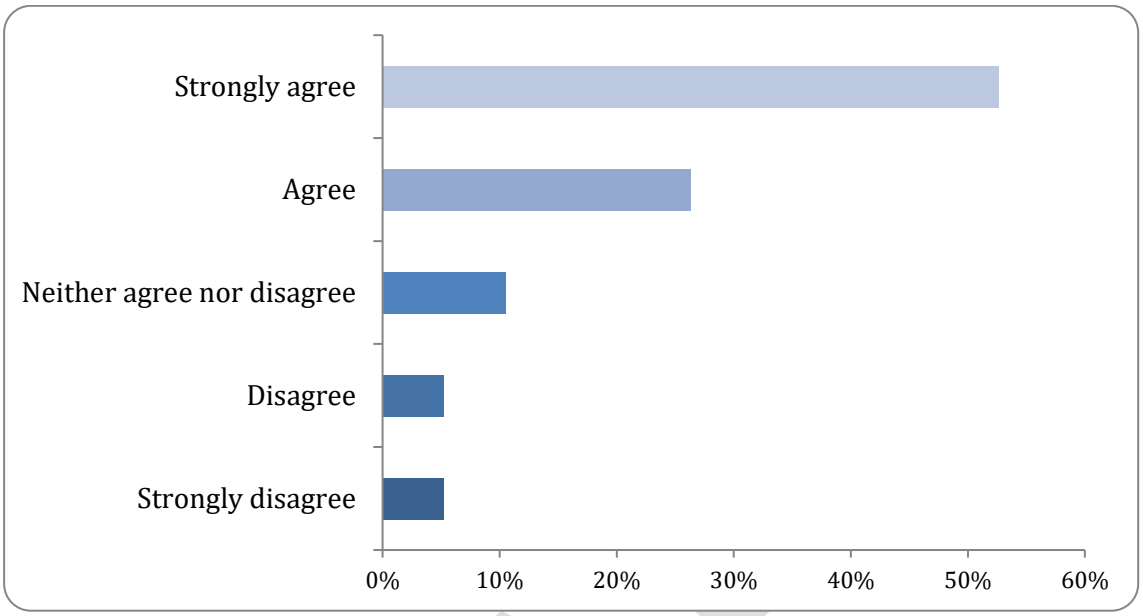
Summary:

The majority of respondents agree with strategy and its priorities – particularly with the focus on harm reduction for all those affected by substance misuse, and on treating it as a complex health and social problem.

Concerns that the strategy is ambiguous with unclear actions, and that the council cannot afford the actions in its current financial situation.

2: How far do you agree with the four areas of priority aims of the substance misuse strategy?

100% of respondents answered this part of the question.



Option	Percent
Strongly agree	52.63%
Agree	26.32%
Neither agree nor disagree	10.53%
Disagree	5.26%
Strongly disagree	5.26%
Not Answered	0.00%

Themes in those who strongly agree:

- Tackling substance misuse should be a priority
- Substance misuse contributes greatly to criminal activity and make a Havering feel unsafe – this is changing over time, and making Havering more like inner London boroughs in terms of crime/substance use
- The approach is targeted correctly, particularly with focus on holistic treatment of substance misuse and systems approach

Themes in those who agree:

- Largely agree with priorities, but may be too ambitious
- More detail on actions is required to know if will be successful or not

Themes in those who are neither agree nor disagree:

- The priorities are implausible to be achieved
- The focus should be on preventing individuals starting substances in the first place
- There should be more emphasis on spiritual support

Themes in those who disagree:

- There is too much emphasis on enforcement
- Lack of understanding how the strategy addresses those unable to engage with services

Themes in those who strongly disagree:

- Concern about the council's financial situation, and question if it should pay for the services

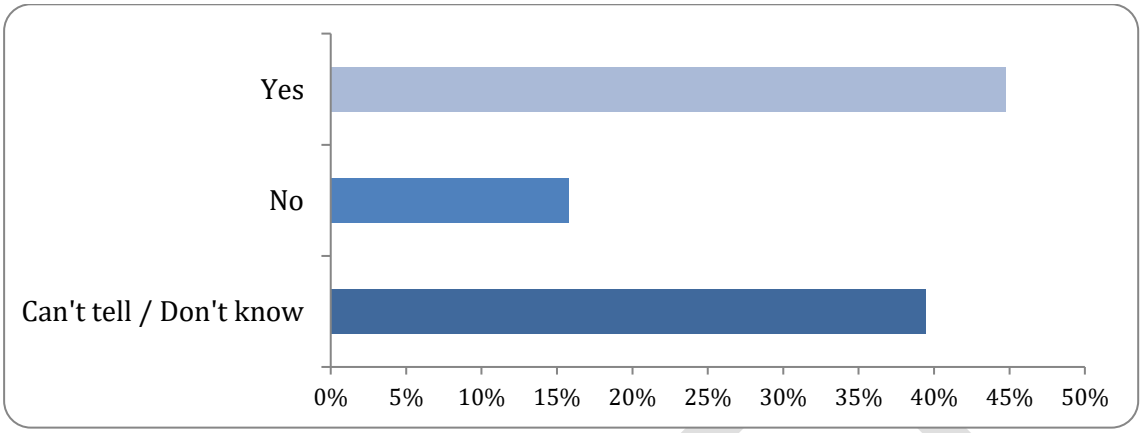
Summary:

Agreement by the majority of respondents that the strategy addresses the needs of the individuals and takes a systems approach to address the multiple factors related to substance misuse.

Continued themes of concern from the remaining respondents about the ability of the council to fund these services, whether it should, and that the strategy should be more detailed about the actions that will be taken to achieve priorities.

3: Did we involve all relevant organisations and services in drafting the strategy?

100% of respondents answered this part of the question.



Option	Percent
Yes	44.74%
No	15.79%
Can't tell / Don't know	39.47%
Not Answered	0.00%

Free-typed answers from those who responded Yes:

- There should be a role for education and training providers
- There are too many organisations involved to reach consensus on topics

Free-typed answers from those who responded No:

Suggestions included:

- Voluntary sector for non-statutory voice/perspective
- Alcohol industry
- Religious/spiritual institutions
- General public and consultation with children/families
- Local Medical Council – recognition NEL ICB was included, but unclear how primary care/GPs were represented

Free-typed answers from those who responded Can't tell/Don't know:

- Drinkware

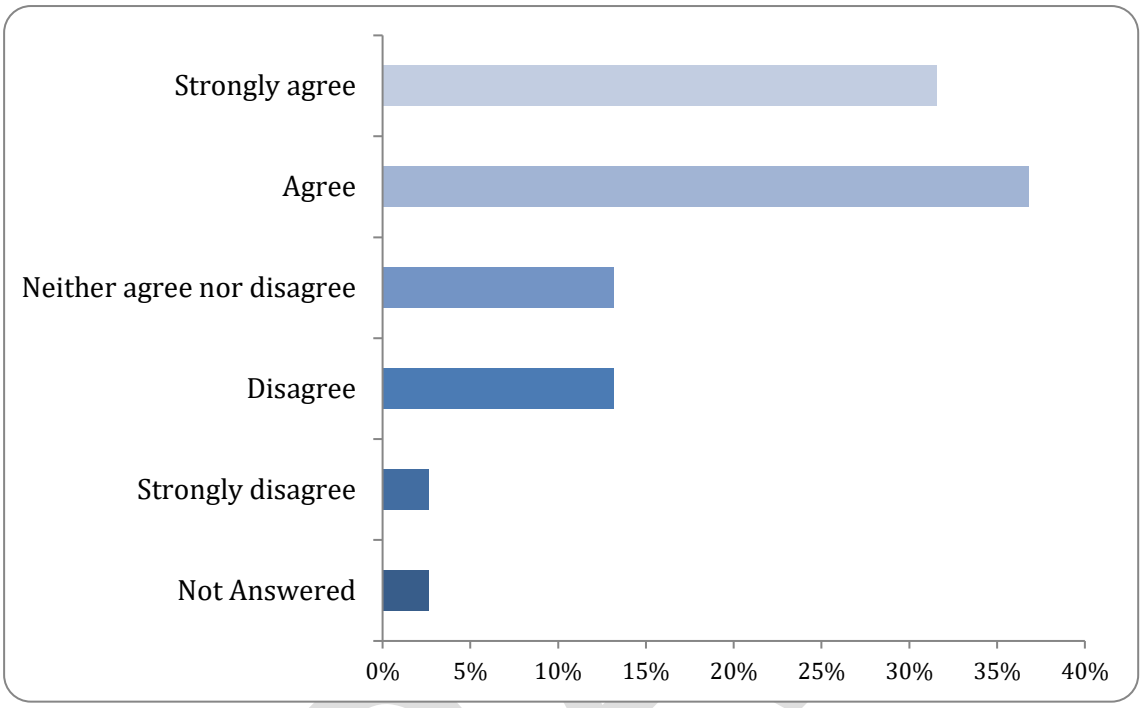
Summary:

45% of respondents think all organisations were included. 39% stated they were not able to tell or didn't know if enough had been included.

16% stated they did not think all relevant organisations were included. Suggestions from all respondents are listed above.

4: Havering Combating Drugs Partnership (Havering CDP) will be monitoring the progress of the delivery plan quarterly, sharing with other partnership boards listed below and publishing an annual report for the public. How far do you agree with this approach?

97% of respondents answered this part of the question.



Option	Percent
Strongly agree	31.58%
Agree	36.84%
Neither agree nor disagree	13.16%
Disagree	13.16%
Strongly disagree	2.63%
Not Answered	2.63%

Themes in those who strongly agree:

- Transparency and sharing information among organisations with a variety of experience is key to an effective response
- Concern that too many organisations can paralyse decision making

Themes in those who agree:

- Monitoring with key metrics and partners for accountability will be effective

Themes in those who are neither agree nor disagree:

- Concern of too many organisations involved for effective decision marking

Themes in those who disagree:

- Continued theme of too many organisations being involved

Themes in those who strongly disagree:

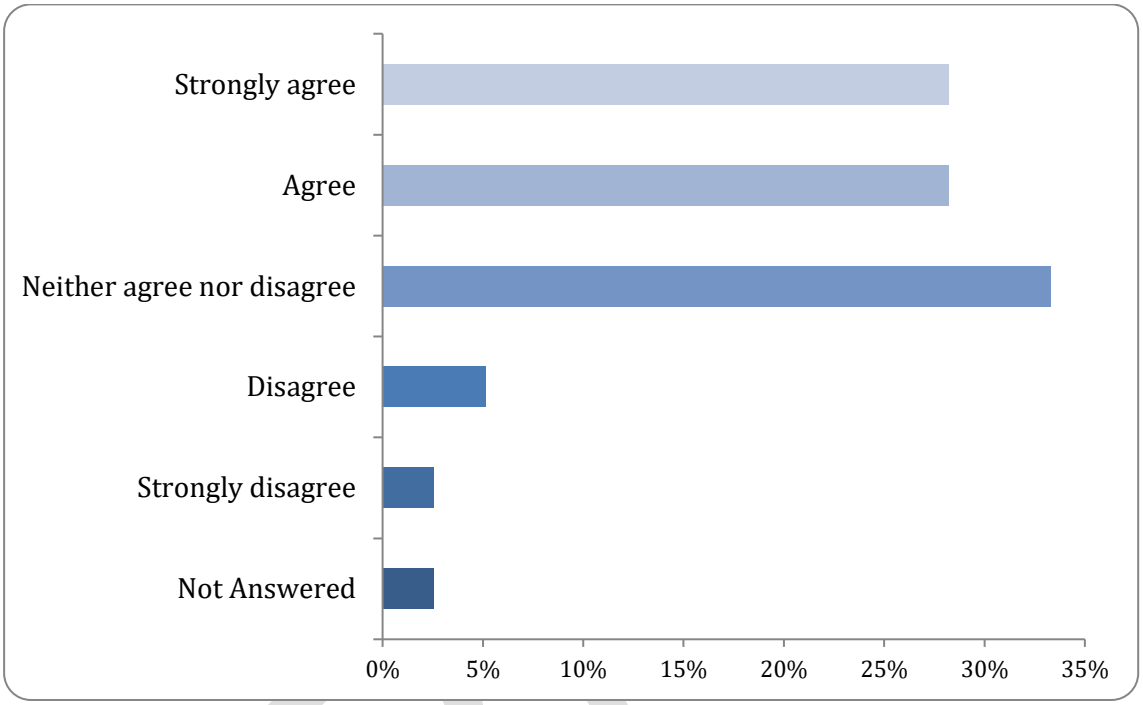
- The CDP should be terminated

Summary:

Agreement between some respondents that a partnership group will lead to more effective working. However, multiple respondents are concerned that the partnership group is too large for decisions to made effectively.

5: Havering Substance Misuse Strategy commits to promoting equality and meeting the needs of all communities, particularly those who have often not received an effective service in the past, including people from ethnic minority backgrounds and women. How far do you agree that this approach is reflected in the strategy?

97% of respondents answered this part of the question.



Option	Percent
Strongly agree	28.21%
Agree	28.21%
Neither agree nor disagree	33.33%
Disagree	5.13%
Strongly disagree	2.56%
Not Answered	2.56%

Themes in those who strongly agree:

- Anyone of any background can be affected by substance misuse
- Those who are most effected are often the ones not addressed by services, but this strategy does consider them

Themes in those who agree:

- Concern of missing those who are less able to engage, and need to have a robust evaluation to ensure we are actually including those less represented

Themes in those who are neither agree nor disagree:

- Concern of how will this be evaluated and actioned
- We should focus on each individual and the total population rather than prioritising any single group

Themes in those who disagree:

- Need for generational shift

Themes in those who strongly disagree:

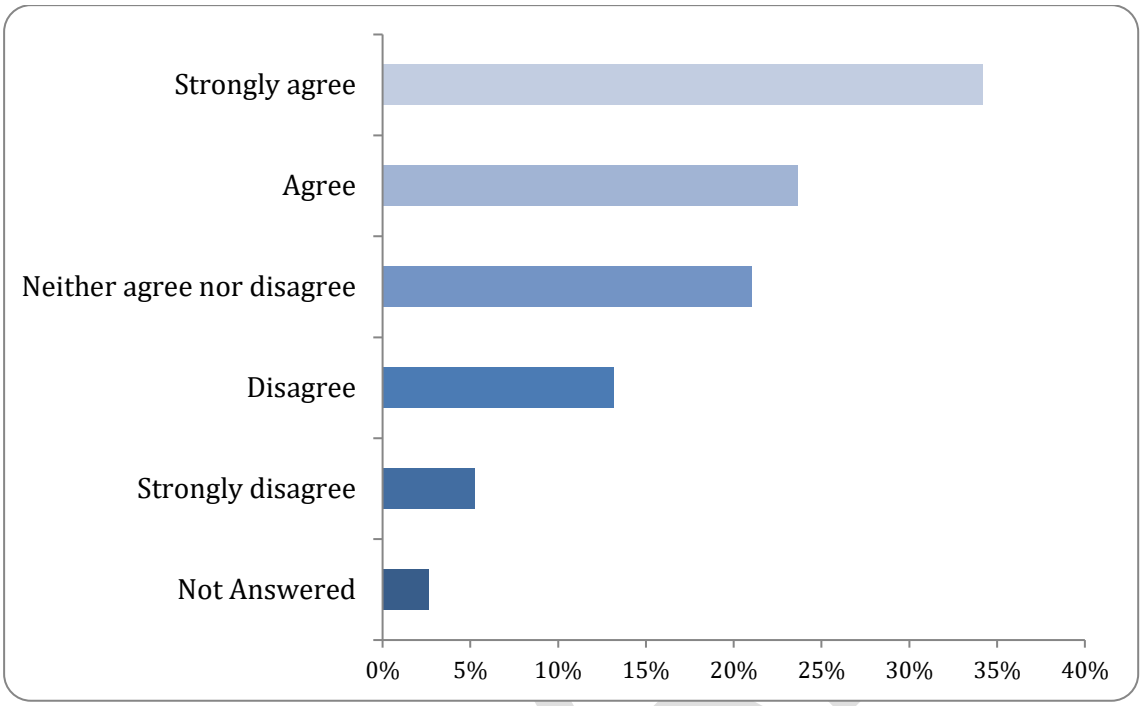
- Concern that strategy is waste of resources

Summary:

Multiple responses indicate concern of how this could be monitored and evaluated within the strategy; while other respondents share their view that we need a whole population and individual focused approach rather the prioritising an individual group.

6: Considering the proposed delivery plan of local and regional organisations working together to tackle the drug supply chains and problematic drinking, how far do you agree that this would be effective?

97% of respondents answered this part of the question.



