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Havering
LONDON BOROUGH

CABINET

7.00 pm	Wednesday 12 March 2025	Council Chamber - Town Hall

Members 9: Quorum 3

Councillor Ray Morgon (Leader of the Council), Chairman

	Cabinet Member responsibility:
Councillor Gillian Ford	Lead Member for Adults & Wellbeing
Councillor Oscar Ford	Lead Member for Children & Young People
Councillor Paul McGeary	Lead Member for Housing & Property
Councillor Paul Middleton	Lead Member for Digital, Transformation & Customer Services
Councillor Barry Mugglestone	Lead Member for Environment
Councillor Natasha Summers	Lead Member for Housing Need & Climate Change
Councillor Christopher Wilkins	Lead Member for Finance
Councillor Graham Williamson	Lead Member for Regeneration

Zena Smith
Head of Committee and Election Services

For information about the meeting please contact:
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Webcast

Please note that this meeting will be webcast.
Members of the public who do not wish to appear in the webcast will be able to sit in the balcony, which is not in camera range.

Please would all Members and officers attending ensure they sit in their allocated seats as this will enable correct identification of participants on the meeting webcast.

Under the Committee Procedure Rules within the Council's Constitution the Chairman of the meeting may exercise the powers conferred upon the Mayor in relation to the conduct of full Council meetings. As such, should any member of the public interrupt proceedings, the Chairman will warn the person concerned. If they continue to interrupt, the Chairman will order their removal from the meeting room and may adjourn the meeting while this takes place.

Excessive noise and talking should also be kept to a minimum whilst the meeting is in progress in order that the scheduled business may proceed as planned.

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

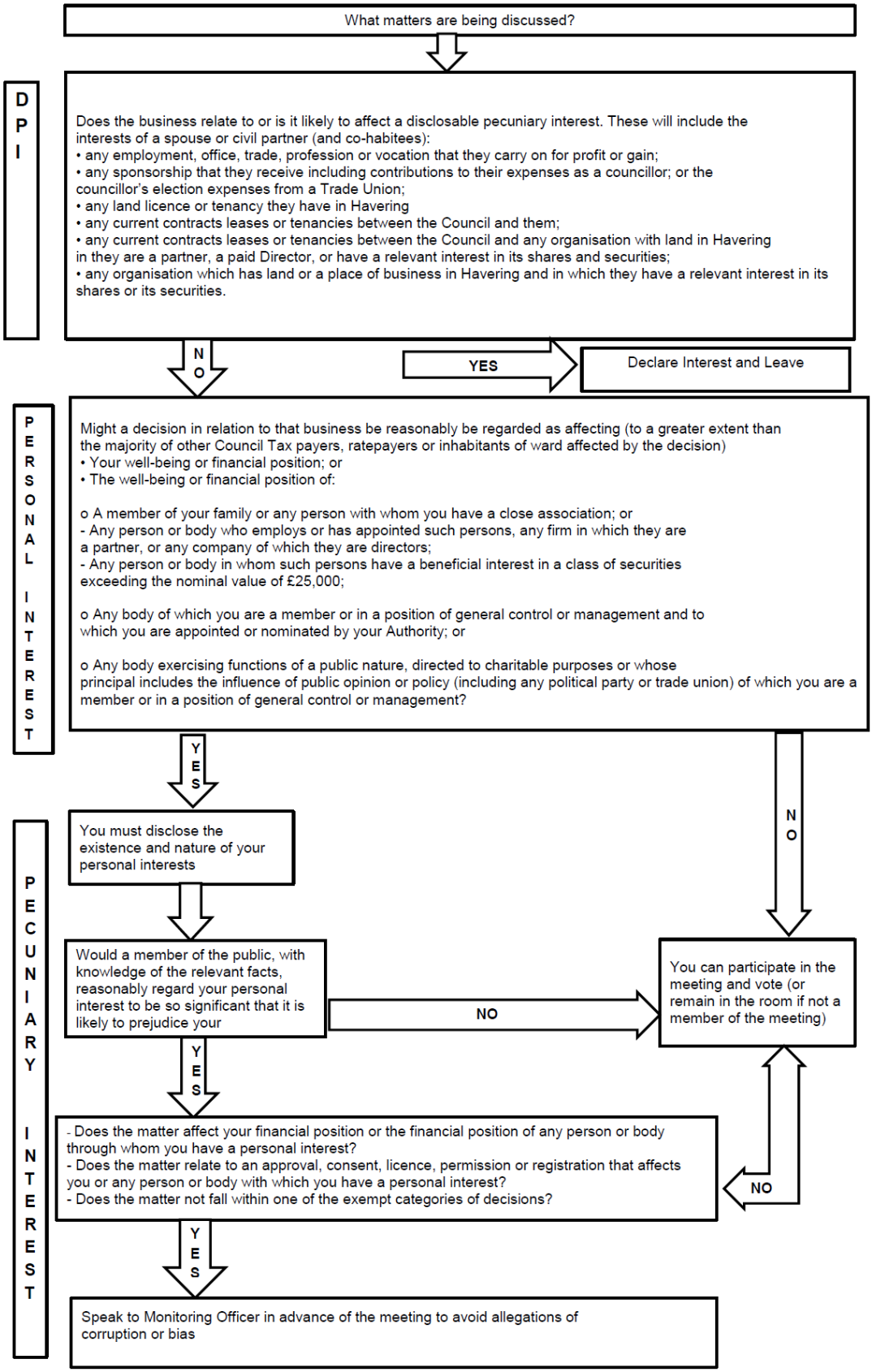
- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF



Principles of conduct in public office

In accordance with the provisions of the Localism Act 2011, when acting in the capacity of a Member, they are committed to behaving in a manner that is consistent with the following principles to achieve best value for the Borough's residents and to maintain public confidence in the Council.

SELFLESSNESS: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

INTEGRITY: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

OBJECTIVITY: In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

ACCOUNTABILITY: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

OPENNESS: Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

HONESTY: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

LEADERSHIP: Holders of public office should promote and support these principles by leadership and example.

AGENDA

1 ANNOUNCEMENTS

On behalf of the Chair, there will be an announcement about the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2 APOLOGIES FOR ABSENCE

If any receive; -

3 DECLARATIONS OF INTEREST

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 7 - 30)

To approve as a correct record, the minutes of the meeting held on **5th February 2025** and to authorise the Chair to sign them.

5 PERMISSION TO PROCURE A FRAMEWORK FOR ADULT SOCIAL CARE- CARE HOME, HOMECARE & SUPPORTED LIVING PLACEMENTS (Pages 31 - 38)

Report attached.

6 PERMISSION TO ENTER INTO A S75 AGREEMENT WITH THE HAVERING PLACE-BASED PARTNERSHIP TO DELIVER THE BETTER CARE FUND 2025-2027 (Pages 39 - 46)

Report attached.

7 HAVERING ALL-AGE SUICIDE PREVENTION STRATEGY 2025-30 (Pages 47 - 160)

Report attached.

8 Q3 CORPORATE PERFORMANCE REPORT (Pages 161 - 174)

Report attached.

9 PERIOD 9 REVENUE & CAPITAL MONITORING REPORT (Pages 175 - 212)

Report attached.

MINUTES OF A CABINET MEETING
Council Chamber - Town Hall
Wednesday, 5 February 2025
(7.00 - 8.41 pm)

Present:
Councillor Ray Morgon (Leader of the Council), Chairman

	Cabinet Member responsibility:
Councillor Gillian Ford	Lead Member for Adults & Wellbeing
Councillor Oscar Ford	Lead Member for Children & Young People
Councillor Paul McGeary	Lead Member for Housing & Property
Councillor Paul Middleton	Lead Member for Digital, Transformation & Customer Services
Councillor Barry Mugglestone	Lead Member for Environment
Councillor Natasha Summers	Lead Member for Housing Need & Climate Change
Councillor Christopher Wilkins	Lead Member for Finance
Councillor Graham Williamson	Lead Member for Regeneration

In attendance: Cllr Michael White (CON), Cllr Keith Prince (CON), Cllr Keith Darvill (Labour), Cllr Martin Goode (EHRG)

46 **ANNOUNCEMENTS**

On behalf of the Chair, there was an announcement about the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

47 **APOLOGIES FOR ABSENCE**

No apologies received, full cabinet in attendance.

48 **DISCLOSURES OF INTEREST**

There were no declarations of interest.

49 **MINUTES**

The minutes of the meetings held on **22nd January 2025,** were agreed as a correct record and the Chair signed them.

50 **LIBRARIES CONSULTATION**

Report: Libraries Consultation

Presented by: Councillor Gillian Ford, Cabinet Member for Adults & Wellbeing

With the agreement of the Chair, **item 12, Libraries Consultation** was brought forward in order that residents present could observe the discussion

Summary:

Councillor Gillian Ford *"Library closures were on the previous Administrations Agenda for budget savings and therefore will not come as a surprise to their Members that we have had to consider the library portfolio within the borough.*

The maintenance and upkeep of Libraries were not a priority for the previous Administration and no budget was set aside for their long-term up-keep and sustainability. We have therefore multiple libraries that require substantial repairs, maintenance, even rebuilds in the case of Collier Row. Having seen the conditions surveys for all of the boroughs libraries, I can confirm the three libraries proposed for closure conditions surveys include cracks in external brick work, roofing problems and single glazed units without kite marks which may not be compliant with Part K of the Building Regulations.

Last year's budget included a £300k cut in library services and MHCLG expects the delivery of the 2024 budget, as a condition of the Capitalisation Directive. Just to reiterate this cut is not part of this year's budget as it is accounted in last years, and formed part of those budget consultations."

Summary: (response to Place Overview & Scrutiny Sub-Committee comments, at end of this summary)

The Council's budget setting exercise for 2023-24 included proposals to reduce the revenue budget of the Council's library service by £300,000 over two years. This prompted the production of a Library Strategy that would set out how the library service would function in the next few years.

This report seeks approval of the Library Strategy.

Amongst other things, the Library Strategy provided for the potential closure of 4 out of 5 branch libraries.

The report considers the outcome of the consultation on the draft Library Strategy that sought views of stakeholders on the Strategy and on the option for the Council to close up to four branch libraries.

Following careful analysis of all the responses received during the consultation including the public survey, stakeholder feedback, petitions and correspondence received, the condition of the libraries, the Council's ability to invest capital, and the Council funding gap it is considered that Council funding for three branch libraries should cease. This will result in the consequential loss of service of three branch libraries that are recommended to close on 31 March 2025 and achieve an annual saving of £288k.

This report also considers a number of options to mitigate the impact of the decision.

Cabinet

1. **Considered** and **noted** the results of the Library Strategy consultation;

2. **Approved** and has adopted the Library Strategy 2024-29 (as attached to this report);

3. **Agreed** the closure of three branch libraries from 1 April 2025 as set out in this report;

4. **Agreed** that the three branch libraries are mothballed from 1 April 2025 and delegates to the Strategic Director of Place the authority to use the branch library buildings for any appropriate meanwhile use, provided that any proposals for the disposal or long term use of the branch libraries be brought to a future Cabinet meeting;

5. **Agreed** that the mitigating actions in section 5 are progressed;

6. **Agreed** that the budget for book stock is continued as set out in this report.

Place Overview and Scrutiny Sub-Committee – Comments And Recommendation To Cabinet On Libraries Consultation

Following its meeting on 3 February 2025, the Place Overview and Scrutiny Sub-Committee submits the following comments and recommendation to Cabinet and requests that Cabinet responds to these at its meeting on 5 February 2025.

The Sub-Committee sought assurance that the EQHIA is correct. This followed a Member query about discrepancies between the EQHIA and Action plan.

Recommendations

1. That Cabinet delay the decision until a second consultation has been carried out, presenting the proposal to close three libraries to the public, as has taken place in other parts of the country. And that the Officer benchmark what is best practice.

Response:
Whilst a second phase consultation is mentioned within the draft library strategy, this is not considered to be a requirement. There are examples of a second phase consultation elsewhere, with Dorset Council carrying out a phase one and a phase two consultation. Phase one was from October 2021 to January 2022 and phase two from September to December 2022. However, phase one was to inform the development of the Library Strategy and Phase two was to consult on the strategy once drafted.

In essence, a phase two consultation in the context of Havering library strategy and recommendations in the Cabinet report would be consulting on the same thing – do you agree/disagree with closing libraries. We already have that information from the consultation carried out and included within the Cabinet report.

A phase two consultation is highly unlikely to provide a substantially different response to the one already received so is perceived to be of little value. If a phase two consultation were to be carried out, this would delay the implementation of library closures and therefore not achieve the required savings that were part of the budget agreed in 2024 February Cabinet.

Even if the Dorset approach had been considered to be an approach Havering chose to follow, time would not have allowed as further delays to a decision being taken would result in the savings required not being achieved. It is worth noting that already the saving identified for 2024/25 of £150k has not been achieved due to the preparation of the draft strategy and subsequent consultation.

DCMS has advised that they do not have any best practice guidance around a single/two phase consultation regarding possible library closures. It is suggested that a two-stage consultation approach should be made clear at the start of the consultation process, together with providing a clear indication of the aims and objectives of each stage. This was not mentioned or made clear at the commencement of the consultation on possible library closures so provides further rationale for not introducing a second consultation at this stage.

There is no expectation from DCMS about carrying out a second consultation. The consultation process is a matter for the Council and the Public Libraries and Museums Act 1964 does not impose any specific requirements with regard to consultation on proposed changes to library services. However, the Libraries as a Statutory Service guidance document sets out the role of Council and the need for public consultation on proposed service changes, and provides guidance on how to conduct a consultation.

Should DCMS receive representations of alleged deficiencies in the consultation by a Council carried out in relation to proposed library changes they do not merit an investigation under section 10 of the Act, unless the changes are likely to have a material impact on the level of service provided, and it can be shown that any deficiencies in the consultation may have resulted in the Council proceeding without a sufficient understanding of local needs.

Therefore, the recommendation is not accepted.

2. That, following the formation of the Friends Group of Harold Wood library, who are seeking funding, the Cabinet delay the decision to close Harold Wood library in order that the group might have time to secure funding

Response:

Whilst it is recognised and appreciated that the Friends of Harold Wood Library have now been formally constituted, the request to allow a period of time for the Friends to raise funding has been stated would be at least 6-9 months. If this were agreed, it would delay the saving attributed to the closure of Harold Wood library and also a decision on the future of the site. Whilst funding might be available if applications are successful, it is questionable as to whether funding could be realised on an ongoing basis to meet the costs of running the library.

The Friends can still have a role to play in providing library related activities within the Harold Wood neighbourhood through supporting a book swap facility, community activities and fundraising to contribute to new provision subject to that being agreed at a future Cabinet meeting and being financially viable.

Therefore, the recommendation is not accepted.

3. That the Cabinet seek the opinion of the 151 Officer on whether savings made elsewhere could be used to offset the overspend generated by keeping the libraries open, and whether that would satisfy the CIPFA report and MHCLG with regards to the Capitalisation Directive

Response:

The conditions attached to the Council being in receipt of 24/25 Exceptional Financial Support required the Council to comply with two things. 1. To publish an Improvement and Transformation Plan and 2. To undergo a CIPFA Financial Management review. As part of the CIPFA Review process, the Council must demonstrate the delivery of savings as one of many requirements of the overall process.

The Review also considered the Council's governance and decision-making arrangements.

At present, the Council has not yet received details of what the process will entail as part of the 25/26 Capitalisation Direction request. The requirements will be set out when the exceptional financial support is agreed by MHCLG. Officers are working with MHCLG to ensure confirmation of both the EFS and the conditions attached will be available in advance of the Budget Setting Full Council meeting.

4. That the Cabinet explore and outline what work needs to be undertaken to ensure that the remaining libraries do not fall into disrepair and be threatened with closure

Response:
Subject to the recommendations of the Cabinet report being agreed, the remaining seven libraries have condition surveys that identify investment required of at least £786k. The condition surveys were visual only to get indicative minimum capital costs and further intrusive surveys would likely identify more costs. The surveys also did not include mechanical and electrical so additional costs should also be expected once these have been included through a further condition survey.

The administration is committed to delivering a quality library service in the remaining seven libraries and will be seeking ways in which to fund the required improvements which will be considered alongside other capital investment requests to ensure the overall capital programme remains affordable.

Therefore, the recommendation is accepted and a timetable for this will be considered by officers in due course.

5. Cost Breakdown – that Cabinet defer decision until further information is provided on both revenue and capital costs.

Response:

The revenue and capital costs are identified within the Cabinet report. The breakdown of these costs have been circulated ahead of this evenings Cabinet meeting. There is nothing in the revenue cost breakdown information that is considered to materially affect the decision, and the response to the previous recommendation regarding condition surveys sets out the position clearly.

Reviewing the cost breakdowns further will delay a decision being made on the recommendations of the Cabinet report and result in not achieving the identified savings.

Therefore, the recommendation is not accepted.

51 **HRA BUSINESS PLAN UPDATE, BUDGET 2025/26 & CAPITAL PROGRAMME 2025/26-2029/30.**

Report: HRA Business Plan update, Budget 2025/26 & Capital Programme 2025/26–2029/30.

Presented by: Councillor Paul McGeary**,** Cabinet Member for Housing and Property

Summary: (response to Overview & Scrutiny comment, at end of this summary)

This report sets a budget for the Council's Housing Revenue Account (HRA) and HRA Major Works and Capital Programme. Cabinet approved the Housing Asset Management Plan 2021-2051 in October 2021 and the budgets and projections of expenditure required to maintain the stock to a good standard have been used in the preparation of the capital programme in this report. A summary is provided of the HRA Business Plan 2024/25-2053/54.

The HRA is a ring-fenced account that is used to manage and maintain the Council's own housing stock. The Council is legally required to not set a deficit budget. The proposed budget will enable the Council to manage and maintain the housing stock to a good standard and provide funding for a significant acquisition, new build and estate regeneration programme. It further sets rents, service charges and other charges for Council tenants and leaseholders for the year 2025/26.

As part of the new regulatory framework for local government housing services, councils are now subject to the Regulator of Social Housing's (RSH) Rent Standard. This has introduced the CPI + 1% increase arrangement, based on the published rate for September 2024 making an increase for 2025/26 of 2.7%.

In order to change any HRA rent liability, the local authority must notify tenants and give 28 days' notice of any change after the authority has made a properly constituted decision of that change. This means that, following a Cabinet decision on rent levels to be charged in any year, the local authority must write to all tenants to advise them of the new rent liability for the following 12 months.

Should the Cabinet adopt the recommendations, a notification will be sent to tenants in the first week of March 2025**,** to make the new charge effective from the first week of April 2025.

Cabinet:

1. **Approve** the Housing Revenue Account Budget as detailed in paragraph 3.5.

2. **Agree** that the rents chargeable for tenants in general needs Council properties owned by the London Borough of Havering be increased by 2.7% from the week commencing 7th April 2025.

3. **Agree** that the rents chargeable for tenants in supported housing Council properties, such as sheltered housing and hostels, owned by the London Borough of Havering, are increased by 2.7% from the week commencing 7th April 2025.

4. **Noted** the full annual rental charge will be billed over 48 weeks of the financial year and to agree the four weeks when rents will not be collected during 2025/26 are: the week commencing of 25th August 2025; 15th December 2025; 22nd December 2025 and the 30th March 2026.

5. **Agreed** that service charges and heating and hot water charges for 2025/26 are as detailed in section 2.11 to 2.23 of this report.

6. **Agreed** that charges for garages should be increased by 2.7% in 2025/26 as detailed in section 2.9 of this report.

7. **Agreed** that the service charge for the provision of intensive housing management support in sheltered housing for 2025/26 shall be as detailed in section 2**Error! Reference source not found.**.24 of this report.

8. **Agreed** the Supported Housing Charge for HRA Hostels as detailed in section 2.30 of this report.

9. **Agreed** that the rent charge to shared ownership leaseholders is increased in line with current lease conditions as detailed in paragraph 2.8 of this report.

10. **Agreed** that the Care-line and Telecare support charge should be increased by 2.7% for 2025/26 as detailed in section 2.28 of this report.

11. **Approved** the HRA Major Works Capital Programme, detailed in Appendix 1a of this report and refer it to full Council for final ratification.

12. **Approve**d the HRA Capital expenditure and financing for the 12 Estates Joint Venture and other acquisition and regeneration opportunities detailed in section 4.4 – 4.14 and Appendix 1b of this report and refer it to Full Council for final ratification.

Overview & Scrutiny Board – Comments To Cabinet on Budget & Related Papers

Following its meeting on 29 January 2025, the Overview and Scrutiny Board submits the following comments to Cabinet and requests that Cabinet responds to these at its meeting on 5 February 2025.

HRA Business Plan Update, Budget 2025-26 and Capital Programme 2025/26 – 2029/30

1. Further details should be given of the impact of the rise in National Insurance contributions. The Board is concerned over any potential shortfall in government funding designed to mitigate this.
    - **Response**: The additional National Insurance contribution cost equates to approximately £135k/year for the HRA. The Council understands that the Ministry of Housing, Communities and Local Government will fund this through additional grant contributions, although any future shortfalls would need to be funded through efficiencies and will need to be apportioned between the HRA and the General Fund.

52 **2025/26 BUDGET AND 2025-2029 MEDIUM TERM FINANCIAL STRATEGY**

Report: 2025/26 Budget and 2025-2029 Medium Term Financial Strategy

Presented by: Councillor Chris Wilkins, Cabinet Member for Finance

Summary: (Overview & Scrutiny comments noted, at end of this summary)

This report consisted of the following listed sections:

Introduction (Section 1)
Background and Strategic Context (Section 2)
The budget process and Medium Term Financial Strategy update (Section 3)
Update on the Medium Term Financial Strategy
Savings process and budget consultation
Fees and charges
Review of Corporate and Service pressures assumptions
Local Government Provisional Finance update
Council Tax Requirement
Proposal for balancing the budget (Section 4)
Balances, Reserves and Contingencies (Section 5)
Dedicated Schools Budget (Section 6)
Housing Revenue Account and 30-year business plan (Section 7)

Five-year Capital Programme and Flexible use of receipts (Section 8)
Robustness of the Council's Budget (Section 9)
Council Tax policies (Section 10)
Equality Impact Assessment (Section 11)
Implications (Section 12 onwards)

Cabinet

1. **Noted** the requirements of Section 106 of the LGA 1992 Act as set out in Section 1 of this report

2. **Noted** the Medium Term Financial Position and the Budget setting process of the Council as set out in Section 3 of this report

3. **Noted** the key assumptions and risks to the 2025/26 budget as set out in **Appendix A** of this report

4. **Noted** the provisional local government finance settlement outcome as set out in **Appendix B** of this report;

5. **Agreed** the savings proposals as set out in Sections 3.15 and **Appendix C** of this report and of this report.

6. **Agreed** the proposed Fees and Charges schedule as set out in paragraph 3.16 and **Appendix D** and for officers to proceed with implementation of the proposed fees and charges, subject to consultation where required.

7. **Agreed** the proposed 2.99% increase in core Council Tax for 2025/26 as set out in paragraph 3.18;

8. **Agreed** the proposed additional 2% Council tax increase for the Adult Social Care Precept as set out in paragraph 3.18;

9. **Agreed** the proposed Council Band D basic amount of Council Tax for 2025/26 of £1823.17 being the amount calculated by the Council, in accordance with Section 31B(1) of the Act, as the basic amount of its council tax excluding the GLA precept for the year (as set out in section 3.17 of this report

10. **Agreed** the proposed Council Tax requirement for 2025/26 to be set at £164.361m as set out **Appendix E** of the report

11. **Agreed** the budgets proposed in this report and as set out in **Appendix F**

12. **Noted** the outcomes from the Public Consultation response as set out in **Appendix G** (*to follow*)

13. **Noted** the Schools budget and DSG as set out in Section 6 of this report which is presented as a separate paper to this cabinet but is an integral part of the budget process

14. **Noted** the S25 Statement of Robustness as set out in **Appendix H** of this report.

15. **Agreed** the Council Tax Support Scheme for 2025/26 as set out in **Appendix I** to this report (unchanged from 2024/25).

16. **Agreed** Council Tax discounts for early payment to be given at a rate of 1.5% as set out in **Appendix J** of this report.

17. **Agreed** to direct officers to disregard War Pension income in the assessment of Housing Benefit as detailed in see Section 11 and **Appendix J** and authorises the Chief Executive to approve any policy required to effect the same.

18. **Noted** the Equalities Impact Assessment in respect of the Council Tax Support Scheme as set out in **Appendix K** to this report and the overall Equalities impact assessment for the Council report set out in **Appendix L**

19. **Noted** that in the event the Capitalisation Direction is not awarded to the value requested before the emergency Full Council meeting on the 5th March, the
Strategic Director of Resources (S151 Officer) will be required to issue a S114 report.

20. **Agreed** the recommendations made in the Treasury Management strategy statement which is presented as a separate paper to this cabinet but is an integral part of the budget process

21. **Agreed** the recommendations made in the Capital Strategy which is presented as a separate paper to this cabinet but is an integral part of the budget process

Cabinet agreed to make the following recommendation to Full Council

- That Full Council approves the proposals at 5 - 17 and 20-21 above
- That Full Council notes the proposals at 1 -4 and 18- 19 above
- That full Council resolves to authorise officers to proceed with the implementation of the fees and charges proposal once agreed by Full Council, subject to consultation where required.
- Adopt the Council Tax Support Scheme for 2025/26 as set out in **Appendix I** of this report (unchanged from 2024/25);
- Agree Council Tax discounts for early payment to be given at a rate of 1.5% as set out in **Appendix J** of this report.
- To direct officers to disregard War Pension income in the assessment of Housing Benefit as detailed in see Section 10 and **Appendix J** and authorises the Chief Executive to approve any policy required to effect the same.