Option	Percent
Strongly agree	34.21%
Agree	23.68%
Neither agree nor disagree	21.05%
Disagree	13.16%
Strongly disagree	5.26%
Not Answered	2.63%

Themes in those who strongly agree:

- Cross agency working is vital to success
- Combining budgets or working between boroughs to ensure effective action
- Emphasis on importance of enforcement and adequate police presence to support local people/businesses

Themes in those who agree:

- Cross agency working is vital to success, but needs proper support

Themes in those who are neither agree nor disagree:

- Concern that enforcement will be impossible with current resources
- Appropriate funding and support needed to ensure effectiveness

Themes in those who disagree:

- Concern strategy will not effectively target supply chains
- Enforcement does not lead to reduction in substance misuse

Themes in those who strongly disagree:

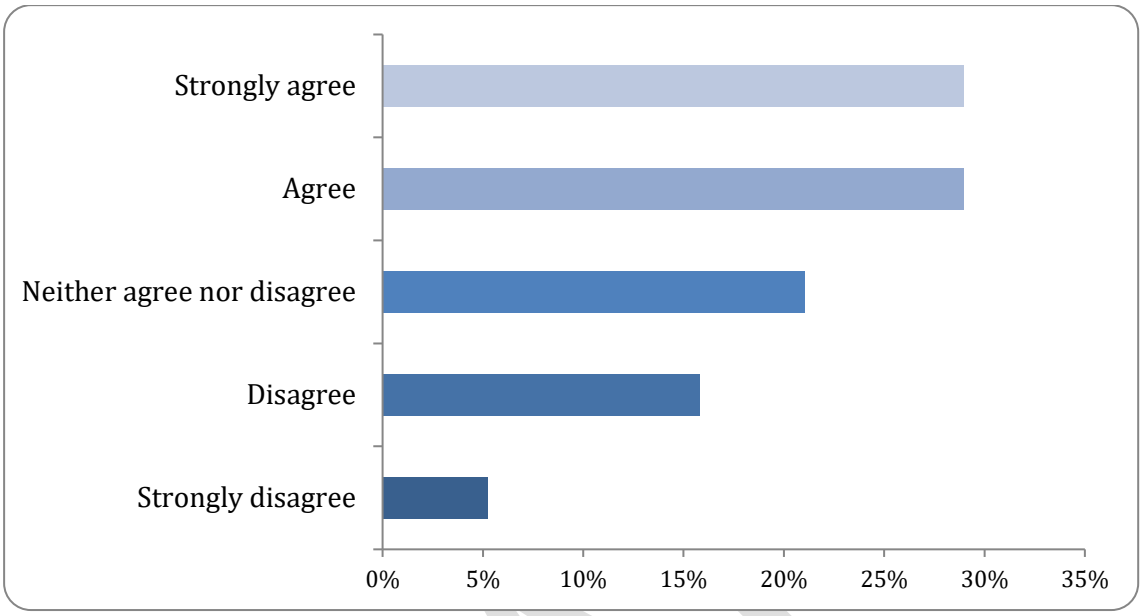
- Continued concern about funding capacity of council
- Concern that enforcement will not be effective

Summary:

Those in agreement with the strategy state that cross agency working is vital, but there is concern from across multiple respondents that enforcement may be ineffective, mainly due to a lack of resource.

7: Considering the proposed delivery plan of partners working together to deliver a world class treatment and recovery system, how far do you agree that this would be effective?

100% of respondents answered this part of the question.



Option	Percent
Strongly agree	28.95%
Agree	28.95%
Neither agree nor disagree	21.05%
Disagree	15.79%
Strongly disagree	5.26%
Not Answered	0.00%

Themes in those who strongly agree:

- Cross agency and partnership working will be effective
- We need to ensure service are well advertised
- Concern that partnership model can be difficult in practice
- Concern that we need to be monitoring and receptive to underserved populations

Themes in those who agree:

- Cross agency and partnership working will be effective
- Concern that mental health needs specific focus

Themes in those who are neither agree nor disagree:

- Concern that strategy does not consider the true complexity of the problem
- Value prevention, and stopping young people from starting
- Need to put resource into direct working, rather than advertising what council is doing

- Continued theme that model may be ineffective

Themes in those who disagree:

- Over ambitious, lack of resource for enforcement and for delivering service
- Lack of detail on how the system will be achieved
- Need to address wider determinants in order to truly create a positive impact

Themes in those who strongly disagree:

- Disagreement that wider determinants contribute to engagement with substance misuse; that becoming addicted is a choice

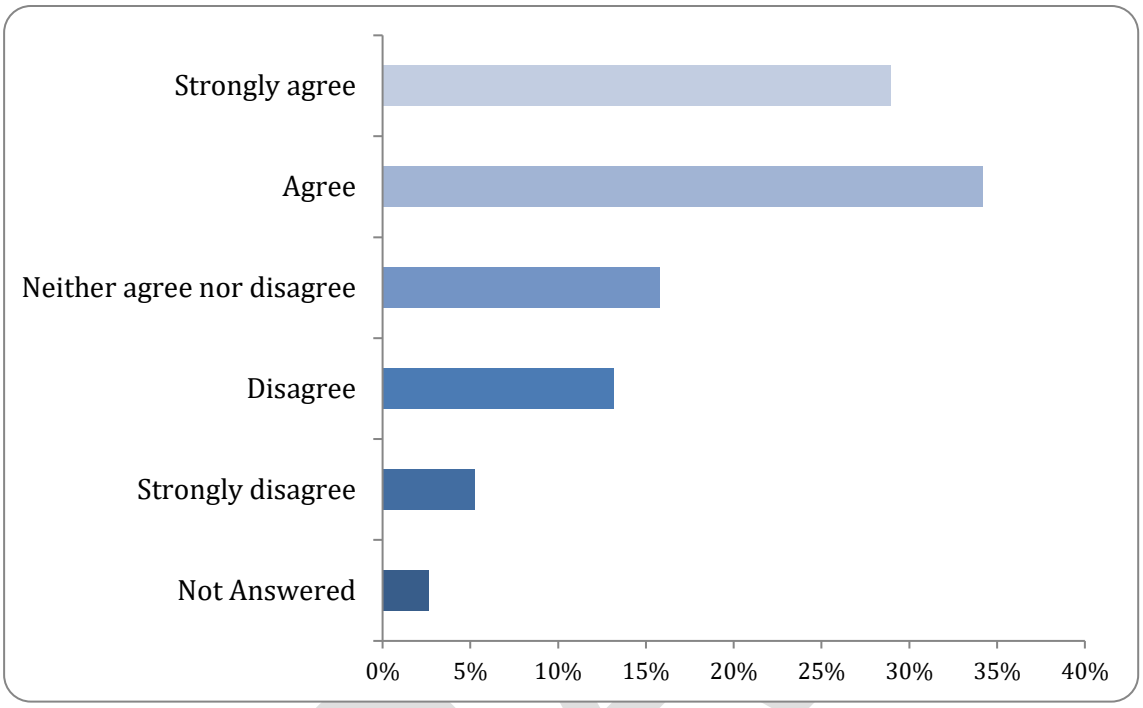
Summary:

Continued theme that some believe partnership working is likely to be effective, but needs to be done appropriately with adequate resourcing and organisation.

Concern that accomplishing a world class treatment and recovery system is over ambitious, and that we do not have the appropriate resource to accomplish the strategy aims.

8: Considering the proposed delivery plan of local and regional organisations working together to achieve a generational shift in the demand for drugs and alcohol misuse, how far do you agree that this would be effective?

97% of respondents answered this part of the question.



Option	Percent
Strongly agree	28.95%
Agree	34.21%
Neither agree nor disagree	15.79%
Disagree	13.16%
Strongly disagree	5.26%
Not Answered	2.63%

Themes in those who strongly agree:

- Benefit in partnership working
- Education is vital on consequences of substance misuse and emotional regulation
- Resource needed for support needed to young people affected by crime and substance misuse in their family and environment

Themes in those who agree:

- Agreement that education and support for young people is vital

Themes in those who are neither agree nor disagree:

- Concern that actions defined in strategy are never carried forward

Themes in those who disagree:

- Unlikely to shift a generations view on substance misuse

Themes in those who strongly disagree:

- Need for inclusion of spiritual institutions/support

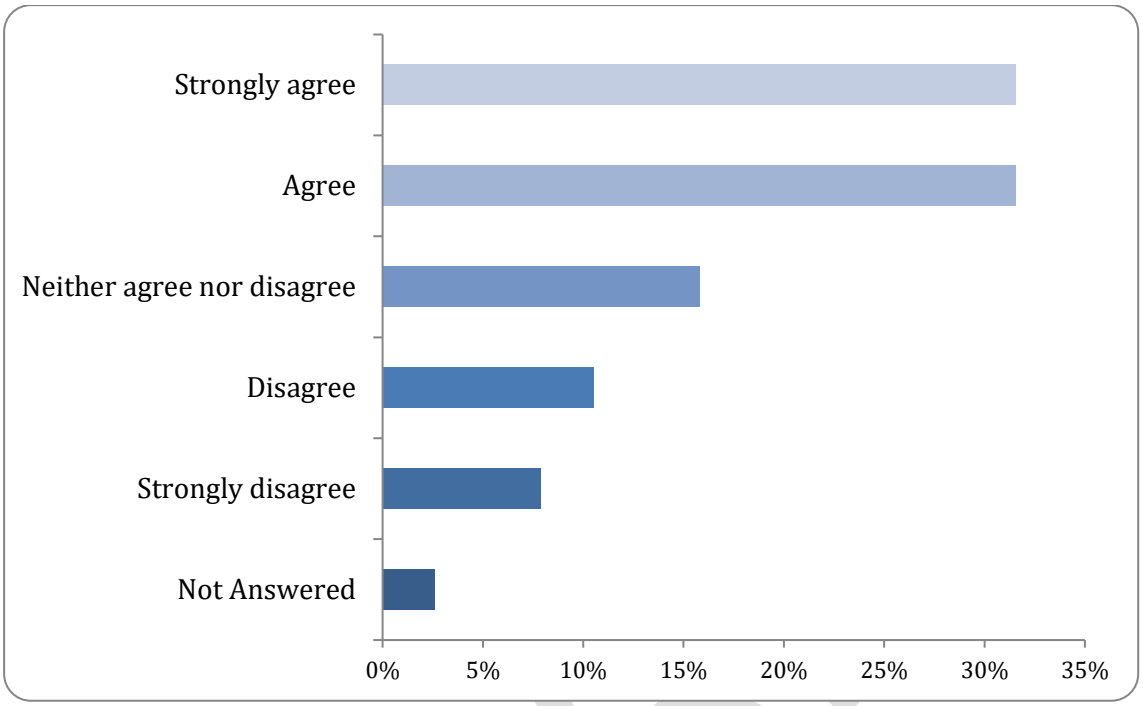
Summary:

Agreement on benefit of partnership working from a majority of respondents. Importance of education and exposure to young people's development and perceptions.

Concern that lack of resource will make this impossible to deliver, and a lack of faith expressed by a few respondents that effective action is ever undertaken.

9: Considering the proposed delivery plan of partners working together to reduce substance misuse risk and harm to individuals, families and communities, how far do you agree that this would be effective?

92% of respondents answered this part of the question.



Option	Percent
Strongly agree	31.58%
Agree	31.58%
Neither agree nor disagree	15.79%
Disagree	10.53%
Strongly disagree	2.63%
Not Answered	7.89%

Themes in those who strongly agree:

- Partnership working and listed actions will be effective, but that we need to ensure the actions are actually taken with individual organisations taking ownership and action

Themes in those who agree:

- Need to ensure partnership working embeds all organisations, and that there is cross-working/joint posts

Themes in those who are neither agree nor disagree:

- Agree with strategy, but lack of confidence that this will actually lead to meaningful action

Themes in those who disagree:

- Too many organisations involved for meaningful decision making

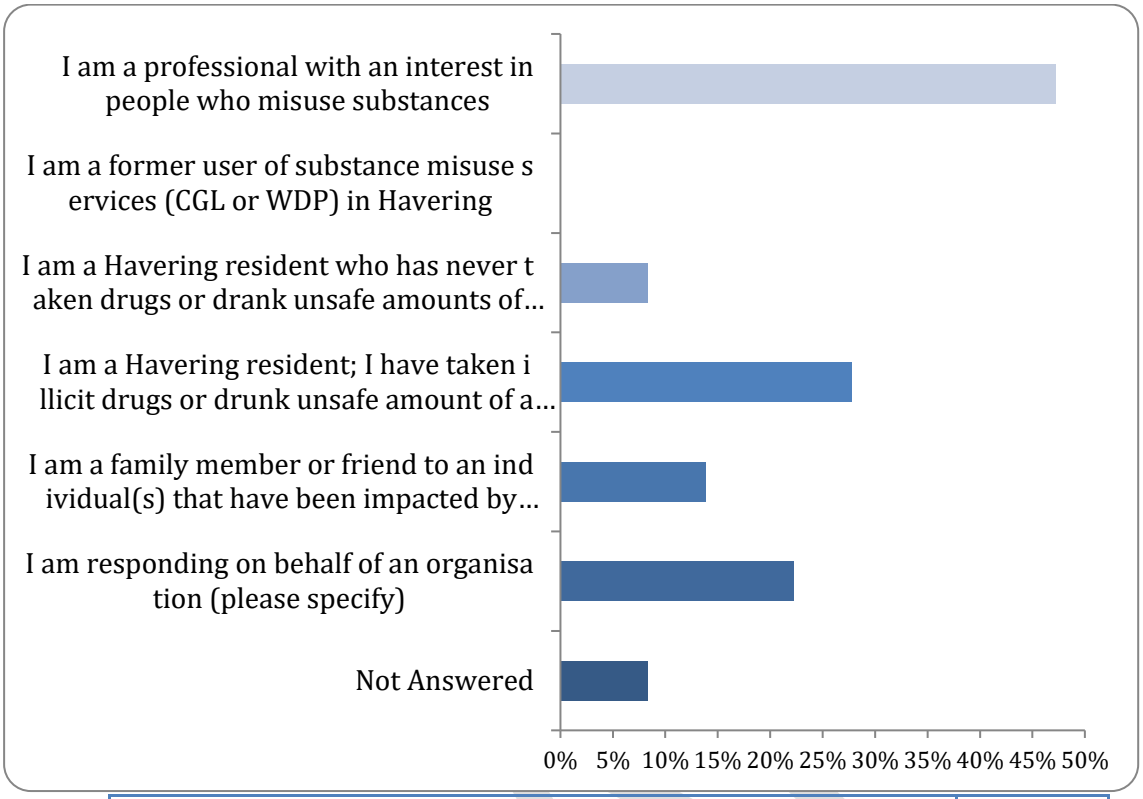
Themes in those who strongly disagree – No comments left with response

Summary:

Themes from those who agree that partnership working is necessary, but needs appropriate resource and execution. Lack of confidence that strategy will be put into effective practice.

10: Which of the following applies to you? (please select all that apply)

95% of respondents answered this part of the question.



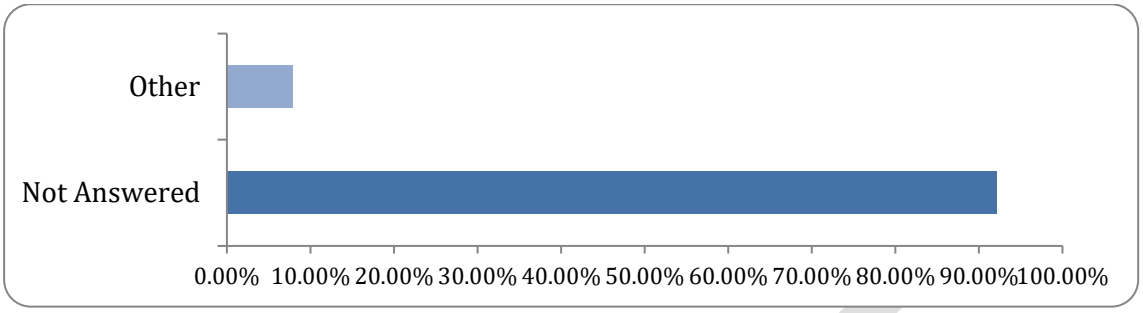
Option	Percent
I am a professional with an interest in people who misuse substances	47.22%
I am a current user of substance misuse services (CGL) in Havering	0.00%
I am a former user of substance misuse services (CGL or WDP) in Havering	8.33%
I am a Havering resident who has never taken drugs or drank unsafe amounts of alcohol	27.78%
I am a Havering resident; I have taken illicit drugs or drunk unsafe amount of alcohol but did not need or use treatment services	13.89%
I am a family member or friend to an individual(s) that have been impacted by drugs and/or alcohol	22.22%
I am responding on behalf of an organisation (please specify)	8.33%
Not Answered	5.56%

Organisations listed were:

- Havering council
- Mind in Havering, Barking & Dagenham
- CCC-FAITHVERSES
- NHS