Cabinet agreed to **delegate** the following decisions:

- **Delegated** to the Strategic Director of Resources (S151 Officer) the power to make further changes to the budget prior to full Council to reflect the final local government finance settlement and confirmation of final figures from the levying bodies

- **Delegated** to the Strategic Director of Resources (S151 Officer) the power to accept on behalf of the Council all grant funding allocated to the Council by external bodies, including central government (but provided that any new application for grant funding shall be in accordance with the Council's scheme of delegations).

- **Delegated** to the Strategic Director of Resources (S151 Officer) in consultation with Service Directors the authority to make any necessary changes to service and the associated budgets relating to any subsequent specific grant funding announcements up to the value of £500k, to administer funding where delays may otherwise adversely impact on service delivery and/or budgetary control, subject to consultation with Cabinet Members as appropriate.

- **Delegated** authority to the Cabinet Member for Adult Social Services and Health and the Leader to approve an annual expenditure plan for the Public Health grant, in consultation with the Strategic Director of Resources and the Director of Public Health.

- **Delegated** to the Strategic Director of People and the Director of Starting Well authority to agree uplift / inflation increases with relevant social care providers for 2025/2026.

Overview & Scrutiny Board – Comments to Cabinet on Budget & Related Papers

Following its meeting on 29 January 2025, the Overview and Scrutiny Board submits the following comments to Cabinet and requests that Cabinet responds to these at its meeting on 5 February 2025.

2025/26 Budget and 2025 – 2029 Medium Term Financial Strategy

1. The Board wishes to record its thanks to the Strategic Director of Resources for the hard work by her and her team in compiling the papers.
2. The Board fully supports ongoing efforts to secure further external grant funding for the Council.
3. The importance of the outcome of the Funding Reforms Review is noted and appreciated by the Board.
4. The Board supports the continuation of grant funding to the Citizens Advice Service.

5. The concerns expressed by officers over the levels of Council Tax arrears able to be collected are shared by the Board and the Board notes efforts by officers to address this.
6. The Board also wishes to record its concern over the cost impact of the rise in National Insurance contributions on the Council's Adult Social Care services.

53 5 YEAR CAPITAL PROGRAMME AND STRATEGY - 2025/26 TO 2029/30

Report: 5 Year Capital Programme and Strategy – 2025/26 to 2029/30

Presented by: Councillor Chris Wilkins, Cabinet Member for Finance

Summary:

The Council is required by statute and as set out in the Prudential Code for Capital Finance in Local Authorities, 2021 Edition, to agree the capital programme and associated capital strategy. Local authorities are required to have regard to the current editions of this code by regulations 2 and 24 of the Local Authorities (Capital Finance and Accounting) Regulations 2003 [SI 3146].

This report sets out the Authority's Capital Strategy and presents the Council's proposed capital budget for 2025/26 and five year Capital Programme to 2029/30.

Cabinet

1. **Will recommend to Council for consideration and approval** the 2025/26 Capital programme of £324m and £1,138m over the full five-year period from 2025/26 to 2029/30.

2. **Will recommend to Council for consideration and approval** the new capital projects being added to the capital programme for 2025/26 as set out in section 2.3 of this report.

3. **Noted** any additional capital needs over and above what is specified in the capital programme for the relevant year will require separate business cases and be agreed by the Strategic Director of Resources (S151 Officer), Capital Strategy manager and Council Members as required and appropriate before being agreed by full Council.

4. **Noted** that the Chief Financial Officer be authorised to allocate funding from the Capital Contingency included within the draft Capital Programme.

5. **Noted** that externally funded schemes can be added to the capital programme up to £500k as and when funding is confirmed.

6. **Approved** the capital strategy contained within this report noting its impact on both the capital programme and the financial implications for setting the revenue budget for 2025/26 to 2029/30.

7. **Noted** the capital prudential indicators included within the capital strategy when approving the capital programme to ensure affordability.

8. **Approved** the Minimum Revenue Provision Policy Statement (section 9 of this report) which determines the amount of money set aside each year for the repayment of debt

9. **Agreed** that the Strategic Director of Resources be authorised to re-profile capital budgets mid-year based on the updated forecasts provided by services and reported to the Executive Leadership Team as part of the capital monitoring process. This will assist in producing more accurate information for treasury management purposes

54 **TREASURY MANAGEMENT STRATEGY STATEMENT (TMSS) AND ANNUAL INVESTMENT STRATEGY 2025/26**

Report: Treasury Management Strategy Statement (TMSS) and Annual investment Strategy 2025/26

Presented by: Councillor Chris Wilkins, Cabinet Member for Finance

Summary:

The Treasury Management Strategy Statement ("TMSS") is part of the Authority's reporting procedures as recommended by the Chartered Institute of Public Finance and Accountancy (CIPFA) Treasury Management ("TM") Code and its Prudential code ("The CIPFA Prudential Code") for capital finance in local authorities. The TMSS also sets out recently introduced changes to the legislative framework, which are generally designed to place restrictions on authorities' commercial activity.

This report fulfils the Authority's legal obligation under the Local Government Act
2003 to have regard to both the CIPFA TM Code/Prudential Code and Government
Guidance, and it covers:

- The Borrowing and Investment Strategies

- Treasury Management and Prudential Indicators

Cabinet

1. **Will recommend to Council for consideration and approval** the 2025/26 Treasury Management Strategy Statement & Annual Investment Strategy

2. **Will recommend to Council for consideration and approval** the revised prudential and treasury indicators set out in Appendix 2 and 3

3. **Will recommend to Council for consideration and approval** the operational and authorised borrowing limits set out in tables 5 & 6 of appendix 2

4. **Noted** the impact the capitalisation direction has on the prudential and treasury indicators, increasing the Capital Financing Requirement (CFR) by £396m by 31st March 2028 set out in table 4 of Appendix 2

55 BRIDGE CLOSE REGENERATION LLP BUSINESS PLAN UPDATE 2025-26

Report: Bridge Close Regeneration LLP Business Plan Refresh 2025-2026

Presented by: Councillor Graham Williamson, Cabinet Member for Development and Regeneration

Summary: (response to Overview & Scrutiny comment, at end of this summary)

1.1 The Council established a joint venture development vehicle, Bridge Close Regeneration LLP ('BCR LLP', 'Joint Venture' or 'JV') to bring forward the proposed regeneration of the site known as Bridge Close (see plan with red line at Appendix A). BCR LLP was until October 2020 jointly owned between the Council and a private sector partner. On 16th September 2020, Cabinet approved the proposed acquisition by the Council of the private sector interest in BCR LLP and on 29th October 2020, the Council entered into a purchase agreement to acquire the interest in BCR LLP that it did not already own from the private sector partner.

1.2 In light of the Council acquiring full control of Bridge Close Regeneration LLP, on 16th December 2020, Cabinet considered a number of recommendations relating to the future funding and delivery of the scheme. Approval was granted for the Council to deliver the regeneration of Bridge Close directly, funding the development entirely through Council resources, predominantly using the Housing Revenue Account. Cabinet approved a budget with referral to and subsequent agreement by Full Council on 3rd March 2021. Subsequently, the Bridge Close Regeneration LLP Business Plan 2022/2023 was approved by Cabinet on 16th February 2022 and thereafter adopted by the Bridge Close Regeneration LLP.

1.3 The Business Plan forms part of a comprehensive suite of project documents, including the Members' Agreement, the Land Agreement, the Land Acquisition Strategy, the Security Agreement and the Loan Note Instruments, which amongst others, set out the strategy and the terms and conditions for provision of funding by the Council as principal Member of the Joint Venture (noting that a wholly owned company of the Council acts as second member of the JV). The Business Plan is a suite of strategy and policy documents, including a budget and financial model with detailed forecasts, which provides a management framework for delivering the vision and objectives for the regeneration of Bridge Close.

1.4 In accordance with the Members' Agreement, the Board of Bridge Close Regeneration LLP must prepare, issue and agree a draft Business Plan to the Council as Member. Once agreed, the draft Business Plan would replace the then current Business Plan as the formal Business Plan adopted by the Bridge Close Regeneration LLP.

1.5 This report provides an update of the Business Plan and a review of key work streams underpinning the delivery of the Council's vision for Bridge Close. It provides an update of the budget and financial model approved by Cabinet in December 2020 and recommends that the updated Business Plan be agreed, noting the significant benefits to the regeneration of Romford town centre, the contribution towards Havering's target for housing delivery, including affordable housing, and the expected financial returns anticipated in the plan.

Cabinet:

1. **Approved** the draft Bridge Close Regeneration LLP Business Plan 2025-2026 (the Business Plan) as attached at Appendix B.

2. **Agreed** the provision of a budget to enable the funding and delivery of the regeneration of Bridge Close as required and detailed within the exempt Financial Implications and Risks section; this budget to be included within the proposed HRA Capital Programme that will be considered by Cabinet in the Housing Revenue Account Business Plan update.

3. **Agreed** that the Cabinet Member for Regeneration, after consultation with the Strategic Director of Place, the Strategic Director of Resources the and the Deputy Director of Legal and Governance, approve detailed business cases, funding arrangements and legal agreements, respectively, as may be required to deliver the regeneration of Bridge Close as per the Business Plan 2025-2026.

4. **Noted** that the Strategic Director of Place will continue discussions with the Havering Islamic Community Centre (HICC) with a view to relocating the HICC to a suitable alternative site elsewhere.

5. **Noted** that the Strategic Director of Place will continue discussions with the London Ambulance Service (LAS) with a view to relocating the LAS to a suitable alternative site elsewhere.

6. **Noted** that the Strategic Director of Place, in consultation with the Strategic Director of Resources the and the Deputy Director of Legal and Governance, will bring forward a report providing status of the proposed making of the Compulsory Purchase Order (CPO) for the Bridge Close Regeneration scheme at the appropriate time in the financial year 2025-2026.

7. **Authorised** the Strategic Director of Place, acting in consultation with the Strategic Director of Resources and the Deputy Director of Legal and Governance, to negotiate, finalise and enter into all necessary legal agreements as may be required, and to do anything incidental to bring into effect the proposed arrangements set out in Recommendations 1-6 inclusive.

Overview & Scrutiny Board – Comments To Cabinet on Budget & Related Papers

Following its meeting on 29 January 2025, the Overview and Scrutiny Board submits the following comments to Cabinet and requests that Cabinet responds to these at its meeting on 5 February 2025.

HRA Business Plan Update, Budget 2025-26 and Capital Programme 2025/26 – 2029/30

2. Further details should be given of the impact of the rise in National Insurance contributions. The Board is concerned over any potential shortfall in government funding designed to mitigate this.
   - **Response**: The additional National Insurance contribution cost equates to approximately £135k/year for the HRA. The Council understands that the Ministry of Housing, Communities and Local Government will fund this through additional grant contributions, although any future shortfalls would need to be funded through efficiencies and will need to be apportioned between the HRA and the General Fund.

56 **HAVERING WATES REGENERATION LLP - IN-YEAR REVIEW OF 2023/24 BUSINESS PLAN**

Report: Havering and Wates Regeneration LLP Business Plan and Budget Update 2024/2025

Presented by: Councillor Graham Williamson, Cabinet Member for Development and Regeneration

Summary: (response to Overview & Scrutiny comment, at end of this summary)

This report provided an update on the 12 Estates Programme. Financial data within this paper utilises the most current information available, for the purpose of informing the HRA Business Plan refresh. The HWR JV Business Plan will be presented to Cabinet once it comes forward in Q1 2025/26.

This update outlines the latest position on:

Work Package One

- New Green - progress on completion and sale receipts.
- Park Rise - progress on completion, sales, and marketing.
- Waterloo & Queen Street – update on scheme phasing and viability.

Work Package Two

- Chippenham Road – design development, planning submission and planned demolition
- Farnham & Hilldene - design development and consultation.

Later Phases

It was noted that work is currently paused on the following sites:

1. Oldchurch Gardens,
2. Maygreen Crescent
3. Delderfield
4. Dell Court
5. Brunswick Court.
6. Royal Jubilee Court.

Cabinet

1. **Noted** The Strategic Director of Place will bring forward a report proposing the use of Compulsory Purchase Order (CPO) powers for the Chippenham Road development. This report will detail the necessity of invoking CPO powers to acquire outstanding land interests.

2. **Delegated** authority for the Strategic Director of Place, in consultation with the Cabinet Member for Development and Regeneration, to agree on and thereafter submit, accept and utilise grant funding bids to support the 12 Sites regeneration programme.

3. **Approved** the revised approach to proceed with a Council-led scheme prioritising the development of Blocks 9, and 10, along with a temporary energy centre, as part of Phase 1 of the Waterloo and Queen Street programme.

4. **Delegated** authority to the Strategic Director of Place to make variations to any of the joint venture agreements, as necessary, to implement the recommendations contained in this report.