- Myplace Harold Hill
- London South Bank University

Other origin



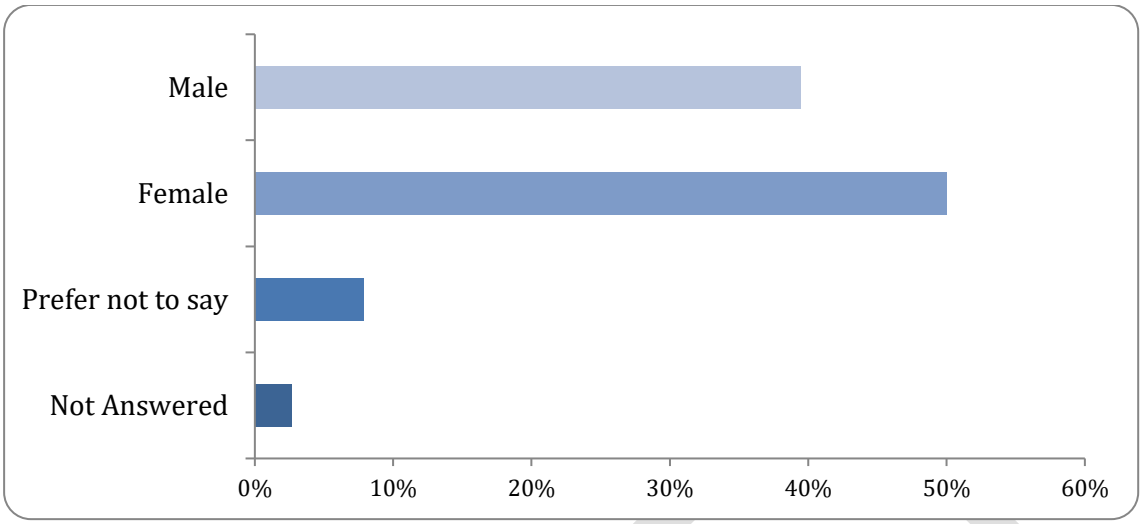
Option	Percent
Other	7.89%
Not Answered	92.11%

Other origins listed were:

- Nurse
- Former user of substance misuse in another borough, now living in Havering
- Ex-police officer

11: Are you / do you identify as

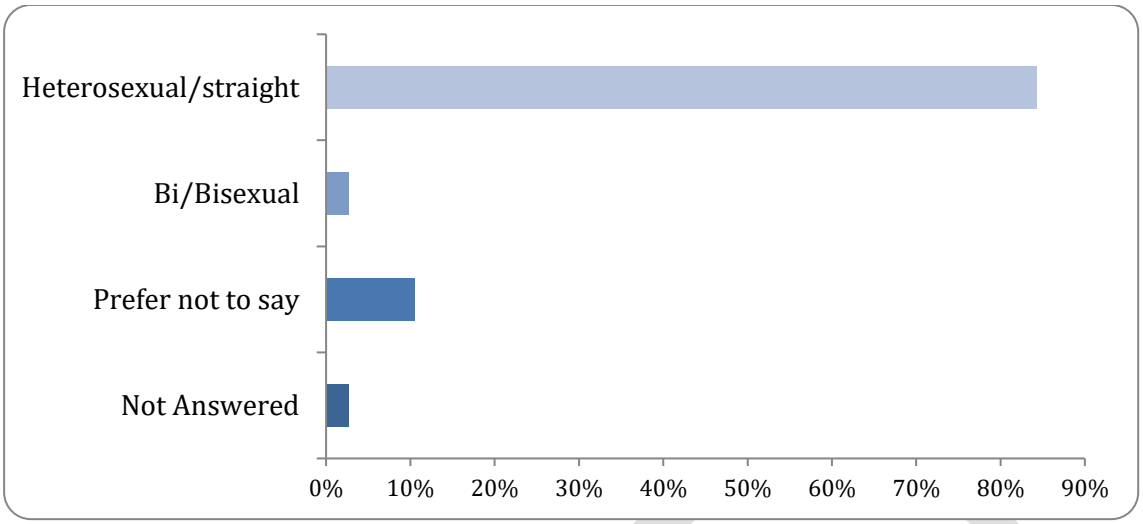
97% of respondents answered this part of the question.



Option	Percent
Male	39.47%
Female	50.00%
Other	0.00%
Prefer not to say	7.89%
Not Answered	2.63%

12: How would you describe your sexual orientation?

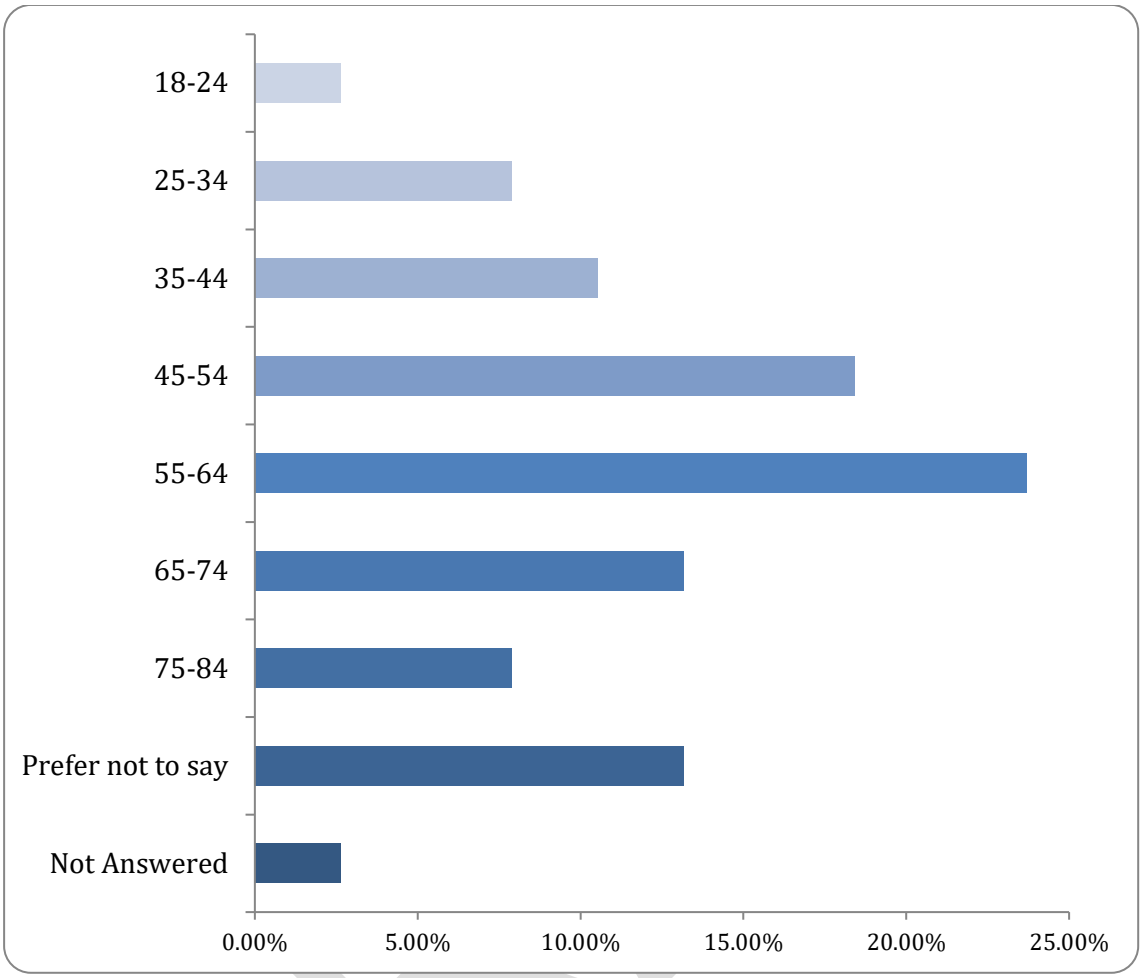
97% of respondents answered this part of the question.



Option	Percent
Heterosexual/straight	84.21%
Bi/Bisexual	2.63%
Gay man	0.00%
Gay woman/Lesbian	0.00%
Other	0.00%
Prefer not to say	10.53%
Not Answered	2.63%

13: What is your age group?

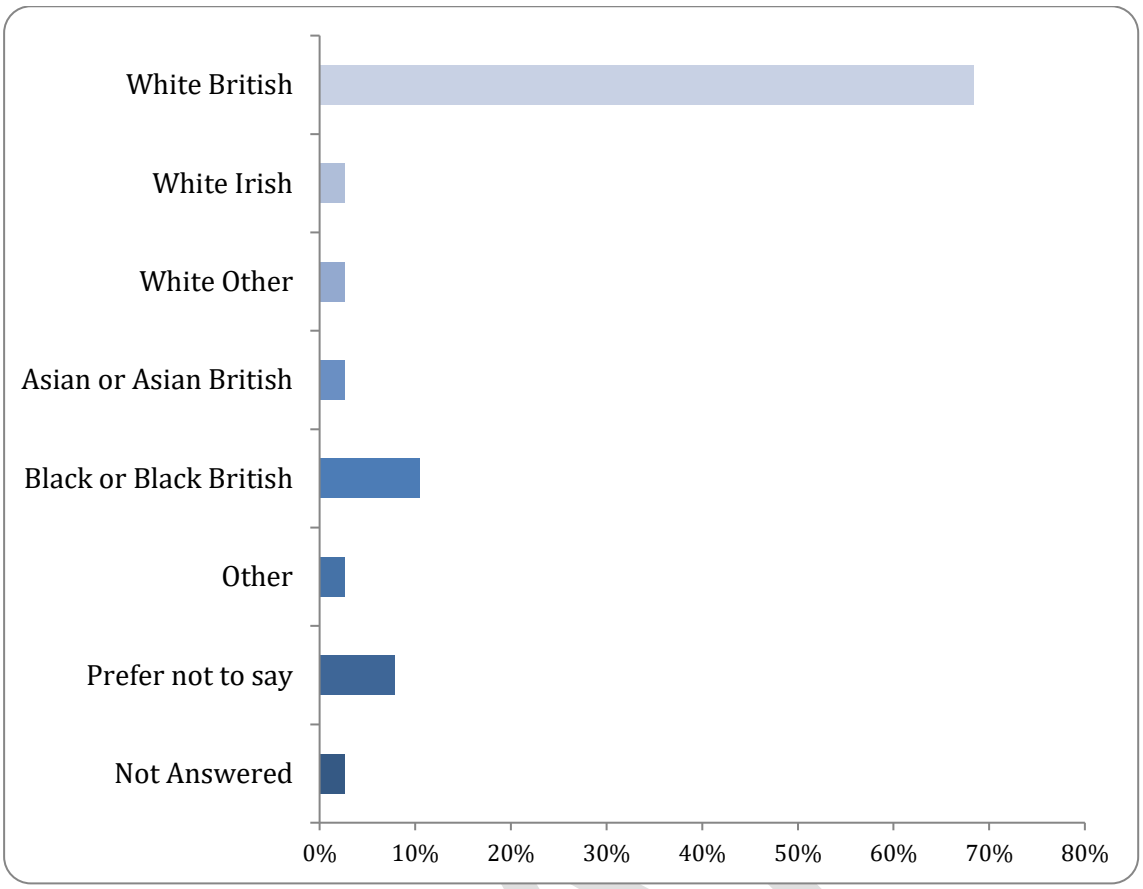
97% of respondents answered this part of the question.



Option	Total	Percent
Under 18	0	0.00%
18-24	1	2.63%
25-34	3	7.89%
35-44	4	10.53%
45-54	7	18.42%
55-64	9	23.68%
65-74	5	13.16%
75-84	3	7.89%
85 or older	0	0.00%
Prefer not to say	5	13.16%
Not Answered	1	2.63%

14: How would you describe your ethnic origin?

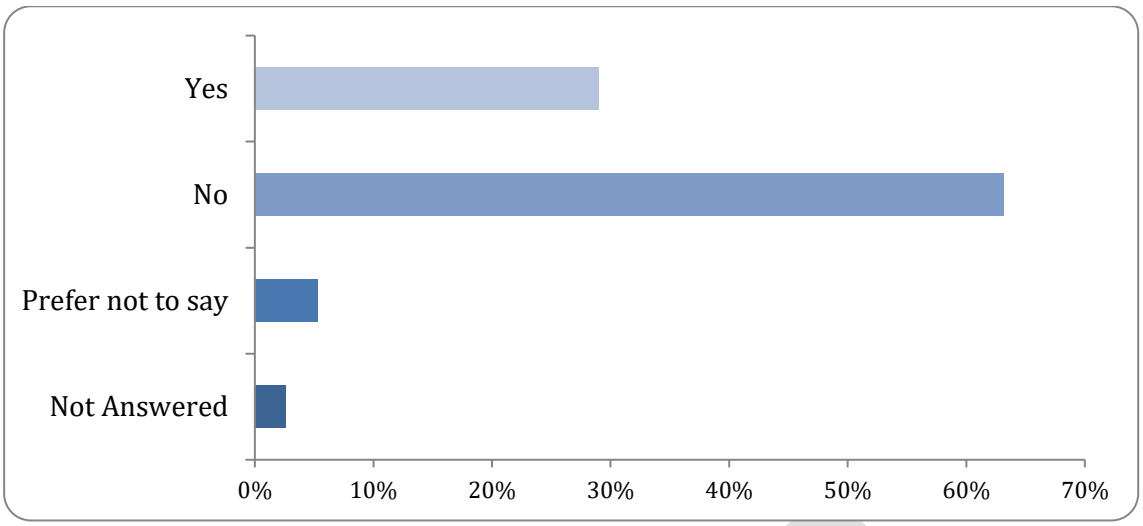
97% of respondents answered this part of the question.



Option	Percent
White British	68.42%
White Irish	2.63%
White Other	2.63%
Mixed	0.00%
Asian or Asian British	2.63%
Black or Black British	10.53%
Other	2.63%
Prefer not to say	7.89%
Not Answered	2.63%

15: Do you consider yourself to have a long-term illness, disability or health problem?

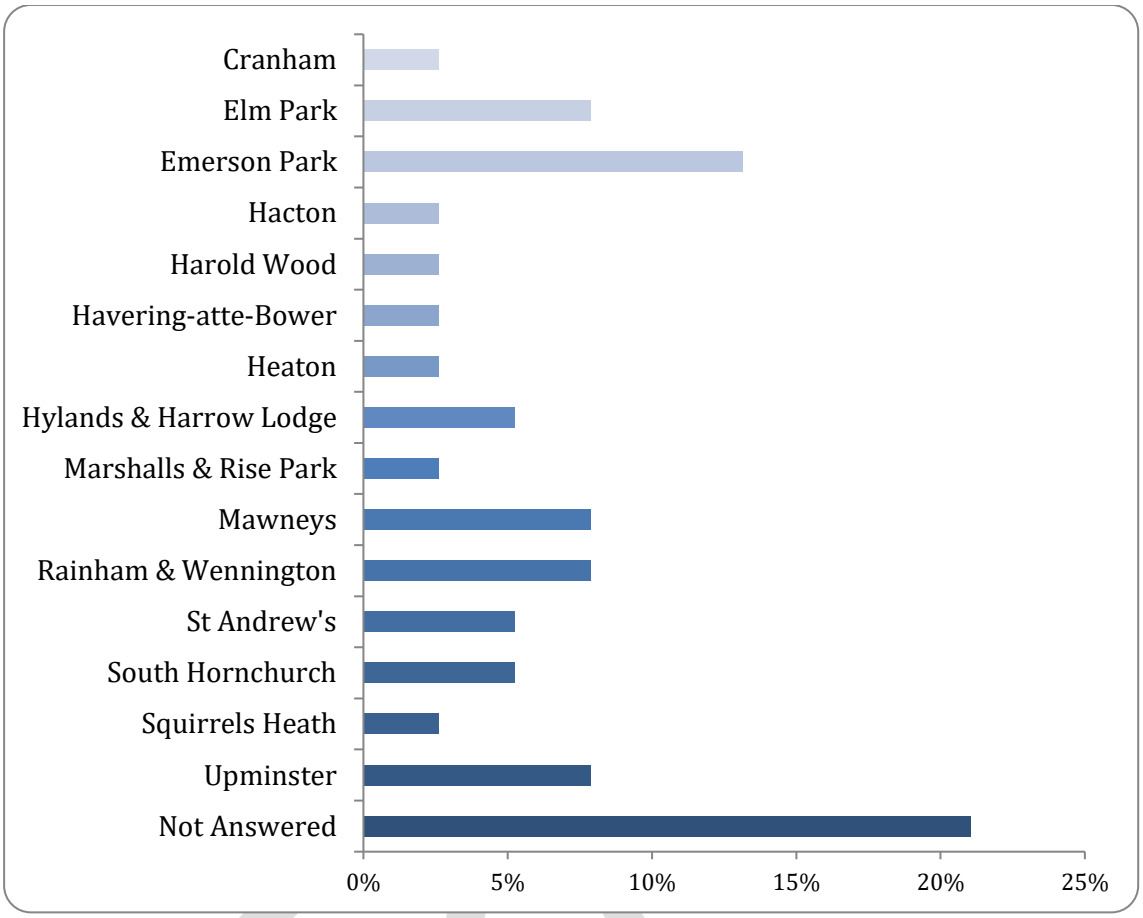
100% of respondents answered this part of the question.



Option	Percent
Yes	28.95%
No	63.16%
Prefer not to say	5.26%
Not Answered	2.63%

16: Where do you live?

79% of respondents answered this part of the question.



Option	Percent
Beam Park	0.00%
Cranham	2.63%
Elm Park	7.89%
Emerson Park	13.16%
Gooshays	0.00%
Hacton	2.63%
Harold Wood	2.63%
Havering-atte-Bower	2.63%
Heaton	2.63%
Hylands & Harrow Lodge	5.26%
Marshalls & Rise Park	2.63%
Mawneys	7.89%
Rainham & Wennington	7.89%
Rush Green & Crowlands	0.00%
St Alban's	0.00%
St Andrew's	5.26%
St Edward's	0.00%
South Hornchurch	5.26%
Squirrels Heath	2.63%

Upminster	7.89%
Not Answered	21.05%

Focus Groups:

Two focus groups were carried out; consisting of people with lived experience of substance misuse. Four former rough sleeps and eight current substance misuser service users were included over the two groups, for a total of 12 participants.