5. **Noted** that the HWR JV Business Plan document will be presented to Cabinet in Q1 2025/26.

Overview & Scrutiny Board – Comments To Cabinet on Budget & Related Papers

Following its meeting on 29 January 2025, the Overview and Scrutiny Board submits the following comments to Cabinet and requests that Cabinet responds to these at its meeting on 5 February 2025.

Havering and Wates Regeneration LLP Business Plan and Budget Update

1. The Board wishes to record its concern over the potential for unsold units at the Park Rise development.

    - **Response**: *O&S Board's concern over the potential for unsold units at the Park Rise development is noted – the position is being monitored by the JV Partnership Board. The Council has the option to purchase unsold units at a discount, as detailed within the Exempt report*

2. It is recommended that it be investigated if sole tenants etc of larger flats in the vicinity of New Green can be moved into the development itself, thus freeing up accommodation for families.

    - **Response** *O&S have suggested that it be investigated if sole tenants of larger flats in the vicinity of New Green can be moved into the development itself, thus freeing up accommodation for families. The scheme is fully occupied at present – this would be a matter to consider when future lettings arise.*

3. More detail should be given on social value aspects of the Joint Venture and the use of s. 106 funding. It is recommended that Havering Wates should consult with ward Members on these issues.

    - **Response**: *Social value is generally delivered during the construction phase and further detail of social value proposals will be conveyed to ward Members at the appropriate time for each development. A S106 Agreement is already in place for Waterloo/Queen Street and details how the funding contributions are to be applied. The planning decision number is P0761.20.*

57 **MERCURY LAND HOLDINGS BUSINESS PLAN UPDATE 2025/26**

Report: Mercury Land Holdings (MLH) Business Plan and Budget Update 2025/26.

Presented by: Councillor Ray Morgon, Leader of the Council.

Summary: (response to Overview & Scrutiny comment, at end of this summary)

This report seeks Cabinet approval for the updated MLH Business Plan 2025/6 and its associated financial commitments. The Business Plan includes an update to the development programme and re-profiles the existing approved funding envelope, which was previously provided by the Council, to projects set out in the Exempt Report & Appendices. The updated Business Plan does not seek any additional funding commitment.

Cabinet should note that the updated MLH Business Plan 2025/6 will, if approved, provide a funding envelope within which MLH can operate. This is because every individual proposal for scheme funding must be supported by the production of a satisfactory business case, which is then subject to further examination and additional governance, at the appropriate time, before the Council can place MLH in funds. This, in turn, is regulated by legally binding funding agreements between the Council as lender and MLH as borrower.

For those not familiar with MLH, and why it was formed, Cabinet resolved to establish a commercially focused company that would deliver housing for private rent and sale in May 2015. Mercury Land Holdings Limited (MLH) was subsequently incorporated in November 2015. MLH is wholly owned by the Council. Since its formation, MLH has established and manages a portfolio of private rented sector (PRS) homes. It has also developed and sold properties for private sale and affordable rent.

The MLH Business Plan seeks to reaffirm MLH's commitment to significant schemes that are critical for the long term success of the company such as Como Street, but also to new schemes which would deliver additional PRS and sale opportunities, that would support the continued growth of the company.

It is proposed that the Council will dispose of assets (land/buildings) to MLH at market value and that the Council will provide finance to MLH through a combination of equity investment and loans. This will constitute capital expenditure for the Council within its approved Capital Programme, to be financed through Council reserves and/or borrowing. The overall financing arrangements will be subject to an assessment of Subsidy Control (State Aid), long term affordability, risk and return on investment by the Council.

The reallocated funds have been modelled and their impact on the Medium Term Financial Strategy (MTFS) is addressed in the exempt part of this report. This seeks to inform Cabinet of the expected outputs from MLH, as

well as advising of any changes in the financial position of MLH and the Council's financial commitments to MLH as an investor.

Cabinet

1. **Approved** the Mercury Land Holdings Limited Business Plan Update (see Exempt Appendix 3).

2. **Agreed** to delegate authority to the Cabinet Member for Regeneration & Development, in consultation with the S151 Officer, the Strategic Director of Place and the Monitoring Officer, to approve the detailed business cases, related viability assessments and funding requirements for the individual schemes noted within the Business Plan as they may be presented during the business plan period, including the authority to enter into all relevant agreements to give effect to the schemes.

3. **Agreed** that the previously allocated funding in the July 2023-2026 Business Plan to MLH, up to a maximum of £270.1 million, is reallocated to projects as updated in the Exempt Agenda, through a combination of equity investment and Subsidy Control compliant loans.

4. **Noted** that the individual schemes are subject to detailed business cases to be approved under delegated authority, as set out in Recommendation 2.

5. **Agreed** to delegate to the Strategic Director of Resources, in consultation with the Assistant Director of Regeneration and Place Shaping, and the Deputy Director of Legal and Governance, the authority to determine the principles and processes by which any assets shall be disposed of and the terms of disposal to MLH.

Overview & Scrutiny Board – Comments To Cabinet on Budget & Related Papers

Following its meeting on 29 January 2025, the Overview and Scrutiny Board submits the following comments to Cabinet and requests that Cabinet responds to these at its meeting on 5 February 2025.

Mercury Land Holdings (MLH) Business Plan and Budget Update 2025/26

1. The possibility should be explored of MLH homes being used as temporary accommodation or to otherwise assist with the housing shortage.

    - ***Response****: With regard to the suggestion of using MLH homes as temporary accommodation or to otherwise assist with the housing shortage, this proposal does not align with the MLH model. MLH*

was established to deliver high quality, private-rented stock, but in so doing sometimes provides opportunities for the HRA to purchase homes which are used to help meet demand for affordable housing (such as Crow Lane and Quarles). Other initiatives are in progress to mitigate temporary accommodation pressures faced by the Council.

2. That MLH be formally requested to make a list of used contractors available to Members.

   - **Response**: MLH have been requested by O&S to make a list of their contractors available to Members. MLH are a separate company, albeit wholly owned by the Council, and as such are not required to make commercial information available in this way. Officers are seeking legal advice on this issue.
     I would respectfully suggest that this recommendation falls outside of the scope of the Business Plan being reviewed at O&S.

3. That the governance structure of MLH be reviewed to ensure that it is still fit for purpose, in line with a re-assessment of whether it is being utilised in such a way as to maximise the impact on the General Fund.

   - **Response**: Cabinet is satisfied that the governance structure for MLH, as set out in the Business Plan Update, remains fit for purpose and that MLH continues to support the Council's financial interests

58 **EDUCATION FUNDING**

Report: Schools and Education Funding

Presented by: Councillor Oscar Ford, Cabinet Member for Children & Young People

Summary:

This report provides an overview of the current status of the Dedicated Schools Grant (DSG) Budget and Havering maintained schools. It sets out some of the current issues in Education funding - in particular the High Needs Block which is under severe financial pressure and also the number of schools that are in deficit and the ways the Council is seeking to mitigate and reduce these problems including participation in the Delivering Better Value (DBV) programme run by the Department for Education (DfE).

It also proposes a review of current funding mechanisms and the rates paid for certain kinds of support. This is in response to calls from schools and other stakeholders that the funding mechanism provide greater flexibility and transparency for schools in meeting pupil needs, and may likewise have the potential to more accurately matching resources to pupil needs.

Cabinet

1) **Noted** the update on the Dedicated Schools Grant Funding for 2025-26 in section 1
2) **Approved** the topslicing of £0.430m from the Schools Block for Growth and Falling Rolls as set out in paragraph 2.4
3) **Approved** the transfer of £1.290m from the Schools Block to the High Needs Block as set out in paragraph 2.5
4) **Approved** the use of the national funding factors, a Minimum Funding Guarantee of 0% and capping of 0.85% in the Havering Local Schools Funding Formula
5) **Noted** the increase in the Early Years Block as a result of the expansion of funded childcare for younger children as set out in section 3
6) **Delegated** authority to the Assistant Director of Education to approve the rate(s) per hour of childcare in line with approach outlined in section 3 after consultation with providers and schools forum
7) **Noted** that there are a number of Havering Maintained Schools that are in overall deficit position and that these schools are required to draw up and implement plans to recover this position as set out in section 5
8) **Noted** the update on the projected deficit on the High Needs Block and the Delivering Better Value Programme as set out in sections 6 and 7
9) **Approved** an increase in the funding of Special Units in mainstream schools to £30,000 per place from September 2024 as set out in section 8
10) **Approved** an increase in the base hourly rate of top up payments for additional support in mainstream schools to £19 an hour from September 2024 as set out in section 9

Chairman

Havering
LONDON BOROUGH

CABINET

Subject Heading:	Permission to procure a framework for Adult Social Care Residential & Nursing Care Home, Homecare and Supported Living Placements.
Cabinet Member:	Councillor Gillian Ford, Cabinet for Health and Adult Care Services
ELT Lead:	Barbara Nicholls, Strategic Director of People
Report Author and contact details:	Alain Rosenberg Alain.Rosenberg@havering.gov.uk
Policy context:	At a local level, this contract supports Havering Council meet its priorities in its Corporate Plan 2024/25. This plan sets out how the Council intends to invest and transform the borough with an emphasis on improving the lives of vulnerable children, adults and families. In summary, this framework ensures the Council fulfils its aim of ensuring that the needs of the most vulnerable are met and that people are supported to be healthy and active.
Financial summary:	The budget for this procurement will come from Adult Social Care budgets. Placements will be called off as required using the brokerage system, from the framework which will have no minimum or maximum value, nor will any commitment to expenditure by the Council be stipulated within the framework contracts. Expenditure will only be incurred when individual packages of care are purchased. The annual expected spend for the framework system will be approx. £90 million. This is based on 2023/24 spend on ASC placements. Therefore, the expected spend for the 4-year framework will be £360 million.
Is this a Key Decision?	Yes (a) Expenditure or saving (including anticipated income) of £500,000 or more

When should this matter be reviewed?

Reviewing OSC: People

The subject matter of this report deals with the following Council Objectives

People - Supporting our residents to stay safe and well	X

SUMMARY

This decision paper is seeking permission to procure a framework for Adult Social Care Residential & Nursing Care Home, Homecare and Supported Living Placements to replace the current Complex Dynamic Purchasing System (DPS).

The procurement of a comprehensive framework for Adult Social Care encompassing Residential & Nursing Care Homes, Homecare, and Supported Living Placements is an indispensable step towards enhancing the quality of care and support for adults in need.

This document outlines the fundamental reasons why such a framework is essential and highlights the multitude of benefits and improvements it brings to the realm of adult social care.

RECOMMENDATIONS

Cabinet to approve the procurement of a framework for Adult Social Care Residential & Nursing Care Home, Homecare and Supported Living Placements.

REPORT DETAIL

The Council has a legal responsibility to assess the needs of any resident or Carer living in the borough who appears to have a need for care and support; and to then determine whether those needs are eligible for this provision from the Council, as stipulated in The Care Act (2014) and The Children and Families Act (2014).

The Council is increasingly delivering a strengths-based model in Social Care. A strengths-based approach identifies, in partnership with residents, what they are able to do and encourages them to talk about what they find difficult to manage and what would help them the most - the outcomes that matter to them. It then explores how these outcomes may be met through their informal networks / making new local, community connections before considering directly commissioned care and support. Regular review enables practitioners to see what's working and not working and if the support provided is fit for purpose.

This decision paper is seeking permission to procure a framework for Adult Social Care Residential & Nursing Care Home, Homecare and Supported Living Placements to replace the current Complex Dynamic Purchasing System (DPS).

The procurement of a comprehensive framework for Adult Social Care encompassing Residential & Nursing Care Homes, Homecare, and Supported Living Placements is an indispensable step towards enhancing the quality of care and support for adults in need.

Ensuring High-Quality Care
A well-structured framework serves as a blueprint for delivering high-quality care and support services. It establishes clear standards and guidelines that care providers must adhere to, ensuring consistency and reliability in the care delivered.

The framework will aid in:

- Setting uniform standards across various care settings to maintain a high level of care quality.
- Enhancing accountability among care providers through regular monitoring and evaluation.
- Facilitating continuous professional development for staff to keep them updated with best practices and new methodologies.

Benefits and Improvements

The implementation of the framework brings about significant improvements in the care and support of adults, including:

- The framework emphasizes holistic care, addressing not only physical health but also emotional, social, and mental well-being.
- By establishing stringent safety protocols, the framework ensures a secure environment for all residents.
- Better coordination among different service providers results in seamless and integrated care.
- Continuous quality assessments help in identifying areas for improvement and implementing necessary changes promptly.

Person-Centered Care

At the heart of the framework lies the principle of person-centered care, which focuses on respecting and responding to the individual's needs, preferences, and values. This approach:

- Encourages residents to actively participate in their care decisions, promoting autonomy and self-esteem.
- Develops personalized care plans that cater to the unique requirements of each individual.
- Fosters a trusting relationship between caregivers and residents, enhancing the overall care experience.

Conclusion

In conclusion, procuring a framework for Adult Social Care Residential & Nursing Care Home, Homecare, and Supported Living Placements is pivotal in ensuring high-quality care and support for adults in need. The framework's emphasis on standardization, person-centered care, and continuous improvement fosters an environment where residents can thrive and live with dignity. The positive impact on well-being and quality of life underscores the necessity of implementing such a framework, making it a cornerstone of modern adult social care.

REASONS AND OPTIONS

Reasons for the decision:

The reasons are set out in the main report

Other options considered:

Option 1 - Do nothing and continue with the current complex DPS

There is an option to do nothing and continue with the complex dynamic purchasing system (DPS) which is currently in place and to extend this by an additional two years built into the

contract until 30th April 2027. This option is not advised due to the current DPS saturating the provider markets due to over subscription and the inability to close lots.

Option 2 – SPOT Purchase ASC Placements
There is an option to just SPOT purchase adult social care placements. This option has been rejected due to the below reasons:

- Frameworks ensure a consistent standard of care, whereas spot purchasing can result in varying quality due to the ad-hoc nature of the arrangements.
- Framework agreements provide predictable costs and service levels, reducing the uncertainty and variability associated with spot purchasing.
- Frameworks foster long-term partnerships with care providers, enhancing trust and reliability, which are crucial for delivering high-quality care.
- Frameworks reduce administrative burdens by streamlining procurement processes, whereas spot purchasing may require repeated negotiations and contract management for each placement.

IMPLICATIONS AND RISKS

Financial implications and risks:

The budget for this procurement of placements will come from current Adult Social Care budgets. Placements will be called off as required using the brokerage system, from the framework which will have no minimum or maximum value, nor will any commitment to expenditure by the Council be stipulated within the framework contracts. Expenditure will only be incurred when individual packages of care are purchased. There are no additional costs as a result of implementing the framework, any additional costs would have materialised due to client growth and client needs.

The annual expected spend for the framework system will be approx. £90 million. This is based on 2023/24 spend on ASC placements. Therefore, the expected spend for the 4-year framework will be £360 million.

To support the implementation and make the framework as effective as possible there is a requirement for a new system, a separate decision paper is being worked on for the additional system. The implementation of this framework is not reliant on the new system and can still be implemented using the current system but will be less effective.

Legal implications and risks:

The Council has a general power of competence under section 1 of the Localism Act 2011 to do anything an individual may generally do subject to any statutory limitations. The Council has the power under this section to agree to the proposals in the recommendations.

The value of the proposed framework is £360 million over 5 years. The subject matter of the contract falls within the light touch regime (LTR) under Schedule 3 of the PCR. The proposed value of the contract exceeds current the threshold for LTR services of £663,540 and therefore is subject to Part 3 of the PCR.

The proposed open tender is compliant with the requirements of both the PCR and the Council's Contract Procedure Rules for contracts of this nature.

Human Resources implications and risks:

The recommendations made in this report do not give rise to any identifiable Human Resources implications or risks.

Equalities implications and risks:

Havering has a diverse community made up of many different groups and individuals. The council values diversity and believes it essential to understand and include the different contributions, perspectives and experience that people from different backgrounds bring. The Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010 requires the council, when exercising its functions, to have due regard to:

I. the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
II. the need to advance equality of opportunity between persons who share protected characteristics and those who do not, and;
III. Foster good relations between those who have protected characteristics and those who do not.

Note: 'protected characteristics' are: age, gender, race and disability, sexual orientation, marriage and civil partnerships, religion or belief, pregnancy and maternity and gender reassignment.

The Council demonstrates its commitment to the Equality Act in its decision-making processes, the provision, procurement and commissioning of its services, and employment practices concerning its workforce. In addition, the Council is also committed to improving the quality of life and wellbeing of all Havering residents in respect of socio-economics and health determinants.

A diverse range of providers has been engaged to deliver personalized services that meet the unique needs of the population. The service is accessible to all individuals, regardless of their disability, condition, or illness.

Health and Wellbeing implications and Risks

The council demonstrates its commitment to the Equality Act in its decision-making processes, the provision, procurement and commissioning of its services, and employment practices concerning its workforce. In addition, the council is also committed to improving the health and well-being of all Havering residents concerning socio-economics and health determinants.

This framework will have a positive impact on the health and well-being of people with complex needs by the ability to set the criteria to meet the needs of a service user and to meet the quality outcomes including health and wellbeing. By allowing choice and competition to meet a service user's requirements, it will improve access to high-quality health and social care services and reduce health inequalities related to these vulnerable groups:

- Adults with a learning disability
- Adults with mental health needs
- Adults with needs resulting from physical and/or sensory disabilities
- Older people with complex needs
- Other vulnerable adults who meet Care Act eligibility criteria

Through the framework and brokerage system, the Council will ensure that each package of care commissioned will deliver personalised and continuity of care with the service user's involvement that helps them achieve their outcomes.

Improving health and well-being will be an essential aspect of each care plan, and suppliers are required to report to the Council on each service user's health and well-being outcomes, including;

- Promoting the independence of individuals to lead the life they wish
- Behaviour and lifestyle such as diet, exercise or self-care
- Mental health and wellbeing
- Access to and quality of education or other training opportunities
- Employment, income, opportunities for economic development
- Access to green space, sports facilities and opportunities to be active
- Opportunity to interact socially with other people, social isolation,
- community support networks and being able to live independently
- Ability to access health and social care services
- Transport, and connections to places within or between the Borough

This framework will lead to an improvement in the quality of life, health and wellbeing for the service users in supported living, residential, nursing, live in, and domiciliary care services.

Environmental and Climate Change Implications and Risks:

The recommendations made in this report do not give rise to any Environmental or Climate Change implications or risks.

BACKGROUND PAPERS

None

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Havering
LONDON BOROUGH

CABINET

Subject Heading:

Approval to enter into a s75 Agreement with the Havering Place-Based Partnership to govern the delivery of the Better Care Fund 2025-2026

Cabinet Member:

Cllr Gillian Ford, Cabinet Member for Adults and Health

ELT Lead:

Barbara Nicholls, Strategic Director of People

Report Author and contact details:

Laura Wheatley

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Policy context:

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

Financial summary:

The Better Care Fund will provide £37,733,806 to be spent on Health and Social Care.

2025-2026	
DFG	£2,552,158
NHS Minimum Contribution	£28,177,595
Local Authority Better Care Grant	£8,419,703
Additional LA contribution	£873,730
Additional NHS contribution	£0
Total	**£40,023,186**

Is this a Key Decision?

(a) Expenditure or saving (including anticipated income) of £500,000 or more

(c) Significant effect on two or more Wards

When should this matter be reviewed?	12th March 2025
Reviewing OSC:	People's Overview and Scrutiny Sub Committee

The subject matter of this report deals with the following Council Objectives

People - Supporting our residents to stay safe and well	**X**
Place - A great place to live, work and enjoy	
Resources - Enabling a resident-focused and resilient Council	

SUMMARY

This report seeks approval to enter into a s75 Agreement with the Havering Place-Based Partnership to govern the delivery of the Better Care Fund 2025-2026.

The oversight for this in Havering will be the Health and Wellbeing Board, with delegated authority to the Cabinet Member for Adults and Health and the Strategic Director of People, to undertake monitoring and scrutiny of the operation of the arrangements.

RECOMMENDATIONS

That Cabinet:

1. Agree to enter into a section 75 agreement with Havering Place-Based Partnership, on the terms and conditions outlined in this report, to govern the delivery of the approved Better Care Fund Plan for Havering for the period 2025/2026.

2. Delegate authority to approve the final terms of the proposed section 75 agreement to the Cabinet Member for Adults and Health, after consultation with the Leader of the Council and the Strategic Director of People.

3. Delegate the function of monitoring the implementation and operation of the Better Care Fund and s75 Agreement to the Cabinet Member for Adults and Health.

4. Delegate authority for all necessary decisions with respect to the implementation and operation of all matters relating to the Better Care Fund and section 75 agreement to the Strategic Director of People.

REPORT DETAIL

This report seeks approval to enter into a s75 Agreement with the Havering Place-Based Partnership to govern the delivery of the Better Care Fund 2025-2026.

Introduction
The Better Care Fund (BCF) is a program established by the UK government to promote the integration of health and social care services. It aims to provide better coordinated and more person-centered care by pooling resources from the National Health Service (NHS) and local government budgets. The initiative is designed to address the challenges posed by an aging population and increasing demand for health and social care services.

Goals of the Better Care Fund
The primary goals of the Better Care Fund are:

- Improving Health and Wellbeing: To enhance the overall health and wellbeing of individuals by providing more coordinated and seamless care services.
- Reducing Hospital Admissions: To reduce unnecessary hospital admissions and readmissions by offering better support and care in the community.
- Enhancing Care Quality: To improve the quality of care provided to patients by integrating health and social care services.
- Promoting Independent Living: To support individuals to live independently for as long as possible by providing the necessary care and support in their homes or communities.

Benefits for Residents
The Better Care Fund offers several benefits for residents, including:

- Coordinated Care: Residents receive more coordinated care, reducing the need for multiple assessments and ensuring that all their healthcare and social care needs are addressed holistically.
- Improved Access: Residents have better access to a range of services, including preventive care, community support, and rehabilitation services, leading to improved health outcomes.
- Enhanced Resident Experience: By providing more personalized and integrated care, patients experience a higher quality of service and greater satisfaction with their care.
- Support for Independent Living: Residents are supported to live independently in their homes, reducing the need for long-term institutional care.

Benefits for Healthcare Providers
Healthcare providers also benefit from the Better Care Fund in several ways:

- Resource Optimization: By pooling resources and working collaboratively, healthcare providers can optimize the use of available resources and reduce duplication of services.

- Improved Communication: Enhanced communication and information sharing between health and social care providers leads to better decision-making and more effective care planning.

- Reduced Pressure on Hospitals: By providing better support in the community, the pressure on hospitals is reduced, allowing them to focus on acute and specialist care.

- Professional Development: Health and social care professionals have the opportunity to develop new skills and knowledge through integrated working practices.

Delivering BCF Key Objectives for 2025-26

Objective 1: Shift from Sickness to Prevention

Havering will implement plans to:

- Provide timely, proactive, and coordinated support for individuals with complex health and care needs.
- Enhance the use of home adaptations and technology to support independent living.
- Offer comprehensive support for unpaid carers.

Objective 2: Support Independent Living and Transition from Hospital to Home

Havering will deliver plans to:

- Prevent avoidable hospital admissions through early intervention and community-based care.
- Ensure timely and effective discharge from hospitals, enabling individuals to recover at home.
- Reduce the need for long-term residential or nursing home care by promoting home-based care solutions.

How Havering Will Meet These Objectives

- Implement agreed joint plan with ICB, signed off by the HWB, involving NHS trusts, social care providers, voluntary partners, and housing authorities.
- Implement BCF objectives to support the shift from sickness to prevention and independent living.
- Comply with funding conditions, including maintaining a minimum NHS contribution to adult social care and meeting specified spending expectations.
- Engage with oversight and support processes, including a regionally led oversight process and enhanced support where there are performance concerns.

Metrics for 2025-2026

Havering will set goals against three headline metrics:

- Emergency hospital admissions for people over 65 per 100,000 populations.
- Average length of discharge delay for all adult patients.
- Long-term admissions to residential or nursing homes for people over 65 per 100,000 populations.

Havering will prepare plans showing projected demand and planned capacity for intermediate care services to support independence and avoid unnecessary hospital admissions.

Delivery via Section 75 Agreement with Havering Place Based Partnerships

The Better Care Fund is delivered through various mechanisms, including Section 75 agreements, which allow NHS bodies and local authorities to pool budgets and integrate services. In Havering, the BCF is implemented via a Section 75 agreement with Havering Place Based Partnership.

Key Features of the Section 75 Agreement:

- Pooled Budgets: Resources from the NHS and local authority are combined to create a single budget for health and social care services.
- Joint Commissioning: Health and social care services are jointly commissioned to ensure that they meet the needs of the local population effectively.
- Integrated Service Delivery: Services are delivered in a more coordinated and integrated manner, providing a seamless experience for patients.
- Shared Governance: Governance structures are established to oversee the implementation and management of the integrated services, ensuring accountability and transparency.

Impact of the Section s75 Agreement:

- Enhanced Collaboration: Health and social care organizations work more closely together, fostering a culture of collaboration and shared responsibility.
- Improved Outcomes: The integrated approach leads to better health and social care outcomes for the local population.
- Efficient Service Delivery: Services are delivered more efficiently, reducing costs and improving value for money.
- Community Engagement: The partnership engages with the local community to ensure that services are responsive to their needs and preferences.

The Care Act 2014

The BCF underpins the implementation of the Care Act 2014, from a health integration perspective. A BCF national condition is the protection of social care services. The schemes will help support Care Act principles, as services are developed to be more personalised and person centred across the whole system.