These were carried out to ensure those less able to engage with the online survey, and those who are currently using services, had their views captured for the consultation.

The following points were collated from both groups and headed under the themes of "The Main Challenges", "Current Good Practice", and "What Would Be Helpful", in order to give an overall view of the feedback:

The Main Challenges:

- **Awareness** of support services by professionals, employers and agencies
    - Lack of knowledge across all sectors that engage with substance misusers about what services are available and how to signpost

- **Access to Mental Health** services
    - There is a requirement to be sober before accessing mental health services, which acts as a barrier when substance misuse and mental health are often interdependent
    - No coordinated support arrival at Farringdon House

- **Stigma**
    - Lack of empathy from officers and support workers
    - Stereotyping, labelling and stigma towards the users
    - Fear of having children taken away or getting into trouble with the police if seek help for substance misuse

- **Delay in early interventions**

- **Barriers to housing and Primary Care**
    - It is important to have a fixed abode for stability, security and motivation to make positive choices
    - Not having this makes GP registration a challenge
    - The complex needs accommodation panel takes a lot of time

- **Access to Recovery (ATR) and Drug Rehabilitation Requirements (DRR)**
    - Many referrals were made without true motivation or proper vetting, resulting in breaches

Current Good Practice:

- **Farringdon house**
    - Multiple professional outreach
    - Social environment which allows peer support
    - Info and support on how to access useful services
    - Farringdon staff help with illiteracy or poor numeracy

What Would Be Helpful:

- **Training** across the agencies on addiction, stigma, who needs urgent referral, what services are available and how to signpost/refer
    - Should be included in the induction of relevant services for all involved staff, suggested were
        - Social services
        - Housing
        - Staff managing benefits system
        - NHS Receptionists
        - A&E staff
        - Job centre
    - Managers in large employers should have training to identify and support employees/colleagues with substance misuse issues
- **Improvement in services and enforcement:**
    - Better integration and coherency of services in their approach – across treating services, social services, and voluntary sector
    - Personal interaction at assessments to make it meaningful and useful
    - Effective use of criminal behaviour order
    - Effective assessment of mental competency
    - Easier GP access
    - Better working between police and rehabilitation services to reduce attrition
    - Improve dual diagnosis care and access to mental health support

    - Focus on early intervention services to reduce burden on already stretched services
- **Campaigning and communication**
    - Using social media messaging to highlight available support
    - Coloured envelopes instead of council logo to be friendlier
    - Improve visibility of services generally
    - Repeat “Just Say No” campaigns
- **Peer support and buddying**
- **Improvements in housing support:**
    - Segregation at homeless hostels to contain incidents early, with separate areas for ex-arsonists, ex-rapists and violent ex-convicts
    - Smaller housing units e.g. 4 beds at Farringdon house – 25 beds too large for effective care
    - Mental health service focused in Farringdon house
- **Taking community and person centered approaches**
    - There should be facilities to keep young people occupied, and help to prevent uptake of substances

Conclusion:

Overall, there is broad agreement with the strategy, but there are several areas of concern which will be responded to by the CDP, and the strategy will be updated where needed.

There were a relatively small number of responses to the survey, so to consider the feedback as representative of all residents is not possible. Throughout development of the strategy and implementation of its actions, there is a need to continue to engage with key stakeholders and be transparent to residents in the CDP's working. This should continue through the lifecycle of the strategy, to ensure the CDP continues to focus on the right initiatives.

Appendix – Consultation Questions

1: How far do you agree with the scope of the substance misuse strategy in Havering?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please tell us why you made this choice

2: How far do you agree with the four areas of priority aims of the substance misuse strategy?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please tell us why you made this choice

3: Did we involve all relevant organisations and services in drafting the strategy?

- Yes
- No
- Can't tell / Don't Know

If no, please name organisation(s) or group(s) missing and explain why you have chosen them.

4: Havering Combating Drugs Partnership (Havering CDP) will be monitoring the progress of the delivery plan quarterly, sharing with other partnership boards listed below and publishing an annual report for the public. How far do you agree with this approach?

- Strongly agree
- Agree
- Neither agree nor disagree

- Disagree
- Strongly disagree

Please tell us why you made this choice

5: Havering Substance Misuse Strategy commits to promoting equality and meeting the needs of all communities, particularly those who have often not received an effective service in the past, including people from ethnic minority backgrounds and women. How far do you agree that this approach is reflected in the strategy?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please tell us why you made this choice

6: Considering the proposed delivery plan of local and regional organisations working together to tackle the drug supply chains and problematic drinking, how far do you agree that this would be effective?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please tell us why you made this choice

7: Considering the proposed delivery plan of partners working together to deliver a world class treatment and recovery system, how far do you agree that this would be effective?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please tell us why you made this choice

8: Considering the proposed delivery plan of local and regional organisations working together to achieve a generational shift in the demand for drugs and alcohol misuse, how far do you agree that this would be effective?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please tell us why you made this choice

9: Considering the proposed delivery plan of partners working together to reduce substance misuse risk and harm to individuals, families and communities, how far do you agree that this would be effective?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please tell us why you made this choice

10: Which of the following applies to you? (please select all that apply):

- I am a professional with an interest in people who misuse substances
- I am a former user of substance misuse services (CGL or WDP) in Havering
- I am a Havering resident who has never taken drugs or drank unsafe amounts of alcohol
- I am a Havering resident; I have taken illicit drugs or drunk unsafe amount of alcohol but did not need or use treatment services
- I am a family member or friend to an individual(s) that have been impacted by drugs and/or alcohol
- I am responding on behalf of an organisation (please specify)
- Other

Your organisation details

If other origin, please specify

11: Are you / do you identify as

- Male
- Female
- Other
- Prefer not to say

12: How would you describe your sexual orientation?

- Heterosexual/straight
- Bi-Bisexual
- Gay man
- Gay woman/Lesbian
- Other
- Prefer not to say

13: What is your age group?

- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85 or older
- Prefer not to say

14: How would you describe your ethnic origin?

- White British
- White Irish
- White Other
- Mixed
- Asian or Asian British
- Black or Black British

- Other
- Prefer not to say

15: Do you consider yourself to have a long-term illness, disability or health problem?

- Yes
- No
- Prefer not to say

16: Where do you live?

- Beam Park
- Cranham
- Elm Park
- Emerson Park
- Gooshays
- Hacton
- Harold Wood
- Havering-atte-Bower
- Heaton
- Hylands & Harrow Lodge
- Marshalls & Rise Park
- Mawneys
- Rainham & Wennignton
- Rush Green & Crowlands
- St Alban's
- St Andrew's
- St Edward's
- South Hornchurch
- Squirrels Heath
- Upminster

Appendix 2: Equality Analysis

Equality & Health Impact Assessment (EHIA)

Document control red ***text (including this note) is for guidance and should be deleted from the actual EqHIA report.***

Title of activity:	*Combating Substance Misuse Strategy*
Lead officer:	*Anthony Wakhisi, Principal Public Health Specialist*
Approved by:	*Mark Ansell, Director of Public Health*
Version Number	**V0.2**
Date and Key Changes Made	*06/12/2023, Transfer of content to this new template*
Scheduled date for next review:	*December 2028*

Did you seek advice from the Corporate Policy & Diversity team? Please note that the Corporate Policy & Diversity and Public Health teams require at least **5 working days** to provide advice on EqHIAs.	Yes
Did you seek advice from the Public Health team?	Yes
Does the EqHIA contain any confidential or exempt information that would prevent you publishing it on the Council's website? See Publishing Checklist.	No

Please note that EqHIAs are **public** documents and unless they contain confidential or sensitive commercial information must be made available on the Council's EqHIA webpage.

Please submit the completed form via e-mail to READI@havering.gov.uk thank you.

1. Equality & Health Impact Assessment Checklist

Please complete the following checklist to determine whether or not you will need to complete an EqHIA and ensure you keep this section for your audit trail. If you have any questions, please contact READI@havering.gov.uk for advice from either the Corporate Diversity or Public Health teams. Please refer to **this Guidance** on how to complete this form.

About your activity

<table>
<tr><td>1</td><td>Title of activity</td><td colspan="3">Havering Combating Substance Misuse Strategy</td></tr>
<tr><td>2</td><td>Type of activity</td><td colspan="3">Multi-agency Strategy</td></tr>
<tr><td>3</td><td>Scope of activity</td><td colspan="3">This is a five year local strategy that aims at working with all partners to:
Break drug supply chains by disrupting the ability of gangs to supply drugs and seizing their cash, bringing perpetrators to justice, safeguarding and supporting victims
Deliver a world-class treatment and recovery system, including; improving access to support by tackling stigma, delivering efficient and effective treatment and recovery system based on a multi-disciplinary multi-agency integrated approach.
Achieve a generational shift in the demand for drugs, including; preventing substance misuse and addiction. Supporting research, service audit, and evaluation.
Reduce risk and harm to individuals, families and communities, including; reducing harm related to substance misuse and safeguarding the vulnerable from abuse and harm. Ensuring care and support for other family members (a Think Family approach)</td></tr>
<tr><td>4a</td><td>Are you changing, introducing a new, or removing a service, policy, strategy or function?</td><td>Yes</td><td rowspan="2">If the answer to <u>either</u> of these questions is ‘YES’, please continue to question 5.</td><td rowspan="3">If the answer to <u>all</u> of the questions (4a, 4b & 4c) is ‘NO’, please go to question 6.</td></tr>
<tr><td>4b</td><td>Does this activity have the potential to impact (either positively or negatively) upon people from different backgrounds?</td><td>Yes</td></tr>
<tr><td>4c</td><td>Does the activity have the potential to impact (either positively or negatively) upon any factors which determine people’s health and wellbeing?</td><td>Yes</td><td>Please use the Screening tool before you</td><td>If you answer ‘YES’, please continue to</td></tr>
</table>

			answer this question.	question **5**.	
5	**If you answered YES:**	**Please complete the EqHIA in Section 2 of this document.** Please see Appendix 1 for Guidance.			
6	**If you answered NO:**	*Please provide an explanation on why your activity does not require an EqHIA. This is essential, in case the activity is challenged under the Equality Act 2010.* *Please keep this checklist for your audit trail.*			

Completed by:	*Anthony Wakhisi, Principal Public Health Specialist, Public Health, London Borough of Havering*
Date:	*06/12/2023*

2. The EHIA – How will the strategy, policy, plan, procedure and/or service impact on people?

Background/context:

Drug use drives crime, damages people's health, puts children and families at risk and reduces productivity – it impacts all, with the most deprived areas facing the greatest burden. According to the UK Government estimates, drugs misuse costs society nearly £20 billion a year. Nearly 3,000 people tragically lose their lives through drug misuse related deaths in England & Wales each year.

In Havering, statistics show substance misuse remains a priority issue that requires a sustained integrated approach to tackle. Latest data show an increase of annual substance misuse related crime incidents. Cases have nearly tripled since 2016 from 388 to 1,084 in 2022. In 2022, 938 possession of drugs crimes and 146 drug trafficking crimes were reported in Havering.

Alcohol-related mortality among males has also been rising in the last three years with the latest data (2020) showing alcohol-related mortality in Havering (57/100,000) was higher than the London average (51/100,000).

It is estimated that there are more than two thirds (67%) opiate and /or crack users aged 15-64 in Havering not in treatment. Of concern also is that out of a total of 364 new adult presentations to treatment for substance misuse during 2019/20, 77 (21%) were parents or adults living with children.

The Havering Combating Substance Misuse Strategy has been drafted in response to the UK 10 year drugs strategy, 'From harm to hope: A 10-year drugs plan to cut crime and save lives' published in December 2021. It is based on best practice guidelines as outlined by the national strategy and includes specific performance indicators that will be monitored locally and reported to the central government. The strategy also utilises findings and recommendations from a comprehensive local drug and alcohol needs assessment carried out in 2022.This new strategy will replace Havering Drug and Alcohol Harm Reduction Strategy 2016-19, the review of which was delayed due to the COVID-19 pandemic.

Vision

The five year strategy's vision is; *reduced drug and alcohol misuse in Havering alongside effective local services that support and safeguard users, families, and communities from the harms of addiction.*

Aim

The aim is to work with all partners to:

- Break drug supply chains by disrupting the ability of gangs to supply drugs and seizing their cash, bringing perpetrators to justice, safeguarding and supporting victims

- Deliver a world-class treatment and recovery system, including; improving access to support by tackling stigma, delivering efficient and effective treatment and recovery system based on a multi-disciplinary multi-agency integrated approach.
- Achieve a generational shift in the demand for drugs, including; preventing substance misuse and addiction. Supporting research, service audit, and evaluation.
- Reduce risk and harm to individuals, families and communities, including; reducing harm related to substance misuse and safeguarding the vulnerable from abuse and harm. Ensuring care and support for other family members (a Think Family approach)
- Reduce drug and alcohol misuse in Havering alongside effective local services that support and safeguard users, families, and communities from the harms of addiction.

Objectives

Specific objectives include:

- To support more young people to resist drug and alcohol misuse
- To reduce drug dealing activities
- To find county lines in North East London and ensure they are closed.
- Increase the number of people seeking advice, support and treatment
- Increase treatment and recovery capacity
- Ensure there is a treatment place for every offender with an addiction
- Ensure support for dual diagnoses- substance misuse, alcohol misuse, learning difficulty or mental health concerns
- Reduce number of substance misuse related hospital admissions
- Ensure physical and mental health conditions of individuals with substance misuse problems are managed by relevant services without waiting to complete substance misuse treatment
- Ensure more people achieve long-term recovery from substance dependency
- Ensure more people recovering from addiction are in sustained employment and in stable and secure housing
- Ensure more families are supported; fewer children taken into care
- Reduce mortality due to substance misuse

Local Strategic Outcomes

Expected outcomes from the implementation of the new strategy include:

- A greater collaboration among members in delivering services that will lead to improved multi-agency working arrangements including the formalisation of previous loose and informal arrangements
- Increased referrals from police, courts and probation into drug treatment
- Improved co-ordination of relevant local services leading to improved delivery of services including easier information sharing and access to information
- Involvement of service users and frontline professionals in the development of the local strategy and associated plans leading to a wider co-operation and ownership of local plans and services
- Service expansion to deliver new high-quality drug and alcohol treatment places
- More people recovering from addiction in sustained employment, stable and secure housing

Stakeholders

The implementation of the strategy will be overseen by representatives of key stakeholders who have been active participants in the development process. This is group is known as the Havering Combating Drugs Partnership (CDP) which was established in August 2022. Below is the list of member organisations and representatives:

Member organisations/representatives of the Havering Combating Drugs Partnership

• LB Havering Public Health • LB Havering Elected member representatives for adults and children services • LB Havering Public Involvement Lead & Communities • Community Safety Partnership and Crime Prevention • Police and Crime Commissioner • Metropolitan Police • Probation Service Representative • Integrated Offender Management and Serious Group Violence • CGL • NELFT • BHRUT A&E • Healthwatch	• LB Havering Housing • Jobcentre Plus / DWP • LB Havering Adult Social Care • LB Havering Children Services • LB Havering Early Help • Schools and Education • Safeguarding Board • NHS NEL ICB • Local Pharmaceutical Committee • GP Representative • Voluntary Care Sector • Youth Justice Board • Service User with Lived Experience • Independent Domestic Violence Advocate • LB Havering Licensing Team • LB Havering Communications

Who will be affected by the activity?

All Havering residents including those directly or indirectly affected by substance misuse and service providers

**Expand box as required*

Protected Characteristic - Age: Consider the full range of age groups

Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	The impacts of substance misuse and resultant addiction are multigenerational and multidimensional, cut across all age groups and go beyond the relatively small cohort with dependency problems.
Neutral		
Negative		Substance misuse drives criminal behaviour, from domestic violence, antisocial behaviour and acquisition crime to sexual exploitation, slavery and gang violence.

		Hence, the partners in Havering will work together to implement programmes that consider unique risk factors and treatment needs at various life stages and age groups (children and young people, working age group and older adults). These broadly include; breaking drug supply chains, delivering a world-class treatment and recovery system, achieving a generational shift in the demand for drugs and reducing risk and harm to individuals, families and communities **Expand box as required*

Evidence:

According to the latest census report (2021), Havering's resident population is estimated to be 262,000. This represents a growth by approximately 24,800 (10.4%) since the last census in 2011. Compared to the last census done a decade ago (2011), the 2021 Census shows the number of children aged under 18 in Havering has seen an increase of 15.2% (from 50,827 to 58,550), greatly outpacing the 4.8% and 3.9% increases in London and England, respectively.

Havering now has a higher proportion of children aged 0-17 (22.3%) than 80% of local authorities in England. The ONS predicts that the 0-17 population will grow to 61,350 by 2031. This is a vulnerable group at high risk of engaging in substance misuse due to their increased interaction with social media some of which appear to promote substance misuse and facilitate easy access.

Furthermore, Havering still has one of the highest proportions of older people aged 65+ in London (second after Bromley). The combined impact of having both a large older population and now a large (and growing) young population is that Havering now has the lowest proportion of working-age adults in London.

Evidence shows there is a growing trend of substance misuse especially alcohol among older people. Furthermore, chronic health conditions tend to develop as part of aging, and older adults are often prescribed more medicines than other age groups, leading to a higher rate of exposure to potentially addictive medications.

**Expand box as required*

Sources used:

Havering Substance Misuse Needs Assessment 2022

Havering Intelligence Hub – Population Intelligence Briefings

Census - Office for National Statistics (ons.gov.uk)

The Influence of Social Media on Teen Drug Use - Addiction Center

Substance Use in Older Adults DrugFacts | National Institute on Drug Abuse (NIDA) (nih.gov)

**Expand box as required*

Protected Characteristic - Disability: Consider the full range of disabilities; including physical, mental, sensory and progressive conditions		
Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	The strategy through its defined priority areas will work with other partners to ensure people living with disability are aware of and can easily access available substance misuse services.
Neutral		
Negative		The strategy has prioritised improvement of dual diagnosis care pathways in implementation of the strategy which includes holistic provision of care for mental and physical health needs alongside substance use. One of the key aims of the Havering CSM strategy is to reduce risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm including people living with disability. Through collaboration with partners, social, economic, and health factors associated with disability which are also risk factors for substance misuse and addiction will be addressed. Disability stigma and stereotypes that are common around substance use by disabled people and their ability to engage in treatment and recovery have also been highlighted and are included in the joint action plans. **Expand box as required*

Evidence:

According to census 2021, there are an estimated 38,449 residents living with mental and physical disability. This is equivalent to 15.3%, of the total Havering population. This is slightly lower than London (15.6%) and England (17.7%) averages.

In 2021 and 2022, a total of 379 adults with dual diagnosis (mental illness and substance misuse) were referred to the Havering treatment service (CGL) from NELFT.

Disabilities and addiction can tragically be a common pair. People with disabilities are substantially more likely to suffer from substance use disorders (SUDs) than the general population, and they are also less likely to receive treatment for them. The inverse can also be true. People with an addiction are also more likely to become disabled, either through accidental injury or through long-term side effects of substance abuse.

A disability and lack of support can easily discourage someone's happiness and sense of purpose in life, creating depressing states. Co-occurring disorders, like depression, anxiety, and unhealed trauma, are especially common among disabled persons, leading many to seek a false sense of comfort with harmful substances.

Individuals with mental and physical disabilities battle unique stressors, such as social perspectives that see them as outsiders, an inability to qualify for certain careers, access to certain benefits, and an inability to participate in a number of activities to the extent that they would like.

Individuals with disabilities are more likely to be unemployed; disabled adults 25 and older are less likely to have completed high school and more likely to live in poverty. They are more likely to be victims of violent crimes and struggle with health conditions like obesity and smoking. All of these factors contribute to the high rates of substance use seen in the disabled community.

The complex interplay of social, economic, and health factors associated with disability are also risk factors for substance use, unhealthy use, and addiction. Disability stigma and stereotypes are common around substance use by disabled people and their ability to engage in treatment and recovery.

Attitudes, discriminatory policies or practices, communications, and physical constraints reflect ableism and affect the ability of people with disabilities to enter addiction treatment. Once treatment is initiated, success can be maximized by meeting specific disability-related needs. For people with physical and sensory disabilities, if physical accessibility and communications accommodations are met, success in addiction treatment presumably should parallel that of people without these disabilities. For people with intellectual, developmental, and cognitive disabilities, success may require additional adaptations.

Promising approaches exist but cross-systems training and collaboration is essential. By reducing ableism, misbeliefs, and stigma and offering flexible treatment approaches along with the required accommodations, people with disabilities who also have addiction should be supported in reducing unhealthy substance use and in their paths to recovery.

**Expand box as required*

Sources used:

Havering Substance Misuse Needs Assessment 2022

Havering Intelligence Hub – Population Intelligence Briefings

Census - Office for National Statistics (ons.gov.uk)

Aspire - Havering | Change Grow Live

Health_inequalities_substance_misuse (2).pdf

Intersection of Disability With Substance Use and Addiction | Oxford Research Encyclopedia of Global Public Health

NDTMS, the national monitoring system: https://www.ndtms.net/

**Expand box as required*

Protected Characteristic - Sex/gender: Consider both men and women		
Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	Evidence shows the prevalence of substance misuse is higher among males than females. However, the impacts of substance misuse cut across all genders and go beyond the relatively small cohort with dependency problems. Substance misuse drives criminal behaviour, from domestic violence, antisocial behaviour and acquisition crime to sexual exploitation, slavery and gang violence. Through partnership working agreed actions will be implemented that address gender specific risk factors and treatment needs. The four priority areas designed to guide this process include; breaking drug supply chains, delivering a world-class treatment and recovery system, achieving a generational shift in the demand for drugs and reducing risk and harm to individuals, families and communities **Expand box as required*
Neutral		
Negative		

Evidence:
According to the 2021 Census, there are approximately 262,052 people living in Havering. Of this, 52% (135,668) are females and 48% (126,384) are males.

Evidence shows the prevalence of substance misuse is higher among males than females. For example, CGL data shows in 2022 there were 277 adult males in treatment as compared to 172 women.

Latest data also shows in 2020/21 the Havering rate of male hospital admissions due alcohol related conditions (1931/100,000) was nearly four times that of females (562/100,000).

Evidence also shows men are more likely than women to use almost all types of illicit drugs and illicit drug use is more likely to result in emergency department visits or overdose deaths for men than for women. However, the impacts of substance misuse cut across all gender and go beyond the relatively small cohort with dependency problems.

**Expand box as required*

Sources used:

Havering Substance Misuse Needs Assessment 2022

Havering Intelligence Hub – Population Intelligence Briefings

Census - Office for National Statistics (ons.gov.uk)

Aspire - Havering | Change Grow Live

Public health profiles - OHID (phe.org.uk)

Substance Use in Women Research Report: References | NIDA (nih.gov)

**Expand box as required*

Protected Characteristic - Ethnicity/race: Consider the impact on different ethnic groups and nationalities		
Please tick (✓) the relevant box:		**Overall impact:** The strategy through its defined priority areas will work with other partners to ensure people of all ethnic backgrounds are aware of and can easily access available substance misuse services without feeling discriminated on racial basis. One of the key aims of the Havering CSM strategy is to reduce risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm. Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by any ethnic group which are also risk factors for substance misuse and addiction. The strategy as specified in action plans, will also identify and address substance misuse related stigma and stereotypes that may be prevalent in some ethnic groups to enhance their ability to engage in treatment and recovery. **Expand box as required*
Positive	✓	
Neutral		
Negative		

Evidence:
According to the 2021 Census, there are approximately 262,052 people living in Havering. White British remains the most common ethnic group in Havering, with 66.5% (174,232) of the population identifying in this group. The next most common ethnic group is Asian, accounting for 10.7% (28,150). Table below shows the ethnic breakdown in Havering according to 2021 census.

Ethnic Group	**Havering (Number)**	**Havering (%)**
Asian, Asian British or Asian Welsh	28150	10.7
Black, Black British, Black Welsh, Caribbean or African	21567	8.2
Mixed or Multiple ethnic groups	9747	3.7
White	197314	75.3
Other ethnic group	5274	2.0

As of September 2022 the majority of patients in CGL treatment were White (298) followed by Black (22) and Asian (15). This is consistent with the Havering ethnic demographic profile.

Evidence shows drug use is generally proportionally greater amongst white communities than minority ethnic groups in the UK but this may change as young people become more absorbed into predominant national culture with the potential for increasing drug problems in these communities. The extreme social stigma associated with drug use in some ethnic groups may also lead to under-estimation of problems and inhibit service provision.

Evidence shows that ethnicity influences health outcomes via multiple routes. For example, experiences of discrimination and exclusion as well as the fear of such negative incidents, can have a significant impact on mental and physical health.

Health-related practices, including healthcare-seeking behaviours, also vary between ethnic groups. Just as importantly, there are marked ethnic differences regarding the wider determinants of health. Taken together these factors result in a complex picture such that some minority ethnic groups appear to have better health status than the White British population and some much worse; with the pattern differing with life stage, disease and risk factor.

Hence, it is difficult and potentially misleading to make generalisations. Nonetheless some groups, notably individuals identifying as Gypsy or Irish Traveller, and to a lesser extent those identifying as Bangladeshi, Pakistani or Irish, stand out as having poor health across a range of indicators.

**Expand box as required*

Sources used:

Havering Substance Misuse Needs Assessment 2022

Havering Intelligence Hub – Population Intelligence Briefings

Census - Office for National Statistics (ons.gov.uk)

Aspire - Havering | Change Grow Live
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf

Policy report - Drugs and diversity_ ethnic minority groups (policy briefing).pdf (ukdpc.org.uk)

**Expand box as required*

Protected Characteristic - Religion/faith: Consider people from different religions or beliefs including those with no religion or belief

Please tick (✓) the relevant box:	
Positive	✓
Neutral	
Negative	

Overall impact:

The impacts of substance misuse and resultant addiction are multidimensional and cut across all religions going beyond the relatively small cohort with dependency problems.

Through the combating substance misuse partnership, the strategy is committed to working with all faith groups in Havering in prevention of substance misuse, treatment, recovery and rehabilitation of affected persons.

The strategy as specified in action plans, will also identify and address stigma and stereotypes that may be prevalent in any religious groups to enhance their ability to engage in treatment and recovery.

**Expand box as required*

Evidence:

According to Census 2021, the most commonly reported religion in Havering is Christian, with 52.2% of the total population in 2021 describing themselves as Christian. This is a reduction from 65.6% in 2011. No religion was the second most common response, with 30.6% identifying in this category, up from 22.6% in 2011. Other religions Accounted for 11.7% of the total Havering population.

Religion and Faith's relationship with substance misuse largely point to the instrumental contribution of these groups to substance abuse prevention and recovery. A large majority of cases show that religious and spiritual beliefs and practices lead to lower levels of substance abuse, including reduced likelihood of using various drugs, in the course of a lifetime.

Among people recovering from substance abuse, some evidence shows that higher levels of religious faith and spirituality are associated with several positive mental health outcomes, including more optimism about life and higher resilience to stress, which may help contribute to the recovery process.

Addiction recovery doesn't have to include religious elements to be effective. However, spiritual practices can be beneficial to many people in recovery.

**Expand box as required*

Sources used:

Havering Substance Misuse Needs Assessment 2022

Havering Intelligence Hub – Population Intelligence Briefings

Census - Office for National Statistics (ons.gov.uk)

Belief, Behaviour, and Belonging: How Faith is Indispensable in Preventing and Recovering from Substance Abuse - PMC (nih.gov)

Religious faith and spirituality may help people recover from substance abuse (apa.org)
Is Religion A Necessary Part of Drug and Alcohol Addiction Recovery? (therecoveryvillage.com)

**Expand box as required*

Protected Characteristic - Sexual orientation: Consider people who are heterosexual, lesbian, gay or bisexual		
Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	Evidence shows the prevalence of substance misuse is higher among lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) persons. However, the impacts of substance misuse cut across all sexual orientations and go beyond the relatively small cohort with dependency problems. Through partnership working agreed actions will be implemented that that will address identified risk factors and barriers to treatment and recovery associated with members of LGBTQ+ community.
Neutral		
Negative		

		Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by the LBGTQ+ community as this are known risk factors for substance misuse and addiction. The strategy as specified in action plans, will also identify and address sexual orientation related stigma to enhance LGBTQ+ person's ability to engage in treatment and recovery. **Expand box as required*

Evidence:

There are approximately 4,000 people in Havering identifying as either gay, lesbian or bisexual. This a significant number but proportionately less than the London and England averages.

Table: Estimated number and percentage of persons by sexual orientation, Havering, London and England

Sexual Orientation	Number	%	London	England
Heterosexual or straight	201,700	97.2%	88.9%	93.3%
Gay or lesbian	2,800	1.3%	2.6%	1.6%
Bisexual	1,100	0.5%	1.2%	1.1%
Other	-		0.7%	0.7%
Don't know or refuse	1,200	0.6%	6.5%	3.3%

According to the Havering CGL records 22 people in treatment identified themselves as LGBTQ+ in 2022. Evidence shows substance misuse is a significant problem among members of the LGBTQ+ community. From alcohol abuse and binge drinking to the use of harder drugs like methamphetamines, heroin, and opioids, many people in the sexual minority struggle with addiction.

Statistics show that LGBTQ+ adults are more than twice as likely as their heterosexual counterparts to use illicit drugs and almost twice as likely to suffer from a substance abuse disorder. There are many contributing factors to the high prevalence. These include; discrimination and social stigma, bullying, harassment and being victims of hate crimes. They also lack support as many choose to keep their sexual identity secret to avoid discrimination. Living this type of double life can create feelings of loneliness and anxiety.

LGBTQ+ persons who do choose to come out often face rejection from family and friends, and as a result often turn to substance abuse to help dull the pain. For those suffering from internalized homophobia, alcohol and drugs serve as a mechanism for silencing negative thoughts.

**Expand box as required*

Sources used:

Havering Substance Misuse Needs Assessment 2022

Office for National Statistics: Annual Population Survey

Aspire - Havering | Change Grow Live

Medley, G., Lipari, R.N., Bose, J., Cribb, D.S., Kroutil, L.A., &McHenry, G.. (2016). Sexual Orientation and Estimates of Adult Substance Use and Mental Health: Results from the 2015 National Survey on Drug Use and Health

**Expand box as required*

Protected Characteristic - Gender reassignment: Consider people who are seeking, undergoing or have received gender reassignment surgery, as well as people whose gender identity is different from their gender at birth

Please tick (✓) the relevant box:	
Positive	✓
Neutral	
Negative	

Overall impact:
Gender reassignment is not currently captured in local drug and alcohol treatment data, but evidence shows it is a major risk factors for substance use.

To ensure substance use treatment services are inclusive, gender identity will be recorded and targeted interventions implemented.

Through partnership working identified risk factors and barriers to treatment and recovery associated with transgender persons will be addressed.

Through collaboration with partners the social, economic, and health inequalities experienced by transgender persons will be identified and tackled as these are known risk factors for substance misuse and addiction.

The strategy as specified in action plans, will also identify and address any gender reassignment stigma within services to enhance their ability to engage in treatment and recovery.

**Expand box as required*

Evidence:

According to Census 2021 data there are over 1,000 residents aged over 16 in Havering who can be classified as transgender.

Detailed breakdown of gender identity in Havering for residents aged 16 and over

Gender Identity	Number	Percentage
Gender identity the same as sex registered at birth	196,462	93.67%
Gender identity different from sex registered at birth but no specific identity given	528	0.25%
Trans woman	228	0.11%
Trans man	212	0.10%
Non-binary	60	0.03%
All other gender identities	39	0.02%
Not answered	12,201	5.82%
Total	209,730	100.00%

Gender reassignment is not currently captured in local drug and alcohol treatment data, but evidence shows it is a major risk factors for substance use. Minority stress theories suggest that high rates of discrimination experienced by transgender people are precipitants of substance use. This risk is likely exacerbated by an inadequate provision of trans-inclusive substance misuse services.

**Expand box as required*

Sources used:

Census - Office for National Statistics (ons.gov.uk)

Prevalence and correlates of substance use among transgender adults: A systematic review - PubMed (nih.gov)

Substance use is higher and more excessive in transgender people: evidence, limitations and gaps (nationalelfservice.net)

**Expand box as required*

Protected Characteristic - Marriage/civil partnership: Consider people in a marriage or civil partnership

Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	Substance misuse in a marriage / civil partnership directly affects both spouses /partners and other family members including children where present. Substance is a major driver of domestic violence among spouses / partners.
Neutral		
Negative		The Havering CSM strategy includes action plans aimed at reducing risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm. Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by any individuals regardless of marital status. The strategy as specified in action plans, will also identify and address stigma and stereotypes related to marital status e.g. civil partnerships that may disadvantage anyone and implement measures that will enhance their ability to engage in treatment and recovery. **Expand box as required*

Evidence:
According to the 2021 census, 1 in 5 homes (21%) have a couple with dependent children while the percentage of households including a couple without children is 13.2%.

Havering had a total of 364 new adult presentations to treatment for substance misuse during 2019/20. Of those, 77 (21%) were parents or adults living with children.

There are approximately 399 adults in Havering with alcohol dependence living with children. Only 80 are in treatment indicating the majority (80%) are unattended to and therefore potentially a threat to child safety. This rate is higher than the national benchmark of unmet treatment need (75%)

There are approximately 189 adults in Havering with opiate dependence living with children. Only 59 are in treatment indicating the majority (69%) are unattended to and therefore potentially a threat to child safety. This rate is higher than the national benchmark of unmet treatment need (72%)

Numerous studies have been done to find trends in drug dependence within single and married groups, and it has been found that an individual's marital status can indeed affect the likelihood of them falling victim to drug abuse. Many studies have shown that marriage actually accelerates a decrease in drug use when compared to those who remain single. But some studies have found adverse results.

It is concluded that marriage may be a protective factor against drug use, but dependent on several factors, such as qualitative spare time, a more mature relationship, a sense of commitment and intimacy.
In the case of a partner who uses drugs or drinks too much, the effect is felt by his or her partner, children, relatives, friends, and co-workers. There is consistent evidence of an association between substance misuse and parental conflict. Most longitudinal studies support the view that substance misuse increases the incidence of parental conflict though there are other studies that highlight how parental conflict can lead to substance misuse.