Section 121 of the Care Act 2014 (Integration of care and support with health services: integration fund) provides for section 75 agreement with regard to expenditure on integration.

Funding Overview

BCF funding consists of mandatory contributions from integrated care boards (ICBs) and local authorities. Local areas can also voluntarily pool additional funding if it represents value for money.

Minimum Contributions

The minimum contributions to the BCF nationally for 2025 to 2026 are as follows:

- Minimum NHS Contribution: £5,614 million
- Local Authority Better Care Fund Grant: £2,640 million
- Disabled Facilities Grant: £711 million

Discharge Funding
The previously ring-fenced discharge fund is now consolidated within the BCF, with a focus on reducing discharge delays. The ICB discharge funding is part of the NHS minimum contribution, while local authority discharge funding is included in the Local Authority Better Care Grant.

NHS Minimum Contribution
The NHS minimum contributions to adult social care from the total national amount will increase by 3.9% compared to 2024 to 2025.

Local Authority Better Care Grant
The Local Authority Better Care Grant must be pooled into a section 75 arrangement under the NHS Act 2006 and used according to BCF plans, without offsetting the NHS minimum contribution to adult social care.

Disabled Facilities Grant
The Disabled Facilities Grant supports housing adaptations to help people stay well and independent. The government plans to review and update the allocations formula and the grant maximum per application, currently £30,000.

Havering Allocation
The 2025 to 2026 Local Authority Better Care Grant, NHS minimum contribution and Discharge Funding for Havering are as follows:

2025-2026	
DFG	£2,552,158
NHS Minimum Contribution	£28,177,595
Local Authority Better Care Grant	£8,419,703
Additional LA contribution	£873,730
Additional NHS contribution	£0
Total	**£40,023,186**

Conclusion
The Better Care Fund is a pivotal initiative aimed at transforming health and social care services in the UK. By promoting integration and collaboration, it enhances the quality of care, improves patient outcomes, and supports independent living. The implementation of the BCF through a Section 75 agreement exemplifies how local authorities and NHS bodies can work together to create a more effective and efficient care system for the benefit of all.

REASONS AND OPTIONS

Reasons for the decision:
There is a statutory requirement for the BCF funds to be managed via pooled funding arrangements.

Other options considered:
The option of not entering into an agreement would only be feasible if we were not signing up to BCF principles and delivery, which is not a desirable option.

IMPLICATIONS AND RISKS

Financial implications and risks:
The recommendations made in this report do not give rise to any identifiable Financial implications or risks.

Legal implications and risks:
The Better Care Fund grant regime requires the Council to work jointly with the Havering Place Based Partnership. The section 75 National Health Service Act 2006 Agreement is the vehicle by which the services that are to be delivered; the mechanism for expenditure; and delivery of outcomes are clarified to ensure each party knows exactly how it will operate and to reduce the risk of disputes. There is no alternative but to enter into the agreement in order to prudently use and retain the grant funding. The terms of the agreement will need to be carefully considered to ensure the Council's interests are not prejudiced in any way and that the risk of disputes are minimised. Legal advice will be provided throughout this process.

The Local Government Act 2000 allows Cabinet to delegate its decision making powers to an individual Cabinet Member or officer of the Council.

Human Resources implications and risks:
The recommendations made in this report do not give rise to any identifiable Human Resources implications or risks.

Equalities implications and risks:
This decision is to ensure that the Council has a section 75 agreement in place to deliver the Better Care Fund.

All identified opportunities for integrated delivery of care and effective integrated commissioning in Havering will be informed by the local population needs identified in the needs assessments and the priorities for health improvement and wellbeing set out in the Health and Well-Being Strategy.

The programme of integration initiatives will enable partner organisations to identify more effective ways of meeting future demographic challenges in the delivery of health and social care services across Havering, such as the significant and growing proportion of older people in the borough and increasing ethnic minority population.

Health and Wellbeing implications and Risks
The recommendations made in this report do not give rise to any identifiable Health and Wellbeing risks.

ENVIRONMENTAL AND CLIMATE CHANGE IMPLICATIONS AND RISKS

The recommendations made in this report do not give rise to any identifiable environmental implications or risks.

BACKGROUND PAPERS

None

Havering
LONDON BOROUGH

CABINET

Subject Heading:	Havering All-Age Suicide Prevention Strategy 2025-30
Cabinet Member:	Councillor Gillian Ford, Deputy Leader
ELT Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Samantha Westrop, Samantha.westrop@havering.gov.uk Isabel Grant-Funck, Isabel.grant-funck@havering.gov.uk
Policy context:	Making suicide prevention everyone's business is a process in which every organisation working in, and for, Havering must do to play their part in keeping people safe from suicide. The strategy sets out how to achieve this; organisation's strategies, policies and services will be suicide-informed, knowledge and awareness amongst Havering residents and Council employees will be increased.
Financial summary:	There are no additional financial costs associated with the adoption of the strategy.
Is this a Key Decision?	Yes, significant effect on two or more Wards
When should this matter be reviewed?	February 2030
Reviewing OSC:	Health

The subject matter of this report deals with the following Council Objectives

People - Supporting our residents to stay safe and well **X**
Place - A great place to live, work and enjoy **X**
Resources - Enabling a resident-focused and resilient Council **X**

SUMMARY

This five-year strategy titled Havering All-age Suicide Prevention Strategy 2025-2030: *Working Together to Save Lives* sets out why death by suicide is a priority for concern, the suicide risk factors and inequalities associated with death by suicide, and what work can be done to help reduce suicidality going forward within Havering. Suicide is often the end of a complex history of risk factors and distressing events, and can result in a profound and long-lasting impact on families and friends, neighbours, workplaces, and schools, and bereavement by suicide is in itself a risk factor for death by suicide.

Every death by suicide is preventable, so the strategy aims to set out suicide prevention activities within Havering; leading to a reduction in the number of deaths by suicide over the next five years. This aim will be met through objectives focused on:

- **identifying** those at increased risk and applying the most effective evidence-based interventions for our local population and setting
- **prevention** activities across the system including increasing knowledge and reducing stigma
- **support** at both individual and population levels, including those at risk of suicide and the bereaved

These objectives will be achieved through the delivery of a detailed action plan, and monitored by a Havering Suicide Prevention Steering Group with a membership drawn from representatives of the Council and NHS, Safeguarding leads, mental health charities, and people with lived experience.

Public Consultation
The suicide prevention strategy went to public consultation and now seeks approval for the strategy to be adopted. The public consultation received views and comments of residents, stakeholders, the voluntary and community sector and workforces of statutory agencies. Responses to the consultation were then analysed. Please see consultation report in the papers attached.

RECOMMENDATIONS

The Cabinet agree the Havering All-age Suicide Prevention Strategy attached.

REPORT DETAIL

The Havering All-Age Suicide Prevention Strategy sets out the objectives to meet the aim of reducing death by suicide in Havering. The strategy is attached, but here is an outline of the content of the report:

- Executive summary
- Foreword
- Strategy on a page
- Introduction, including timescales and consultation details
- What we know about suicide, including national and Havering data, risk factors for suicide, and inequalities
- Priority groups
- Working together, including multi-agency case review panels, vision, aim, objectives, all-age strategy explanation
- How we will fulfil our three objectives (identify, prevent support)
- Governance of strategy
- Glossary of terms
- Appendices, including high-level action plan, Main sources of evidence, members of Havering Suicide Prevention Stakeholder Group

REASONS AND OPTIONS

Reasons for the decision:
Havering Council has a responsibility to improve health and wellbeing and reduce inequalities for residents in accordance with the Health and Social Care Act 2012.

Death by suicide is a significant public health problem, globally, nationally and locally. The current suicide rate for Havering is higher than the rate for London as a whole although not statistically significantly different to England, according to 2020-2022 ONS data. According to Samaritans, for every death by suicide, 135 people are impacted on average. Havering, on average, has a resident death by suicide once every three weeks, meaning that on average 2,340 people are impacted by Havering deaths by suicide per year, if not more.

The risk of death by suicide is not the same across the whole population, as people living in the most disadvantaged communities face the highest risk of dying by suicide. Inequalities also exist in the distribution of risk factors based on age, disability, gender identity and sexual orientation, ethnicity, religion and faith, maternity and stigma of mental ill-health. The strategy sets out these inequalities in detail.

The strategy is an all-age strategy because the suicide risk factors arise at different life stages; experiences throughout life, from childhood to old age, affect suicide risk. For example, children who have been suicide-bereaved, or experienced another adverse childhood experience have an increased lifetime risk of death by suicide and need specific support.

Other options:

Do not adopt the strategy, which means there is no strategic plan to reduce deaths by suicide in Havering.

IMPLICATIONS AND RISKS

Financial implications and risks:

This report is seeking approval for Cabinet to agree the Havering All-age Suicide Prevention Strategy.

There are no foreseen financial implications or risks associated with the adoption of the proposed suicide prevention strategy. Its implementation will be carried out by existing resources budget from within the Public Health funding source.

Should the strategy result in increased uptake of health services, these costs would fall to the NHS.

These financial implications have been signed off by the Head of Finance.

Legal implications and risks:

The Local Authority has a general duty under s 2B of the National Health Service Act 2006 as follows:

"2BFunctions of local authorities and Secretary of State as to improvement of public health
(1)Each local authority must take such steps as it considers appropriate for improving the health of the people in its area.
…
(3)The steps that may be taken under subsection (1) or (2) include—
(a)providing information and advice;
(b)providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way);
(c)providing services or facilities for the prevention, diagnosis or treatment of illness;
(d)providing financial incentives to encourage individuals to adopt healthier lifestyles;
(e)providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment;
(f)providing or participating in the provision of training for persons working or seeking to work in the field of health improvement;
(g)making available the services of any person or any facilities."

The proposed strategy is one of the ways that the Local Authority can comply with this statutory duty and therefore there are no legal implications in approving this."

Human Resources implications and risks:
There does not appear to have any direct workforce implications with the implementation of the Strategy. It is therefore cleared from a HR perspective.

Equalities implications and risks:
A full Equality and Health Impact Assessment has been carried out and is attached in background papers.

Health and Wellbeing implications and Risks
The Suicide Prevention Strategy 2025-2030 aims to positively impact mental health and wellbeing in Havering by reducing stigma, increasing awareness and promoting early intervention. Additionally, it focuses on improving resilience and effective coping mechanisms, as well as empowering Havering residents through strong support networks at all stages of life.

Death by suicide is a significant public health problem, globally, nationally and locally. A death by suicide not only effects the victim, but also their friends, family and wider community. It can deeply impact the mental health and emotional wellbeing of those connected to the victim, including colleagues, neighbours and others within the local area. This ripple effect can even lead to suicidal thoughts among those affected. The risk factors, and subsequent deaths from suicide, are not equally distributed across society. Havering Council has a responsibility to improve health and wellbeing and reduce inequalities for residents in accordance with the Health and Social Care Act 2012.

As part of meeting this responsibility, the suicide prevention strategy clearly outlines the commitment of Havering Council, through working with partners across the wider system, to prevent death by suicide, reduce health inequality, and to support those who are bereaved by suicide.

ENVIRONMENTAL AND CLIMATE CHANGE IMPLICATIONS AND RISKS

There are no environmental or climate change impacts from this decision. The recommendations made in this report do not appear to conflict with the Council's policy.