Children affected by both parental substance misuse and conflict are more at risk of presenting with mental health issues. A number of other stressors (including housing, financial instability, crime, schooling or parental mental health) can act cumulatively to increase a child's risk of negative outcomes.

**Expand box as required*

Sources used:

Havering Substance Misuse Needs Assessment 2022

Census - Office for National Statistics (ons.gov.uk)

11043-A-2018.pdf (recentscientific.com)

Examination of the links between parental conflict and substance misuse and the impacts on children's outcomes - GOV.UK (www.gov.uk)

How Substance Abuse Affects Spouses/Marriage - Addiction Resource

**Expand box as required*

Protected Characteristic - Pregnancy, maternity and paternity: Consider those who are pregnant and those who are undertaking maternity or paternity leave		
Please tick (✓) the relevant box:		**Overall impact:** Substance use during pregnancy and motherhood is both a public health and criminal justice concern. Negative health consequences associated with substance use impact both the mother and the developing fetus. A substance misusing male spouse is also a potential risk to both the mother and developing fetus especially where there is physical and emotional abuse. Through partnership working pregnant mothers identified as misusing substance will be referred for timely and appropriate intervention. Risk factors and barriers to treatment and recovery associated with pregnant mothers and their spouses where applicable will also be addressed. The Havering CSM strategy includes action plans aimed at reducing risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm including pregnant mothers. Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by any individuals including pregnant mothers. **Expand box as required*
Positive	✓	
Neutral		
Negative		

Evidence:
Data on pregnant women who misuse drugs and alcohol is not readily available and unreliable as many do not disclose this during their contact with health and social care services due to related stigma and fear of punishment. Havering CGL records show there was one pregnant mother in treatment in 2021 and 2022.

Illicit drugs, solvents or medicines should not be misused during pregnancy due to the risk of clinical and neonatal complications, including increased risk of mortality, and the risk of poor behavioural and developmental outcomes in drug-exposed children.

According to the NHS England Maternity records (2019), most women for whom substance misuse status was recorded (95.5%) reported at their booking appointment that they had never misused illicit drugs, solvents or medicines. Around 5,500 women (1.2%) reported that they were currently misusing illicit drugs, solvents or medicines; and over 15,000 women (3.3%) reported previously misusing these substances.

Substance misuse was most common in women aged under 25 with nearly 1,500 women (1.6%) reporting currently using and around 5,800 (6.4%) stating that they had misused illicit drugs, solvents or medicines in the past. For those living in the most

deprived areas, 2.5% said they were currently misusing illicit drugs, solvents or medicines and 4.1% reported previously misusing these substances.

Medical experts are still undecided exactly how much – if any – alcohol is completely safe during pregnancy, so the safest approach is not to drink at all. Drinking in pregnancy can lead to long-term harm to the baby, and the more you drink, the greater the risk.

Drinking heavily throughout pregnancy can cause the baby to develop a serious condition called Fetal Alcohol Syndrome (FAS) and other difficulties.

Drinking with a new-born baby is particularly risky at night for both parents. Parents are often unable to be as attentive to their infant and they can also fall asleep holding the baby which leaves them at greater risk of suffocation.

Using illegal or street drugs during pregnancy, including cannabis, ecstasy, cocaine and heroin, can have a potentially serious effect on the unborn baby. Medical advice is clear that all drug use should be stopped during pregnancy.

**Expand box as required*

Sources used:
Havering Substance Misuse Needs Assessment 2022

Aspire - Havering | Change Grow Live

Parents with alcohol and drug problems: adult treatment and children and family services - GOV.UK (www.gov.uk)

Pregnant women and substance use: fear, stigma, and barriers to care | Health & Justice | Full Text (biomedcentral.com)

Alcohol and drug use – Homerton Health Visiting (hackneyandcityhealthvisiting.nhs.uk)
https://www.bmj.com/content/bmj/369/bmj.m1627.full.pdf

https://assets.publishing.service.gov.uk/media/5dc00b22e5274a4a9a465013/Health_of_women_before_and_during_pregnancy_2019.pdf

**Expand box as required*

Socio-economic status: Consider those who are from low income or financially excluded backgrounds

Please tick (✓) the relevant box:	
Positive	✓
Neutral	
Negative	

Overall impact:

There is a strong association between socioeconomic position, social exclusion and substance-related harm in relation to both alcohol and other drugs in the general population. People living in more deprived areas and with lower individual resources and socioeconomic capital are at greater risk of harm. The highest levels of alcohol and drug-related deaths in the UK occur in those areas of greatest neighborhood deprivation.

Substance misuse and dealing tends to thrive more among deprived communities. Through partnership working the strategy aims at

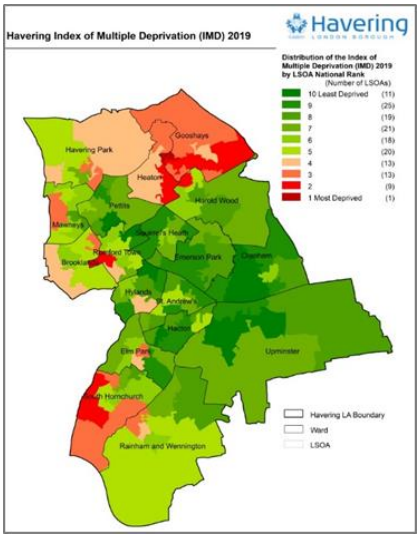
		identifying and breaking drug supply chains by disrupting the ability of gangs to supply drugs and seizing their cash, bringing perpetrators to justice, safeguarding and supporting victims. Through partnership working, substance misuse risk factors and barriers to treatment and recovery associated with socioeconomic deprivation will be addressed. The Havering CSM strategy includes action plans aimed at reducing risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm including those from deprived communities Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by social-economically deprived individuals and communities. **Expand box as required*

Evidence:

There is a strong association between socioeconomic position, social exclusion and substance-related harm in relation to both alcohol and other drugs in the general population. People living in more deprived areas and with lower individual resources and socioeconomic capital are at greater risk of harm. The highest levels of alcohol and drug-related deaths in the UK occur in those areas of greatest neighbourhood deprivation.

Being in education or employment and being in good physical health can increase the chances of successful substance misuse treatment, whilst substance misuse can also impact on education, employment and health. Having housing problems or living in an area of higher deprivation can reduce the chances of successful treatment.

The Index of Multiple Deprivation (IMD) 2019 is the official measure of relative deprivation for small areas (or neighbourhoods) in England. The IMD ranks every small area (Lower Super Output Area) in England from 1 (most deprived) to 32,844 (least deprived). For larger areas the proportion of LSOAs within the area that lie within each decile can be compared.



Decile 1 represents the most deprived 10% of LSOAs in England while decile 10 shows the least deprived 10% of LSOAs. Ten LSOAs (6.7%) in Havering are in decile 1 and 2 i.e. most and second most deprived LSOA's nationally. These deprived areas are in the north and south of the borough and along its western boundary are shown in map below. Overall, Havering is among the least deprived areas in London and nationally.

Gooshays and Heaton wards which are relatively more deprived in Havering also had the highest number of reported **substance misuse related incidents** in 2021 (307 and 275 incidents respectively).

*Expand box as required

Sources used:
Havering Substance Misuse Needs Assessment 2022

Safestats (london.gov.uk)

English indices of deprivation 2019 - GOV.UK (www.gov.uk)

Advisory Council on the Misuse of Drugs (2018) What are the risk factors that make people susceptible to substance use problems and harm?

Public Health England (2016) The Public Health Burden of Alcohol and the Effectiveness and Cost Effectiveness of Alcohol Control Policies

PHE, Health matters: preventing drug misuse deaths (2017)

*Expand box as required

Health & Wellbeing Impact: Please use the Health and Wellbeing Impact Tool on the next page to help you answer this question.

Consider both short and long-term impacts of the activity on a person's physical and mental health, particularly for disadvantaged, vulnerable or at-risk groups. Can health and wellbeing be positively promoted through this activity?

Please tick (✓) all the relevant boxes that apply:	
Positive	✓
Neutral	
Negative	

Overall impact:
The combating substance misuse strategy will have a positive impact on the health and wellbeing of all Havering residents. This impact is clearly outlined in the strategy document as local strategic outcomes. These include:

- A greater collaboration among members in delivering services that will lead to improved multi-agency working arrangements including the formalisation of previous loose and informal arrangements
- Increased referrals from police, courts and probation into drug treatment
- Improved co-ordination of relevant local services leading to improved delivery of services including easier information sharing and access to information
- Involvement of service users and frontline professionals in the development of the local strategy and associated plans leading to a wider co-operation and ownership of local plans and services
- Service expansion to deliver new high-quality drug and alcohol treatment places
- More people recovering from addiction in sustained employment, stable and secure housing

*Expand box as required

		Do you consider that a more in-depth HIA is required as a result of this brief assessment? Please tick (✓) the relevant box **Yes** ☐ **No** ✓

Evidence:
The use and abuse of alcohol and psychoactive substances is a worldwide public health issue with harms extending from the level of the individual to the family, community, and society. The UK is among the countries in Europe most affected by drugs and demand for them across the population is very high: over three million adults reported using drugs in England and Wales in the last year (2021).

Drug use drives crime, damages people's health, puts children and families at risk and reduces productivity – it impacts all, with the most deprived areas facing the greatest burden. According to the UK Government estimates, drugs misuse costs society nearly £20 billion a year. Nearly 3,000 people tragically lose their lives through drug misuse related deaths in England & Wales each year.

In Havering, statistics show substance misuse remains a priority issue that requires a sustained integrated approach to tackle. Latest data show an increase of annual substance misuse related crime incidents. Cases have nearly tripled since 2016 from 388 to 1,084 in 2022. In 2022, 938 possession of drugs crimes and 146 drug trafficking crimes were reported in Havering.

Alcohol-related mortality among males has also been rising in the last three years with the latest data (2020) showing alcohol-related mortality in Havering (57/100,000) was higher than the London average (51/100,000). In 2020/21 there were a total of 528 Havering adults in drug treatment services. The number has not changed significantly in the last 5 years indicating there still many people who require treatment but are not accessing it.

To achieve this outcomes the strategy includes four priority areas that aim at addressing the physical and mental wellbeing of Havering residents affected by substance misuse directly or indirectly. The four priority areas to be implemented over a five year period include:

Breaking drug supply chains by disrupting the ability of gangs to supply drugs and seizing their cash, bringing perpetrators to justice, safeguarding and supporting victims

Delivering a world-class treatment and recovery system, including; improving access to support by tackling stigma, delivering efficient and effective treatment and recovery system based on a multi-disciplinary multi-agency integrated approach.

Achieving a generational shift in the demand for drugs, including; preventing substance misuse and addiction. Supporting research, service audit, and evaluation.

Reducing risk and harm to individuals, families and communities, including; reducing harm related to substance misuse and safeguarding the vulnerable from abuse and harm. Ensuring care and support for other family members (a Think Family approach).

**Expand box as required*

Sources used:
Havering Substance Misuse Needs Assessment 2022

From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)

World Drug Report 2023 - Special Points of Interests (unodc.org)

Drug misuse in England and Wales: year ending March 2020 (Office for National Statistics).

Why do people use alcohol and other drugs? - Alcohol and Drug Foundation (adf.org.au)

**Expand box as required*

3. Health & Wellbeing Screening Tool

Will the activity / service / policy / procedure affect any of the following characteristics? Please tick/check the boxes below
The following are a range of considerations that might help you to complete the assessment.

Lifestyle YES ☒ NO ☐	**Personal circumstances** YES ☒ NO ☐	**Access to services/facilities/amenities** YES ☒ NO ☐
☐ Diet	☒ Structure and cohesion of family unit	☒ to Employment opportunities
☐ Exercise and physical activity	☒ Parenting	☐ to Workplaces
☐ Smoking	☒ Childhood development	☒ to Housing
☐ Exposure to passive smoking	☒ Life skills	☐ to Shops (to supply basic needs)
☒ Alcohol intake	☒ Personal safety	☐ to Community facilities
☒ Dependency on prescription drugs	☒ Employment status	☐ to Public transport
☒ Illicit drug and substance use	☐ Working conditions	☐ to Education
☐ Risky Sexual behaviour	☐ Level of income, including benefits	☐ to Training and skills development
☐ Other health-related behaviours, such as tooth-brushing, bathing, and wound care	☐ Level of disposable income	☒ to Healthcare
	☐ Housing tenure	☒ to Social services
	☒ Housing conditions	☐ to Childcare
	☐ Educational attainment	☐ to Respite care
	☐ Skills levels including literacy and numeracy	☐ to Leisure and recreation services and facilities
Social Factors YES ☒ NO ☐	**Economic Factors** YES ☒ NO ☐	**Environmental Factors** YES ☐ NO ☒
☒ Social contact	☐ Creation of wealth	☐ Air quality
☒ Social support	☐ Distribution of wealth	☐ Water quality
☐ Neighbourliness	☐ Retention of wealth in local area/economy	☐ Soil quality/Level of contamination/Odour
☐ Participation in the community	☐ Distribution of income	☐ Noise levels
☐ Membership of community groups	☐ Business activity	☐ Vibration
☐ Reputation of community/area	☐ Job creation	☐ Hazards
☐ Participation in public affairs	☒ Availability of employment opportunities	☐ Land use
☒ Level of crime and disorder	☒ Quality of employment opportunities	☐ Natural habitats
☒ Fear of crime and disorder	☒ Availability of education opportunities	☐ Biodiversity
☒ Level of antisocial behaviour	☒ Quality of education opportunities	☐ Landscape, including green and open spaces
☒ Fear of antisocial behaviour	☒ Availability of training and skills development opportunities	☐ Townscape, including civic areas and public realm
☒ Discrimination	☒ Quality of training and skills development opportunities	☐ Use/consumption of natural resources
☒ Fear of discrimination	☐ Technological development	☐ Energy use: CO2/other greenhouse gas emissions
☐ Public safety measures		☐ Solid waste management

☐ Road safety measures	☐ Amount of traffic congestion	☐ Public transport infrastructure

4. Outcome of the Assessment

The EqHIA assessment is intended to be used as an improvement tool to make sure the activity maximises the positive impacts and eliminates or minimises the negative impacts. The possible outcomes of the assessment are listed below and what the next steps to take are:

Please tick (✓) what the overall outcome of your assessment was:

	1. The initial screening exercise showed a strong indication that there will be no impacts on people and need to carry out an EqHIA. 2. The EqHIA identified no significant concerns OR the identified negative concerns have already been addressed	→	**Proceed with implementation** of your activity
	3. The EqHIA identified some negative impact which still needs to be addressed	→	**COMPLETE SECTION 5:** **Complete action plan** with measures to mitigate the and finalise the EqHIA
	4. The EqHIA identified some major concerns and showed that it is impossible to diminish negative impacts from the activity to an acceptable or even lawful level	→	**Stop and remove** the activity or **revise** the activity **thoroughly.** **Complete an EqHIA on the revised proposal.**

5. Action Plan

The real value of completing an EqHIA comes from identifying the actions that can be taken to eliminate/minimise **negative** impacts and enhance/optimise positive impacts. In this section you should list the specific actions that set out how you will mitigate or reduce any **negative** equality and/or health & wellbeing impacts, identified in this assessment. Please ensure that your action plan is: more than just a list of proposals and good intentions; if required, will amend the scope and direction of the change; sets ambitious yet achievable outcomes and timescales; and is clear about resource implications.

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
Age	Improved access to available substance misuse services for people of all ages. Holistic provision of care for mental and physical health needs alongside substance use. Safeguarding of children and the elderly from abuse and harm related to substance misuse Reduction in stigma and stereotypes that are common around substance use	The partners in Havering will work together to implement programmes that consider unique risk factors and treatment needs at various life stages and among specific age groups. Details of specific activities are included in the strategy action plan	• Reduction in number of children and other vulnerable persons involved in drug supply. • Reduced drug use • Reduced drug-related deaths and harm • Increased engagement in treatment for people with substance misuse problems • Improved treatment and recovery outcomes for service users	5 years, annual reviews and quarterly progress monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
	among people of various age groups. Reduced demand for drugs.				
Disability	Improved access to available substance misuse services. Holistic provision of care for mental and physical health needs alongside substance use Safeguarding of the people with disabilities from abuse and harm related to substance misuse Reduction in stigma and stereotypes that are common around substance use by disabled people.	The strategy through its defined priority areas will work with other partners to ensure people living with disability are aware of and can easily access available services. The strategy has prioritized improvement of dual diagnosis care pathways in implementation of the strategy which includes holistic provision of care for mental and physical health needs alongside substance use. One of the key aims of the Havering CSM strategy is to reduce risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm. Through collaboration with partners, social, economic,	• Reduced drug use among people living with disabilities • Reduced drug-related deaths and harm among people living with disabilities • Increased engagement in treatment for people with disability and substance misuse problems • Improved treatment and recovery outcomes for service users with disabilities.	5 years, annual reviews and quarterly progress monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
		and health factors associated with disability which are also risk factors for substance misuse and addiction will be addressed. Disability stigma and stereotypes that are common around substance use by disabled people and their ability to engage in treatment and recovery have also been highlighted and are included in the joint action plans. Details of specific activities are included in the strategy action plan			
Sex/gender	Improved access to available substance misuse services by all genders. Holistic provision of care for mental and physical health needs alongside substance use Safeguarding of all vulnerable persons from abuse and harm related to substance misuse	Through partnership working agreed actions will be implemented that that address gender risk factors and treatment needs. The four priority areas designed to guide this process include; breaking drug supply chains, delivering a world-class treatment and recovery system, achieving a generational shift in the demand for drugs and reducing risk and harm to	• Reduced drug use among people of all genders • Reduced incidence of drug-related crime, deaths and harm • Increased engagement in treatment for people of all genders with substance misuse problems	5 years, annual reviews and quarterly progress monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
	Reduction in stigma and stereotypes that are common around substance use. Reduced demand for drugs.	individuals, families and communities Details of specific activities are included in the strategy action plan	• Improved treatment and recovery outcomes for all service users.		
Ethnicity/race	Improved access to available substance misuse services by all ethnic groups. Holistic provision of care for mental and physical health needs alongside substance use for all ethnic groups Safeguarding of all vulnerable persons from abuse and harm related to substance misuse among all ethnic groups. Reduction in ethnic based stigma and stereotypes around substance use. Reduced demand for drugs among all ethnic groups.	The strategy through its defined priority areas will work with other partners to ensure people of all ethnic backgrounds are aware of and can easily access available substance misuse services without feeling discriminated on racial basis. One of the key aims of the Havering CSM strategy is to reduce risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm. Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by any ethnic group which are also risk	• Reduced drug use among people of all ethnic groups • Reduced incidence of drug-related crime, deaths and harm among all ethnic groups • Increased engagement in treatment for people of all ethnic backgrounds with substance misuse problems • Improved treatment and recovery outcomes for all service users from various ethnic groups.	5 years, annual reviews and quarterly progress monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
		factors for substance misuse and addiction. The strategy as specified in action plans, will also identify and address stigma and stereotypes that may be prevalent in some ethnic groups to enhance their ability to engage in treatment and recovery.			
Religion/faith	Improved access to available substance misuse services by members of all religion /faith groups. Holistic provision of care for mental and physical health needs alongside substance use for members of all religion /faith groups. Safeguarding of all vulnerable persons from abuse and harm related to substance misuse among members of all religion /faith groups. Reduction in religious / faith based stigma and stereotypes	The impacts of substance misuse and resultant addiction are multidimensional and cut across all religions going beyond the relatively small cohort with dependency problems. Through the combating substance misuse partnership, there is a commitment to work with all faith groups in Havering in prevention of substance misuse, treatment, recovery and rehabilitation of affected persons. The strategy as specified in action plans, will also identify and address stigma and stereotypes that may be	• Reduced drug use among people of all religious / faith groups • Reduced incidence of drug-related crime, deaths and harm among all religious / faith groups • Increased engagement in treatment for people of all religious / faith backgrounds with substance misuse problems • Improved treatment and recovery outcomes for all service users from	5 years, annual reviews and quarterly progress monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
	around substance use. Reduced demand for drugs among all religious/ faith groups	prevalent in any community or religious groups to enhance their ability to engage in treatment and recovery.	various religious / faith groups.		
Sexual orientation	Improved access to available substance misuse services by all regardless of sexual orientation. Holistic provision of care for mental and physical health needs alongside substance use for all regardless of sexual orientation. Safeguarding of all vulnerable persons from abuse and harm related to substance misuse and sexual orientation especially among members of the LBGTQ+ community. Reduction in sexual orientation based stigma and stereotypes around substance use. Reduced demand for	Evidence shows the prevalence of substance misuse is higher among LGBTQ+ persons. However, the impacts of substance misuse cut across all sexual orientations and go beyond the relatively small cohort with dependency problems. Through partnership working agreed actions will be implemented that that will address identified risk factors and barriers to treatment and recovery associated with members of LBGTQ+ community. Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by the LBGTQ+ community as this are known risk factors for substance misuse and addiction.	• Reduced drug use among LGBTQ+ persons. • Reduced incidence of drug-related crime, deaths and harm among LGBTQ+ persons. • Increased engagement in treatment LGBTQ+ persons with substance misuse problems • Improved treatment and recovery outcomes for LGBTQ+ service users.	5 years, annual reviews and quarterly progress monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
	drugs among all regardless of sexual orientation but with more attention on members of the LBGTQ+ community.	The strategy as specified in action plans, will also identify and address sexual orientation stigma to enhance their ability to engage in treatment and recovery.			
Gender reassignment	Gender reassignment will be recorded in all treatment records Improved access to available substance misuse services by transgender persons. Holistic provision of care for mental and physical health needs alongside substance use for transgender persons. Safeguarding of all vulnerable persons from abuse and harm related to substance misuse and sexual orientation among members transgender persons. Reduction in sexual	Gender reassignment is currently not sufficiently captured in local drug and alcohol treatment data, but evidence shows it is a major risk factors for substance use. To ensure substance use treatment services are inclusive, gender identity will be recorded and targeted interventions implemented. Through partnership working identified risk factors and barriers to treatment and recovery associated with transgender persons will be addressed. Through collaboration with partners the social, economic, and health inequalities experienced by transgender persons will be identified and tackled as	• Improvement in recording of transgender in treatment records • Reduced drug use among transgender persons. • Reduced incidence of drug-related crime, deaths and harm among transgender persons. • Increased engagement in treatment by transgender persons with substance misuse problems • Improved treatment and recovery outcomes for transgender service users.	5 years, annual reviews and quarterly progress monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
	orientation based stigma and stereotypes around substance use. Reduced demand for drugs among all regardless of sexual orientation but with more attention on transgender persons.	these are known risk factors for substance misuse and addiction. The strategy as specified in action plans, will also identify and address any gender reassignment stigma within services to enhance their ability to engage in treatment and recovery.			
Marriage/civil partnership	Improved access to available substance misuse services by all persons regardless of marital status. Holistic provision of care for mental and physical health needs alongside substance use for people in marriage /civil partnership. Safeguarding of all vulnerable persons from abuse and harm related to substance misuse among people in marriage / civil partnerships. Reduction in stigma	Substance misuse in a marriage / civil partnership directly affects both spouses /partners and other family members including children where present. Substance misuse is a major driver of domestic violence among spouses / partners. The Havering CSM strategy includes action plans aimed at reducing risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm including those in marriage / civil partnership.	• Reduced drug use among people in marriage / civil partnerships. • Reduced incidence of drug-related crime, deaths and harm among people in marriage / civil partnerships. • Increased engagement in treatment by people in marriage / civil partnership with substance misuse problems • Improved treatment and recovery outcomes for people	5 years, annual reviews and quarterly progress monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
	and stereotypes directed towards persons in civil partnerships that may drive them to substance misuse. Reduced demand for drugs among all regardless of marital status.	Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by any individuals regardless of marital status. The strategy as specified in action plans, will also identify and address stigma and stereotypes related to marital status e.g. civil partnerships that may disadvantage individuals from sufficiently engaging in treatment and recovery.	in marriage / civil partnership.		
Pregnancy, maternity and paternity	Improved access to available substance misuse services by all persons during pregnancy/ maternity and paternity periods. Holistic provision of care for mental and physical health needs alongside substance use for all persons during pregnancy/ maternity and paternity periods.	Substance use during pregnancy and motherhood is both a public health and criminal justice concern. Negative health consequences associated with substance use impact both the mother and the developing fetus. A substance misusing male spouse is also a potential risk to both the mother and developing fetus especially where there is physical and emotional abuse. Through partnership	• Reduced drug use during pregnancy/ maternity and paternity periods. • Reduced incidence of drug-related crime, deaths and harm during pregnancy/ maternity and paternity periods. • Increased engagement in treatment by people in pregnancy/	5 years, annual reviews and quarterly progress monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
	Safeguarding of all vulnerable persons from abuse and harm related to substance misuse among all persons during pregnancy/ maternity and paternity periods. Reduction in stigma and stereotypes directed towards persons during pregnancy/ maternity and paternity periods that may drive them to substance misuse. Reduced demand for drugs among all persons during pregnancy/ maternity and paternity periods.	working pregnant mothers identified as misusing substance will be referred for timely and appropriate intervention. Risk factors and barriers to treatment and recovery associated with pregnant mothers and their spouses where applicable will also be addressed. The Havering CSM strategy includes action plans aimed at reducing risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm including pregnant mothers. Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by any individuals including pregnant mothers.	maternity and paternity periods and with substance misuse problems • Improved treatment and recovery outcomes among people affected by pregnancy/ maternity/ paternity and substance misuse problems.		
Socio-economic status	Reduced drug supply by disrupting supply chains. Improved access to	There is a strong association between socioeconomic position, social exclusion and substance-related harm in	• Reduced drug supply as evidenced by number of supply chains disrupted	5 years, annual reviews and quarterly monitoring updates.	Tha Han, Public Health Consultant

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
	available substance misuse services by all persons especially those from deprived areas. Holistic provision of care for mental and physical health needs alongside substance use for all especially those from deprived areas. Safeguarding of all vulnerable persons from abuse and harm related to substance misuse among all persons with more attention on those from deprived areas. Reduction in stigma and stereotypes directed towards persons from deprived areas that may drive them to substance misuse. Reduced demand for drugs among all persons with more attention on those from deprived areas.	relation to both alcohol and other drugs in the general population. People living in more deprived areas and with lower individual resources and socioeconomic capital are at greater risk of harm. The highest levels of alcohol and drug-related deaths in the UK occur in those areas of greatest neighborhood deprivation. Substance misuse and dealing tends to thrive more among deprived communities. Through partnership working the strategy aims at identifying and breaking drug supply chains by disrupting the ability of gangs to supply drugs and seizing their cash, bringing perpetrators to justice, safeguarding and supporting victims. Through partnership working, substance misuse risk factors and barriers to treatment and recovery associated with socioeconomic deprivation will be addressed.	• Reduced drug use among people in deprived areas. • Reduced incidence of drug-related crime, deaths and harm in deprived areas. • Increased engagement in treatment by people in deprived areas • Improved treatment and recovery outcomes among people in deprived areas.		

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
		The Havering CSM strategy includes action plans aimed at reducing risk and harm to individuals, families and communities by reducing harm related to substance misuse and safeguarding of the vulnerable from abuse and harm including those from deprived communities Through collaboration with partners the strategy aims at identifying and tackling any social, economic, and health inequalities experienced by social-economically deprived individuals and communities.			

Add further rows as necessary

***** You should include details of any future consultations and any actions to be undertaken to mitigate negative impacts.

** Monitoring: You should state how the impact (positive or negative) will be monitored; what outcome measures will be used; the known (or likely) data source for outcome measurements; how regularly it will be monitored; and who will be monitoring it (if this is different from the lead officer).

6. Review

In this section you should identify how frequently the EqHIA will be reviewed; the date for next review; and who will be reviewing it.

Review: **Scheduled date of review:** December 2028 **Lead Officer conducting the review:** Public Health Consultant, Substance Misuse. **Expand box as required*

Please submit the completed form via e-mail to READI@havering.gov.uk thank you.

Appendix 3: Strategy delivery plan

1 Breaking drug supply chain:

Identified Need / Priority	Action *What we will do to improve our local system and meet national and local priorities*	Resources *What we need to be able to achieve it*	Timescale *When will this be completed?*	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation *Who will lead and report on this?*	Metric *How we will measure success*
1 Collect and share intelligence	1.1 Serious Violence Duty needs assessment and develop serious violence duty strategy	Support from partners with in the Serious Violence duty working group	Jan-24	CSP - Serious Violence Group	Community Safety Partnership	Community Safety	Needs assessment and serious violence strategy published on council webpage by 31 January 24
	1.2 Improved analysis of Drug Rehabilitation Requirement (DRR) or Alcohol Treatment Requirement (ATR); Test on arrest data / Drug Intervention Programme (DIP) breeches; Follow up of breaches	No additional resources required	Ongoing with quarterly updates	CSP - Reducing Reoffending Group	Police Probation services CGL	Police CGL	Successful completions of Alcohol Treatment Requirement (ATR) / Drug rehabilitation requirement (DTR) Test on arrest data
	1.3 Establishment of joint analytic group and a set of baseline data sets	Establishment of joint analytic group and a set of baseline data sets	Mar-24	Joint Analytic Group	Joint Analytic Group, CSP, CGL , NELFT	Public Health	Joint analytic group in place and established set of indicators and baseline datasets.
	1.4 Review and Strengthening of the National Referral Mechanism (NRM) process	Training - Safeguarding	Ongoing with quarterly updates	CSP - Safeguarding Boards	CSP/ Youth Justice Board (YJB)	Safeguarding adults and children	Number of NRM assessments and referrals completed

Identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation	Metric
	What we will do to improve our local system and meet national and local priorities	*What we need to be able to achieve it*	*When will this be completed?*			*Who will lead and report on this?*	*How we will measure success*
2 Monitor and help disrupt county lines – collaborate across borders/ modern day slavery	2.1 Awareness raising and training for staff on Modern day slavery	Training - Safeguarding and capturing data i.e. number of referrals	Ongoing with biannual updates	CSP - Safeguarding Boards	Safeguarding Boards	Safeguarding training lead	Number of training sessions delivered
	2.2 National data on county lines and disruption updates for CDP	Drugs Focus to talk to CST	Ongoing with quarterly updates	TTCG	Police	Police	Number of county lines closed and disruptions
	2.3 Cross border police operations between East Area BCU and Essex to target individuals.	Operation Gambler	Ongoing with quarterly updates	Havering Joint Taskforce (HJTF)	HJTF / CSP / Police	Enforcement Team	Number of incidents and arrests
3 Investigate the transfer of money from drug businesses	3.1 Money laundry, child exploitation for money laundry and data sharing	This is business as usual and covered by existing ISA and terms of reference for groups	Ongoing with quarterly updates	CSP	Police & LBH Insights Team	Police & LBH Insights Team	Number of cases investigated and completed

Identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How we will measure success***
	3.2 Tackling drug debt and use of drugs in the criminal justice system	This will be done on a case by case basis by offender managers	Ongoing with quarterly updates	CSP	CSP & Police	Police	Number of incidents and successful interventions
4 Target retail and middle market	3.3 Identify and investigate cannabis factories, laughing gas market and cuckooing; issue closure orders and drugs warrants	Business as usual taking a proactive approach	Ongoing with quarterly updates	CSP	CSP & Police	Police	Number of drugs warrants served and number of cannabis factories identified and closed
	3.4 Data/ Intelligence sharing on cannabis factories, cuckooing, drug warrants	Business as usual taking a proactive approach	Ongoing with quarterly updates	CSP	CSP, Police & Joint analytic group	Police	Number of cannabis factory closures and related incidents
5 Limit the density of alcohol outlets and hours of retail sale near local hot spots – (alcohol related crime/ nuisance reports)	5.1 Clamp down on existing licensees who sell over the limits Alcohol or do not adhere to the regulations; Proactive and increase licence reviews	Police and Council Licensing teams	Ongoing with quarterly updates	Licensing Committee	Licensing team, Police	Police Council licensing	Number of successful licensing reviews

Identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How we will measure success***
	5.2 Work with planners to influence the Local Plan refresh to limit the proliferation of Licensed premises and alcohol sale hours at retail outlets	CSP resources ASB/crime data Density of outlets with alcohol licence	Ongoing with quarterly updates	CSP	Planning Licensing Community Safety Public Health	Planning	LOCAL PLAN REFRESH featuring the limits of retail outlet density
6 Community safety/vigilance, street policing, council enforcement assets	6.1 Better sharing of ASB data Identify lead for data collation within the police	No extra resources required	Ongoing with quarterly updates	Tasking group, monthly ASB meeting	Community Safety and police	Police	Number of ASB cases identified
	6.2 Data from Housing re thefts etc.	Data not currently shared	Ongoing with quarterly updates	CSP	Housing	Housing	Availability of data Number of theft incidents and arrests
7 Survey emerging markets e.g. vapes, freeports, online sales, underage sales, mixing cannabis or THC with vapes	7.1 Selling of vapes to be added to licensing. Licences restricted near schools and colleges	Intelligence to be shared by partners	Ongoing with quarterly updates	CSP	Trading standards	Trading Standards	Number of successful seizures

Identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How we will measure success***
8 A communications strategy	8.1 Co-badged with Health , Police and Local Authority 'Did you know Facts' e.g. cost and consequences of drugs Early identification and sign posting communicate what we've achieved	Lead officer time Cost for effective use of social media platforms, newsletters, Apps	Ongoing with quarterly updates	CSP	CSP, Public Health, Police, CGL	Public Health	Comms strategy in place Number of information drops
	8.2 Inform , advise and highlight the risks for YP to schools, colleges, Alternative Providers and Pupil Referral Units	Help accessing academies SPOCs for schools School nurses School councillors	Regular updates	CSP	Education Police- safer Schools Public Health, CGL	Public Health	Healthy schools London – number of schools meeting criteria (Drugs& Alcohol education part of HSL criteria).