BACKGROUND PAPERS

Papers attached:

1. Havering Suicide Prevention Strategy 2025-2030
2. Suicide Prevention Strategy Consultation Report
3. Suicide Prevention Needs Assessment
4. Havering Suicide Prevention Strategy 2025-2030 EHIA
5. Havering Suicide Prevention Strategy 2025-2030: Easy-read version

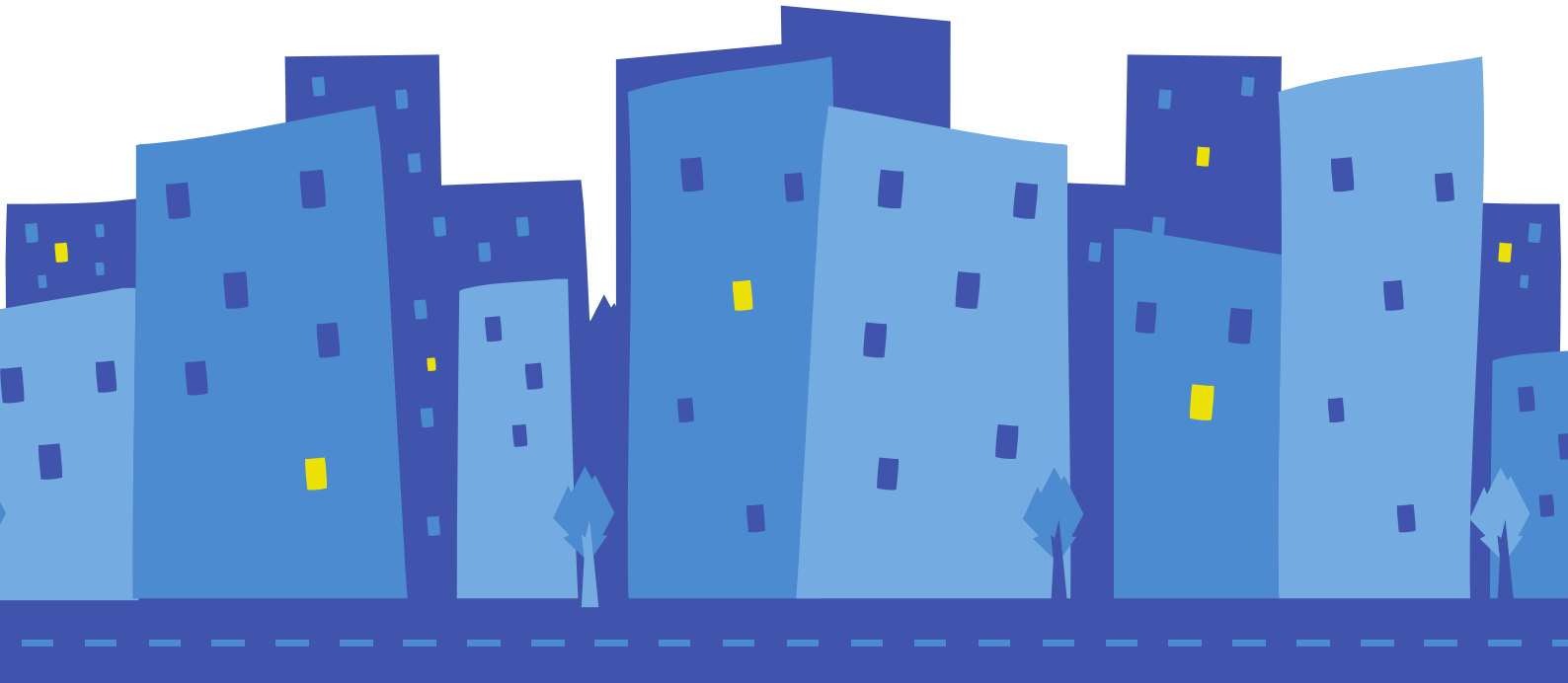
Suicide Prevention Strategy

Easy-Read Version

Content warning: The content of this document may be emotionally challenging as it discusses dying by suicide and self-harm.

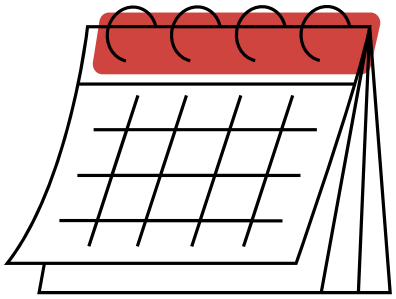
Support is available:

- **Samaritans** – a listening service which is open 24/7 for anyone who needs to talk.
- **Shout** – a free confidential 24/7 text service offering support if you're in crisis and need immediate help.



Suicide is what we call it when a person ends their own life.
Self-harm is when someone hurts themselves on purpose.

Every 3 weeks, someone in Havering dies by suicide.



Havering Council and partners have made a strategy to reduce the number of suicides in Havering. This strategy describes what should be done over the next 5 years.

It makes many people sad when someone ends their own life or hurts themselves on purpose.

We want to stop people from ending their own lives and hurting themselves.

We want people affected by suicide and self-harm to:

- feel safe and not judged
- get help when they need it
- be able to help other people

Who is affected?

Suicide can affect anyone. It does not matter what age or gender they are or where they live.

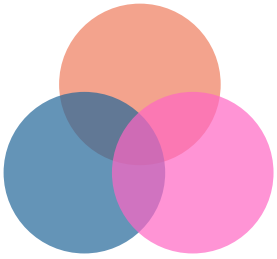
But some people are more likely to take their own life than others. We call them priority groups.
Priorities are the things that are most important.

Priority groups for suicide:

1. Men in their 40s and 50s
2. People being helped by mental health services
3. People who break the law
4. Autistic people
5. Children and young people
6. Pregnant women and women who recently had a baby
7. People who are in the army, marines, navy or airforce
8. People who live with a lot of physical pain

What causes suicide?

Suicide is complicated. It is caused by lots of things that often overlap.



There are groups who will be at risk, including:

- People who are bullied
- People who lost their job or don't have one
- People who have just got divorced or separated from their partner
- People who hurt themselves on purpose (self-harm)
- People stressed about school or college
- People who have depression or anxiety
- People who take drugs or drink too much alcohol
- People who do not have a secure place to sleep
- People who have had very bad experiences when they were young
- People who are sad because someone dies, especially if they died by suicide
- People who are lonely
- People who have money troubles

Not everyone who experiences these things will be at risk of suicide, but it can make the risk greater.

This plan will help everyone. But we know there is specific work to do to help people most at risk of suicide.

What we want:

We want to make sure that everyone works together to help prevent suicide in Havering.

We want professionals, employers, family and friends to know how to give and get support.

We want to make services better. So they are kind when people reach out for help.

We want people to know where to get help when they need it.

We want people to get support when they know someone who has been affected by suicide.

What we will do:

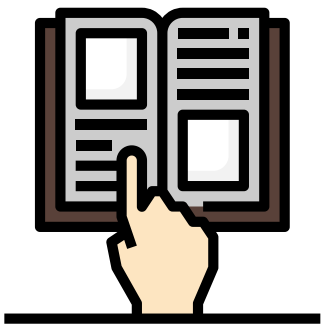
We will offer training and support to a range of services and people.

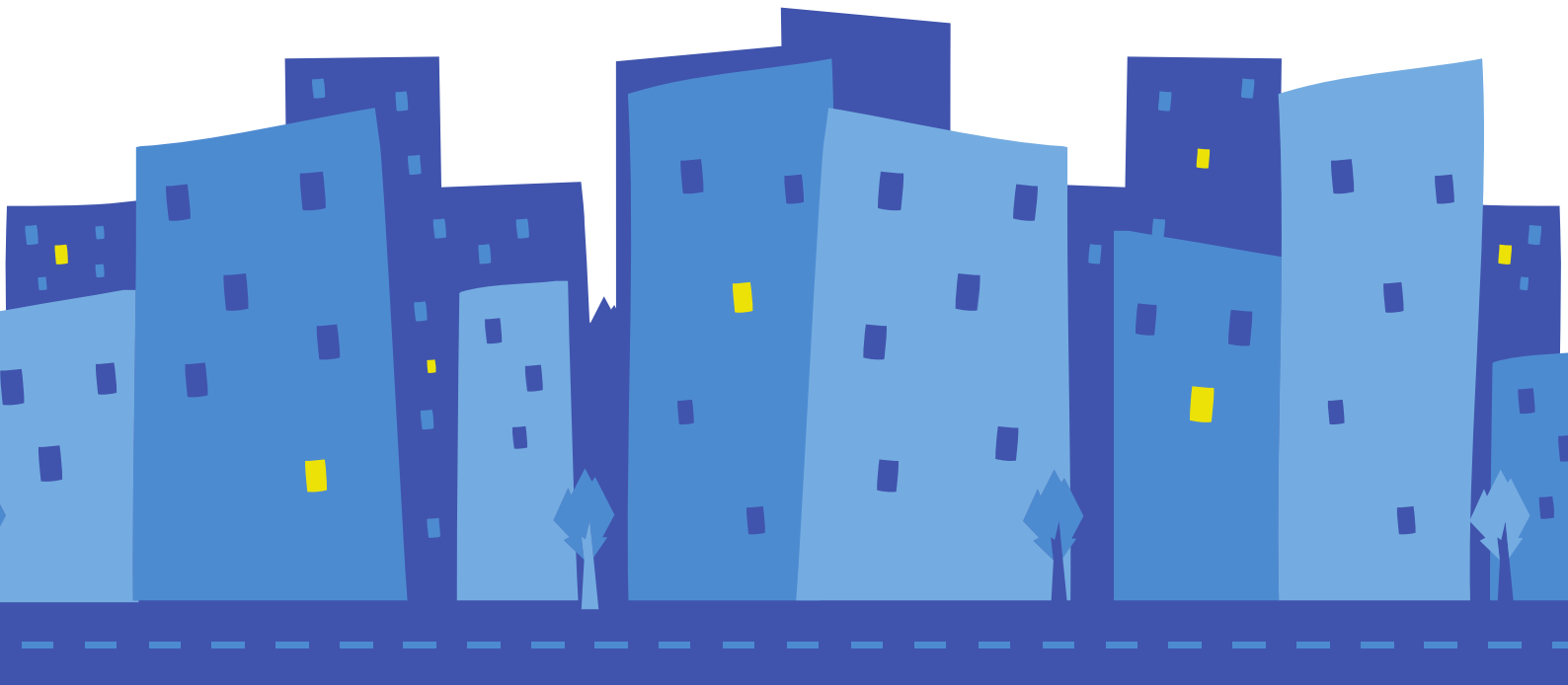
We will make sure services work together to give people all the support they need.

We will find ways to respond quickly to people who need help and improve how we respond to risks in Havering.

We will include people who have lived experience of suicide to help make decisions about suicide prevention work.

We will collect facts to understand why people kill themselves and who needs support and help to stay safe.





London Borough of Havering

Havering all-age suicide prevention strategy 2025-2030

Working together to save lives

Content warning: The content of this needs assessment may be emotionally challenging as it discusses suicidality and self-harm.

Support is available:

- Samaritans – a listening service which is open 24/7 for anyone who needs to talk.
- Campaign Against Living Miserably (CALM) - CALM's confidential helpline and live chat are open from 5pm to midnight every day.
- Shout – a free confidential 24/7 text service offering support if you're in crisis and need immediate help.

Document Control

Document details

Name	Havering Suicide Prevention Strategy 2025 - 2030
Version number	Version 1.0
Status	Final Version
Author	Samantha Westrop, Assistant Director Public Health, LBH Isabel Grant-Funck, Public Health Strategist, LBH Elaine Greenway, Assistant Director Public Health, LBH Luke Squires, Public Health Practitioner, LBH Esosa Edosomwan, Public Health Practitioner, LBH
Lead Officer	Mark Ansell, Director of Public Health, LBH
Approved by	
Scheduled review date	2030

Version history

Version	Change	Date	Dissemination
0.9	Alt text added to figures	23/09/2024	Internal
1.0	Consultation changes and updates	21/11/2024	Internal

Equality & Health Impact Assessment record

<table>
<tr><td>1</td><td>Title of activity</td><td colspan="3">Havering Suicide Prevention Strategy 2025-2030</td></tr>
<tr><td>2</td><td>Type of activity</td><td colspan="3">A multiagency strategy to prevent suicide</td></tr>
<tr><td>3</td><td>Scope of activity</td><td colspan="3">- What is the scope and intended outcomes of the activity being assessed?
- Make sure you highlight any proposed changes.
- Please make sure that your description is understood by everyone, including members of the public

This document sets out the local strategic approach for reducing deaths by suicide in the Borough. .</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="3">If the answer to <u>any</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 (9 protected characteristics)?</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></tr>
<tr><td>5</td><td>If you answered YES:</td><td colspan="3">Please complete the EqHIA in Section 2 of this document. Please see Appendix 1 for Guidance.</td></tr>
<tr><td>6</td><td>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.</td><td colspan="3"></td></tr>
</table>

Date	Completed by	Review date

Contents

Executive summary

A death by suicide is often the culmination of a complex interplay of risk factors and distressing life events, and results in a profound and long-lasting impact on families and friends. The effects extend beyond immediate circles, rippling through communities to affect neighbours, workplaces, schools and other social networks. Bereavement by suicide increases the risk of those affected taking their own lives.

Public health measures to reduce access to means of suicide and improve care for those who are at risk have contributed to a reduction in the national suicide rate since the 1980s. However, between 2015 and 2023, 194 lives were lost to suicide in Havering; averaging 19 deaths by suicide per year among residents[1].

From 2005 to 2021, the rate of suicide in Havering did not differ significantly from the London average. However, from 2020 to 2022, London recorded its lowest suicide rate at 6.9 per 100,000 people. This improvement in suicide rates was not seen in Havering, and consequently Havering now has a significantly higher rate of death by suicide (9.6 per 100,000) than London as a whole.

The risk of death by suicide is not evenly distributed across society. Those who are experiencing homelessness, debt, unemployment, or living in poverty are at heightened risk for poor mental health and suicide. Self-harm is the strongest predictor of death by suicide, with over half of those who die by suicide having a history of self-harm, often within the period leading up to their death[2]. In Havering, emergency hospital admissions for intentional self-harm are currently similar to the London average, yet there remains a need for targeted support and prevention strategies to reduce these admissions and support those who self-harm.