2 Delivering a world-class treatment & recovery system

Identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
1. The impact of substance misuse on individuals and community	Produce and review local needs assessment to identify needs, trends, priorities and inequalities including de-stigmatisation of addiction and engagement with affected individuals and communities	Information and data sharing, stakeholder involvement, analytic data group to lead on needs assessment. Including qualitative data from service users.	Consistent with local and national timelines	Analytic Data Group	Havering Council, YP and Adult Treatment Service, NELFT, BHRUT, ICB, Police and other criminal justice agencies.	Public Health	Number of people accessing services including demographic details Correct data on status of substance misuse and treatment outcomes in the borough Improved patient outcomes Number of drug related deaths Number of drug related hospital admissions

Identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
2 Education and awareness and Information and advice for the public on treatment access and self-care	2.2 Promote awareness of services with Health and Social Care Workforce and wider public including the use of appropriate materials for education and awareness	Videos, posters, social media, events	Ongoing with quarterly updates	Joint treatment and recovery group	CGL, Havering Council	Havering Council	Number of engagement training sessions Number of trained GPs Post campaign / awareness sessions participant knowledge levels Prevalence of substance misuse
3 Culturally sensitive services	Commission an independent review of services to assess their cultural competency and equalities.	Funding, engagement	March 2024	Joint treatment and recovery group	Public Health	Public Health	Number of awareness sessions Prevalence of substance misuse Improved patient outcomes
4 Data sharing	Establish Power BI Dashboard	Funding, IT support, Information governance support, Analysts	March 2024	Joint Analytic Group	Public Health	Public Health	Improved patient outcomes Improved data access Functional data sharing platform

Identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
							Data sharing agreements
5 GP/ Primary Care Involvement	Introduce targeted shared care arrangements to improve GP involvement in recovery plans of alcohol dependent service users including provision of clinical satellites in GP practices.	GPs, Adult Treatment & Recovery Provider, Public Health	TBC	Joint treatment and recovery group	Adult Treatment & Recovery Provider, NEL Shared Care Group, PCNs, LMC	CGL	Adult service performance report
6 Adults dependent on prescribed drugs	Review the needs of adults dependent on prescribed drugs and agree recommendations to improve prevention, training and awareness, treatment and/or guidance, support to reduce dependency.	NEL ICB, GP, BHRUT, Medicines Safety, Nursing, Pain Consultant, Clinical Psychologist, Pharmacists, LTC Commissioner. Councils, Adult Treatment Provider	December 2024	Joint treatment and recovery group	NEL Dependence of Medicines Stewardship Group	NEL ICB	Hospital admissions from prescription drug misuse and toxicity
7 Engagement of adult offenders released from prison	Improve joint working between prisons and community services by increasing the proportion of referrals and engagement of adult offenders released from prison (from 30% to 75%)	Adult Treatment & Recovery Provider, Prisons, Probation and engagement with resettlement panels	March 2025	Joint treatment and recovery group	Adult Treatment & Recovery Provider	CGL	Combatting Drugs Outcomes Framework - Number / proportion engaging in

Identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
							treatment 3 weeks after leaving prison
8 Dual Diagnosis	8.1 The ICB will work in partnership with key stakeholders to support the joint care for individuals with substance misuse and mental health problems 8.2 Evaluate current service provision and gaps, engage with service users, explore peer support for these group of patients 8.3 Review complex cases with multiple diagnosis i.e. substance misuse, EUPD, combined with mental health problems and anti-social personality disorder, criminal justice systems via a Complex and Dual Diagnosis group between NELFT and CGL	Relevant providers and commissioners working together reviewing the joint care of individuals with substance misuse and mental health problems Resource (Time) to invest in appropriate psychological interventions for those with emotionally unstable personality disorders compounded by substance misuse, high level of anti-social behaviour, regular contact with police and criminal justice systems	Update on progress by Jan 2024.	Joint treatment and recovery group	Havering PbP Mental health oversight group, ICB, NELFT, LBH, Substance Misuse Service and Third Sector	NELFT	6- monthly progress report and review after 18 months

Identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
9 Community pharmacy substance misuse service provision	9.1 Review how community pharmacies provide needle exchange services to include mechanisms of taking action where there is an observed problem with a patient. 9.2 Explore possibility of increasing funding for commissioning more pharmacies to provide substance misuse interventions	Commissioning policy review and funding	Ongoing with annual updates	Joint treatment and recovery group	CGL , LPC	CGL	TBC

3. Achieving a generational shift in the demand for drugs and excessive alcohol

identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
1 Information, awareness and staff training	1.1 Being present in the places that children use to communicate e.g. social media, snapchat, tiktok and local busy bodies for awareness and support pathways.	Social media, colleges, consider Geolocation based campaigns e.g. in snapchat, Instagram and twitter, schools. Targeting parents, carers and adults in children's lives; promote through our social media channels and partners/service providers social media; taking advantage of issues/locations when they occur; fund specific campaigns that tackle this issues; Input to PSHE curriculum; CPOMS (online server that records all child protection items)	Ongoing with quarterly updates	Prevention Group	Comms, youth centres/workers, member of the core working group, co-produce with young people (Youth Council) Parents/Carers. Partners, faith and religious orgs, youth organisations - third party promotion. Use schools social media; The Bridge (Frances Bardsley School); DSLs; Local celebrities; local sports teams/ heroes etc.	Public Health and Communication	Number / proportion of people reporting drug misuse in the last 12 months Prevalence of opiate and non opiate use
	1.2 Work closely with schools: Find out what schools are doing and see if there are any good practice that can be promoted and built on. e.g., junior citizen programme	Annual Safeguarding audit could have an additional question regarding quality of PSHE on addiction/substance use/misuse examples to possibly track some good practice - to be disseminated;	annually	Education Strategic Partnership	Comms, youth centres/workers, member of the core working group, co-produce with young people; WiseUp CGL; Education Services; BAP (behaviour and attendance partnership)	Education Strategic partnership. Havering School improvement Service	completion of Audit Question; gathering schools good practice, organisations offering support; and the sharing of this/these interventions; take up of

identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
							referrals to WiseUp
	1.3 online reporting for children when they are concerned/worried about substance misuse - (To be included in the needs assessment)	Utilise existing systems in schools to enable children to report; (internal concerns reporting systems) - CPOMS/ MyConcern; National / Central database to report and share anonymised concerns; i.e. 'the student voice'; Further development of the HaRVA tool to enable better information sharing and risk assessment by schools and other partners on contextual risk; Promotion of the OWL app to report crime and ASB; DSL team	annually	Education Strategic Partnership	schools; School Improvement; Specialist Safeguarding Team (Havering CS) Joni Blyth Community Safety; Colleges; Leaving Care; Designated safeguarding leads	Havering School improvement Service	# of reports; link to #referrals; and prevalence of drug and alcohol use by children

identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
	1.4 Interventions to target young people in colleges to teach or coach them on how to manage their new independence and make informed decisions. How to manage money, recreation to reduce the demand for drugs and alcohol.	Using voluntary services to develop programme ; Also Start at Year 10 or Year 11 through PSHE lessons or drop down days	year two	Adolescent Safeguarding Strategy Board	Colleges/Youth Groups; Prospects; WiseUp; Faith and Religious orgs; (other 16+ organisations?); Schools	Youth service/YJS	# sessions delivered plus feedback on these sessions
	1.5 Training Themes: Improve the understanding of push and pull factors for professionals to enable a more emphatic workforce; Consider language for cultural sensitivity; Tackling stigma goes hand in hand with information and advice but consider engagement.	Training for professionals	year one onwards	HSCB and wider strategic safeguarding partnership forums	Havering Safeguarding Partnership - Training offer	Havering Social Care Academy	# training delivered ; feedback from training; quality and # of referrals to WiseUp

identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
2 Links to World class treatment and recovery system	2.1 Interventions targeted at older adults 40s, 50s and above who have now picked up drugs because they can afford it.	publicity campaigns; establish the extent of this problem; potential for age specific services	first year and ongoing BAU	Joint treatment and recovery group	Comms; CGL;	CGL	minimum of one campaign per year, based on learning from audits and intelligence
	2.2 First time users with children <5yrs- CGL to do a home visit with awareness of what's a risk vs what's a safeguarding concern	hidden harm worker in CGL; along with targeted partner: i.e. police, social worker	establish model and roll out in year two	Havering Safeguarding Children's Partnership (HSCP)	CGL; Social Care Academy; Children's Social Care	CGL	# of visits completed
3 Supporting young people and families most at risk of substance misuse	3.1 Develop more services focused on young adults rather than children as a lot has been done in schools for children	Ask colleges; apprenticeships, employers (NHS) what their issues are around substance misuse; link to national campaigns; youth charities; Leaving Care team; Detached youth workers; Night-time economy partnership/collaboration; Hub office in Romford; Host an Havering event for 6th forms	year two starting with a campaign to raise awareness and respond to issues as partners see them	Prevention Group	Prevention Group; Dean Gordon; Youth Service; NCC DSLs; Night-time Economy partners including traders; emergency services; HSCB and HASP	Youth Service	age of referrals to WiseUp and Aspire reflects focus on this age group = 16 - 25 years

identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
	3.2 Check and support high risk families to reduce the impact cost of living	Budgeting skills. Debt management offer from DWP;	year one and ongoing	Social Care Early Help	LBH Early Help service; DWP; HSSWs (Home school support workers)	DWP: HSSWs	#of support effective interventions where debt has been reduced/managed
	3.3 Consider debt bondage: children get drawn in through debt bondage manufactured by those leading the county lines (Training)	Training for professionals lead by the social care academy in partnership with Catch22/Rescue and Response	Ongoing with quarterly updates	HSCP	Havering Safeguarding Partnership - Training offer	Rescue and Response Team	#training delivered; case studies of impact of debt bondage work
4 Links to breaking the supply chain	4.1 actions to reduce high strength alcohol use and support to street drinkers	licence variation/conditions to reduce high strength sales where street drinking has been identified; CGL led outreach work;	Ongoing with quarterly updates	Havering Community Safety Partnership	Public Protection and CGL	Public Protection	# of reductions

identified Need / Priority	Action	Resources	Timescale	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer	Metric
	What we will do to improve our local system and meet national and local priorities	***What we need to be able to achieve it***	***When will this be completed?***			***Who will lead and report on this?***	***How will we measure success?***
5 Collect and share intelligence	5.1 Data- Collect trends regarding all forms of drugs usage- prescribing data, slang terms, location data etc.	Locations of concern MACE and HARM panels; a forum/method for identifying and sharing information on prescribing and wider substance misuse; Health/ Public Health resources; Adult Safeguarding Board; Community Safety Partnership	year two and ongoing BAU	Joint Analytic Group	Children and Adult Safeguarding: social services; police; probation services; relevant charities; CGL (drug and alcohol service) Health and Public Health	Public Health	confidence in data picture of substance misuse in Havering and by whom
	5.2 Define clearly how impact will be measured	Develop the data set for 5.1 above: # arrest; #users of services, # incidents in licenced premises; # alcohol related crime and hospital admissions - overtime; reduction of hotspot street drinking;	year one	Joint Analytic Group	Children and Adult Safeguarding: social services; police; probation services; relevant charities; CGL (drug and alcohol service) Health and Public Health	Public Health	completion of first draft of data set

4 Reducing risk and harm to individuals, families and communities

identified Need / Priority	Action *What we will do to improve our local system and meet national and local priorities*	Resources *What we need to be able to achieve it*	Timescale *When will this be completed?*	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer *Who will lead and report on this?*	Metric *How will we measure success?*
1 Information, advice and staff training	1.1 For the public around a. Exploitation of the vulnerable by drug trade b. Early recognition of addiction c. consequences and how to avoid peer pressure d. Seeking support e. Destigmatisation f. Confidence on social services and Improving the image of social services through training and communication work	Educating the community around acceptance and destigmatisation Stories from people with lived experience (e.g., very short video clips) Video clips codesigned with service users, young people and people from communities that do not seek support Exercising corporate social responsibility Funding required to implement the above Utilising existing resources from transitional safeguarding -MyPlace.	Ongoing with quarterly updates	Prevention Group	CDP and LA communications Schools Shared resources with the GLA and other boroughs in the ICS Voluntary care sector Faith & Religious orgs ICB	Public Health	minimum 1 videoclip per borough to be shared with London, esp lived experience Toolkit for young people, schools and social services Public engagement events informing about substance misuse Increased number in the treatment for alcohol and drugs Comms material to improve confidence on social services

identified Need / Priority	Action *What we will do to improve our local system and meet national and local priorities*	Resources *What we need to be able to achieve it*	Timescale *When will this be completed?*	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer *Who will lead and report on this?*	Metric *How will we measure success?*
	1.2 For professionals (D&A services, social services, NHS, Housing, statutory organisations) dealing with substance misuse clients around cultural competence in working with individuals at risk Incorporating into training then audit	Health inequality funding from ICB	March 2024	Prevention Group	PbP, ICB	Public Health	Cultural competence report Numbers in treatment Recovery rate Completion of Alcohol Qq in NHS HC

identified Need / Priority	Action *What we will do to improve our local system and meet national and local priorities*	Resources *What we need to be able to achieve it*	Timescale *When will this be completed?*	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer *Who will lead and report on this?*	Metric *How will we measure success?*
	1.3 Advise employers on awareness and employment of substance misuse and mental health; Clarity around employment law and rehabilitated individuals	Expertise in producing the toolkit Time for engagement Communication material Working with employment team when clients are ready Linking with Beam to use their support and tools. Increasing opportunity for volunteering and training	March 2025	Prevention Group	DWP working with employers: Peabody (HA in Havering) Beam AA LA, schools NHS, Police Chamber of Commerce (BID)	CGL	Employment of individuals treated in substance misuse services Healthy workplace certification or alike
2 Multidisciplinary multiagency support to those at higher risk or those who suffered from harm of drugs and alcohol misuse.	2.1 Early intervention in multidisciplinary support	Police to signpost to CGL Better Living CGL working with partners	March 2024	Joint treatment and recovery group	Local area coordinators (Harold Hill - Connectors) Faith & Religious orgs Street pastors The AA	CGL	Engagement in treatment School exclusion and suspension that are drug and alcohol related

identified Need / Priority	Action *What we will do to improve our local system and meet national and local priorities*	Resources *What we need to be able to achieve it*	Timescale *When will this be completed?*	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer *Who will lead and report on this?*	Metric *How will we measure success?*
	2.3 Family group and family support pathway	CDP Working group on family support with GPs, CAMHS, social services, NELFT therapists, VAWG	March 2025	Joint treatment and recovery group	Havering CDP (subgroup), PbP, Safeguarding Adults and Children	CGL	Children in need with drug as a factor Reduction in safeguarding case reviews related to parental substance (D&A) misuse
	2.4 Substance misuse and mental health outreach to high risk communities	CDP Working group on family support with GPs, CAMHS, social services, NELFT therapists, VAWG	March 2025	Joint treatment and recovery group	CGL, NELFT	CGL	Reduction in safeguarding case reviews related to wrong door policy
	2.5 Cross-regional cooperation for housing settlement where there is supportive family roots	Changing perception of the community	March 2025	Joint treatment and recovery group	Housing demand CGL ESOL classes Community groups	Housing	Number of successful settlements where accommodation has been sustained for minimum 2 years.
3 Needle exchange, supervised consumption	Prevention and management of Blood Borne Viruses	TBC	Ongoing with quarterly updates	Joint treatment and recovery group	CGL, LPC	CGL	Maintenance of micro elimination status

identified Need / Priority	Action *What we will do to improve our local system and meet national and local priorities*	Resources *What we need to be able to achieve it*	Timescale *When will this be completed?*	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer *Who will lead and report on this?*	Metric *How will we measure success?*
4 Research, audit and surveillance	**Joint research, audit and surveillance system**	TBC		Joint Analytic Group	CDP	Public Health	Surveillance reports, Participation in national/ regional studies
5 Awareness and training around neurodiversity	5.1 To understand more about neurodiversity and personality disorders and the interlink with substance misuse; Agencies ensure staff attend	Expertise and participation from NELFT, Social services, CGL and GPs Training (coordinated by CGL and NELFT)	March 2025	Joint treatment and recovery group	NELFT CEPN CLDT (Community Learning Disability Team) Havering adult and children services and LBH comms co-designing with individuals with lived experience	CGL	Number of practitioners/ professionals trained across disciplines
6 Reduction risk and harm to communities	6.1 Inspection of products in vape shops	Trading standards conducting visits	December 2024	Community Safety Partnership	Trading standards	Trading standards	Reduction in complaints around vapes

identified Need / Priority	Action *What we will do to improve our local system and meet national and local priorities*	Resources *What we need to be able to achieve it*	Timescale *When will this be completed?*	Strategic Delivery & Planning Group	Key Organisations	Lead Organisation & Named Officer *Who will lead and report on this?*	Metric *How will we measure success?*
	6.2 Refine harm and risk reduction activities (e.g. drink driving course) with feedback from individuals and families with lived experience	More a comment, such course already exist why co design another one, rise mutual for example already deliver what was an accredited programme; not commissioned locally	March 2025	Community Safety Partnership	CDP	Community Safety Partnership	suggestion made to involve service user feedback
	6.3 The risk of alcohol and substance misuse on health are reduced in designing Local Plan	TBC	March 2026	Prevention Group	Planning and Regen Public Protection	Planning	Local Plan identifying evidence to support locational policies with scope and specification on retail density of alcohol outlets. With joint work with licensing of such outlets.

This page is intentionally left blank