This suicide prevention strategy has been informed by national strategy and evidence, key population groups that are at higher risk, and additional local priorities. The complex nature of suicide means that prevention requires a coordinated, multi-agency approach spanning strategy, policy and frontline service delivery, in particular where local agencies come into contact with individuals who are more at risk. While most deaths by suicide occur within the home, one-third of deaths by suicide in Havering take place in public places. This highlights the need to mitigate the risks in these settings, both to prevent deaths and to manage the broader impact on the Havering community.

The strategy development has been led by the Council, in collaboration with the Lead Member for Adults and Wellbeing, the Public Health Service, and a wide range of Council and NHS frontline services. Over 20 stakeholder organisations contributed, alongside individuals who have experienced the pain of losing a loved one to suicide or have faced suicidal ideation themselves. Direct engagement and feedback was conducted with the Youth Council, Primary Care Networks (including GPs) and with head teachers and staff across Havering's education system.

[1] Suicide Prevention Strategy (havering.gov.uk)
[2] The National Confidential Inquiry into Suicide and Safety in Mental Health (2021), https://documents.manchester.ac.uk/display.aspx?DocID=55332

Every death by suicide is preventable, so we aim to improve the success of suicide prevention activities within Havering; leading to a reduction in the number of deaths by suicide over the next five years. This aim will be met through implementing objectives focused on:

- **identifying** those at increased risk and applying the most effective evidence-based interventions for our local population and setting
- **prevention** activities across the system including increasing knowledge and reducing stigma
- **support** at both individual and population levels, including those at risk of suicide and the bereaved

These objectives will be achieved through the delivery of a detailed action plan, the development of which was informed through consultation with the Suicide Prevention Stakeholder Group, detailed in Appendix 1. This detailed action plan will be monitored by a Suicide Prevention Strategy Steering Group, with representatives from the Council, NHS, safeguarding leads, mental health charities, and people with lived experience.

The strategy focuses on prevention, system coordination and addressing the wider determinants of health that influence the risk of a person dying by suicide. It outlines overarching goals and provides a framework for collaborative action across the wider system to reduce deaths by suicide in Havering, with the specific activities and timelines detailed in an accompanying action plan. Partner organisations are likely to have local policies, strategies and operational procedures relating to suicide prevention, and coordinated multi-disciplinary working, drawing on strengths and opportunities, will deliver the maximum benefit for the people of Havering.

Foreword

As co-signatories to this strategy we believe that every suicide is preventable, and each life lost to suicide is one too many. Far too many of us have experienced the pain and grief that suicide inevitably leaves behind, being personally affected or standing alongside others who have gone through the tragic loss of a partner, child, parent, friend or colleague.

We strongly support the approach that this draft strategy sets out: that **preventing suicide is everyone's business.** Every organisation working in, and for, Havering residents will play their part in keeping people safe from suicide. We want communities, employers, colleagues, friends and families to know how to talk to someone they care about to support prevention of suicide.

This strategy sets out how we can achieve this; organisations' strategies, polices and services will be suicide-informed, with a workforce that is trained to understand and respond to suicide risk and bereavement. We know that even small conversations can be key for prevention. We will work to increase knowledge and awareness amongst residents, volunteers and the wider workforce on how to recognise those at risk, ask the right questions, listen without judgement and signpost to help.

We want our Borough to be a place where suicide is not considered a solution to any problem; where people know where to go for help, and how to help one another. We believe that, together, we can make a difference to save lives and prevent families and communities from experiencing suicide loss.

We take this opportunity to thank everyone who has contributed to the development of this suicide prevention strategy, especially those who have shared their experience of losing someone to suicide; providing a better understanding of how to prevent similar grief and pain.

Councillor Gillian Ford
Deputy Leader of the Council and Cabinet Member for Adults and Wellbeing

Dr Mark Ansell
Director of Public Health, London Borough of Havering

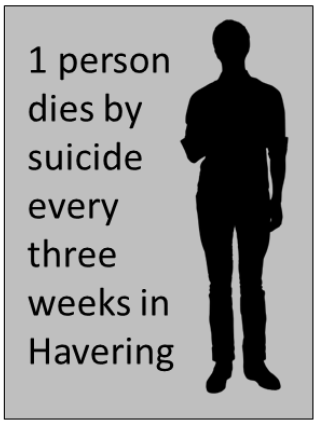
Dr Maurice Sanomi
Senior GP Partner and Havering Partnership Clinical and Care Lead for Mental Health (NEL ICB)

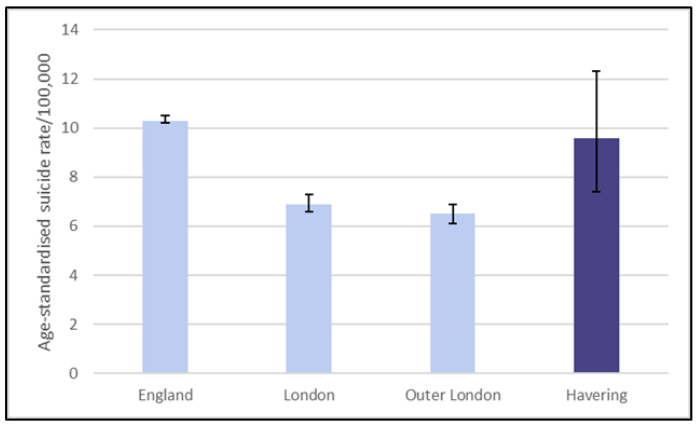
Strategy on a Page

Bereavement | Academic pressure | Substance misuse

Relationship breakdown | Loss of or insecure housing | Previous self-harm or suicide attempt

Debt and financial problems | Loss of employment | Bullying, violence, trauma, abuse





Rates of death by suicide in Havering are higher than London as a whole, and Outer London.
Source: Office for National Statistics, Suicides in the United Kingdom: 2022 Registrations.

Priority groups

- Middle-aged men
- Children and young people
- Mental health service users
- Pregnant women and new mothers
- Neuro-divergent people
- In contact with criminal justice
- Living with chronic pain
- Armed forces veterans

For targeted prevention

Preventing suicide is everyone's business

*Our Borough should be a place where **suicide is not considered a solution to any problem**; where people know where to go for help, and how to help one another.*

Identify

Evidence informed action
- Local surveillance
- National and regional intelligence
- Case-specific information

Prevent

Knowledge and prioritisation
- Policy and strategy review
- Suicide-informed services

Partnership working
- Improved, coordinated services
- Reducing access to method of death

Stigma reduction
- Language, education, training and engagement

Support

Individual level
- Bereaved by suicide
- Those who self-harm
- Suicidal ideation
- Suicide survivors
- Those in crisis

Population level
- Responsible media content and signposting
- Community outreach and training

Social isolation | Depression and severe mental illness (SMI)

Introduction

A death by suicide is often the culmination of a complex interplay of risk factors and distressing life events, and results in a profound and long-lasting impact on families and friends. The effects extend beyond immediate circles, rippling through communities to affect neighbours, workplaces, schools and other social networks. Bereavement by suicide, in particular, increases the risk of those affected taking their own lives.

This five-year, all-age *Havering Suicide Prevention Strategy 2025-2030* summarises what we will do to prevent such loss of life and so avoid the pain caused by losing someone to suicide.

The strategy development has been led by the Council, in collaboration with the Lead Member for Adults and Wellbeing, the Public Health Service, and a wide range of Council and NHS frontline services. Over 20 stakeholder organisations contributed, alongside individuals who have experienced the pain of losing a loved one to suicide or have faced suicidal ideation themselves. Direct engagement and feedback was conducted with the Youth Council, Primary Care Networks (including GPs) and with head teachers and staff across Havering's education system.

Work on this strategy commenced in 2023 by bringing together key information about suicide in the Borough: identifying risk factors and vulnerabilities, and gathering evidence from national and regional strategies and guidance. A comprehensive list is available in Appendix 1 but the main documents include:

- National strategy: *Suicide prevention in England: 5-year cross sector strategy*
- National Institute for Health and Care Excellence (NICE) Guidelines
- The NHS Long Term Plan
- Local Government Association Local Suicide Prevention Planning: a practice resource
- London-wide and NEL-wide arrangements and priorities for suicide prevention

The Vision for Havering is that the Borough should be a place where **suicide is not considered to be a solution to any problem**; where people know where to go for help, and how to help one another. The Borough will be **home to communities that are happy, thriving and resilient**. People living in Havering will, with the **right support at the right time**, recover from crisis, psychological distress and mental disorder, by having **access to safe, integrated and compassionate services**.

This consolidation of key information led to the development of a Suicide Prevention Needs Assessment, which informed three multi-agency stakeholder workshops, held in July 2023, September 2023 and May 2024. Stakeholder engagement and the 2018-2023 Barking and Dagenham, Havering, and Redbridge Suicide Prevention Strategy also shaped the vision and contents of this strategy.

During the development of this strategy, partners in Havering continued implementing initiatives under the 2018-2023 strategy, including:

- Providing and promoting information and training on suicide prevention for frontline workforces, residents and others who work in the borough.
- Participating in North East London initiatives, such as support for people bereaved by suicide.

- Engaging in London-wide suicide prevention arrangements, including signing the data-sharing agreement for real-time suspected suicide notifications.
- Ensuring people in crisis are identified, taken to a place of safety and discharged with robust safety plans[1].

Timescales

This strategy covers the period Q1 (April) 2025 – Q4 (March) 2030.

Consultation

The Havering Suicide Prevention Strategy was developed through a consultation process aimed at capturing both broad community and stakeholder input, as well as detailed feedback from professional stakeholders of particular relevance to the contents of the strategy.

1. **Public Consultation Survey**
   The first phase of the consultation involved a public-facing survey hosted on Havering Council's *Citizen Space* platform from September 10th, 2024 to October 18th, 2024. An easy-read version of the strategy was available alongside the long-read version to aid accessibility and support the engagement of those with different learning needs and young people.

   The survey invited feedback from residents, Councillors, local businesses, public sector organisations, community groups and organisations, those who work in suicide prevention and individuals with lived experience.

   Links to the online survey were promoted through Living (Havering Newsletter) and Havering Council social media channels. The consultation was also promoted to the Havering Suicide Prevention Stakeholder Group, the Live Well Network, Liberty and Havering Crest Primary Care Networks, the PSHE (primary schools) network, the BAP (secondary schools) network, the Havering Integrated Care Coordination and Social Prescribing Network, the Practice Manager's Forum and the Community Mental Health Board.

2. **Stakeholder Focus Groups**
   To gather deeper insights, focus groups were conducted with key stakeholders, including Primary Care Networks (PCNs) and GPs, the Youth Council, and head teachers and staff from primary and secondary school networks.

Please see the Havering Suicide Prevention Strategy Public Consultation Report that summarises how consultation feedback and focus group findings shaped the final strategy and the associated action plan.

What we know about suicide

This strategy includes key insights from the Havering Suicide Needs Assessment.

National Context

From 2020-22, there were 16,449 suicides registered in England and Wales, equivalent to a rate of 10.5 deaths per 100,000 people[3]. "Suicide and injury or poisoning of undetermined intent" was the leading cause of death for both males and females aged 20 to 34 years in the UK between 2001-18[4].

Public health measures have reduced national suicide rate since the 1980s, though rates have remained stable over the last two decades. The 2016 NHS five-year forward view for mental health targeted to reduce suicides by 10%[5], but this target has not been met, with rates in 2020-22 (10.4/100,000) unchanged from 2013-15 (10.1/100,000)[3].

The Secretary of State for Health announced the ambition for zero suicides in mental health inpatient units, acknowledging the 42% reduction in inpatient deaths by suicide between 2009–2011 and 2018–2020[6]. This highlighted the importance of continuing efforts to reduce deaths by suicide within these settings, while emphasising the need to address deaths by suicide in other contexts, particularly in the home, the most common location of deaths by suicide in Havering, and in public places, which amount for approximately one-third of cases.

Havering Data

The current suicide rate for Havering is higher than the rate for London as a whole although not statistically significantly different to England (2020-22 data). On average, there have been 19 deaths by suicide per year in Havering since 2015[7]. In 2021-2022, the Havering suicide rate for males was 13.5 per 100,000; almost double the suicide rate for females (7.2 per 100,000).[7] There is wide variation in age-adjusted rate of suicide across the London Boroughs (Figure 1). Havering is one of five London Boroughs with a significantly higher rate than London as a whole, but a similar rate to England.[3,8]

[3] www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2022registrations
[4] Leading causes of death, UK - Office for National Statistics (ons.gov.uk)
[5] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[6] Hunt *et al.* (2024) Psychiatric in-patient care in England: as safe as it can be? An examination of in-patient suicide between 2009 and 2020. Cambridge University Press.
[7] NEL Suicide Prevention Data Dashboard
[8] The most recent age-adjusted rate of suicide in Havering is 9.6 per 100,000 population (95%CI: 7.4 – 12.3). This rate is not statistically significantly different from England, (10.3 per 100,000 [95%CI: 10.2 – 10.5]) but higher than London (6.9 per 100,000 [95%CI: 6.6 – 7.3]).

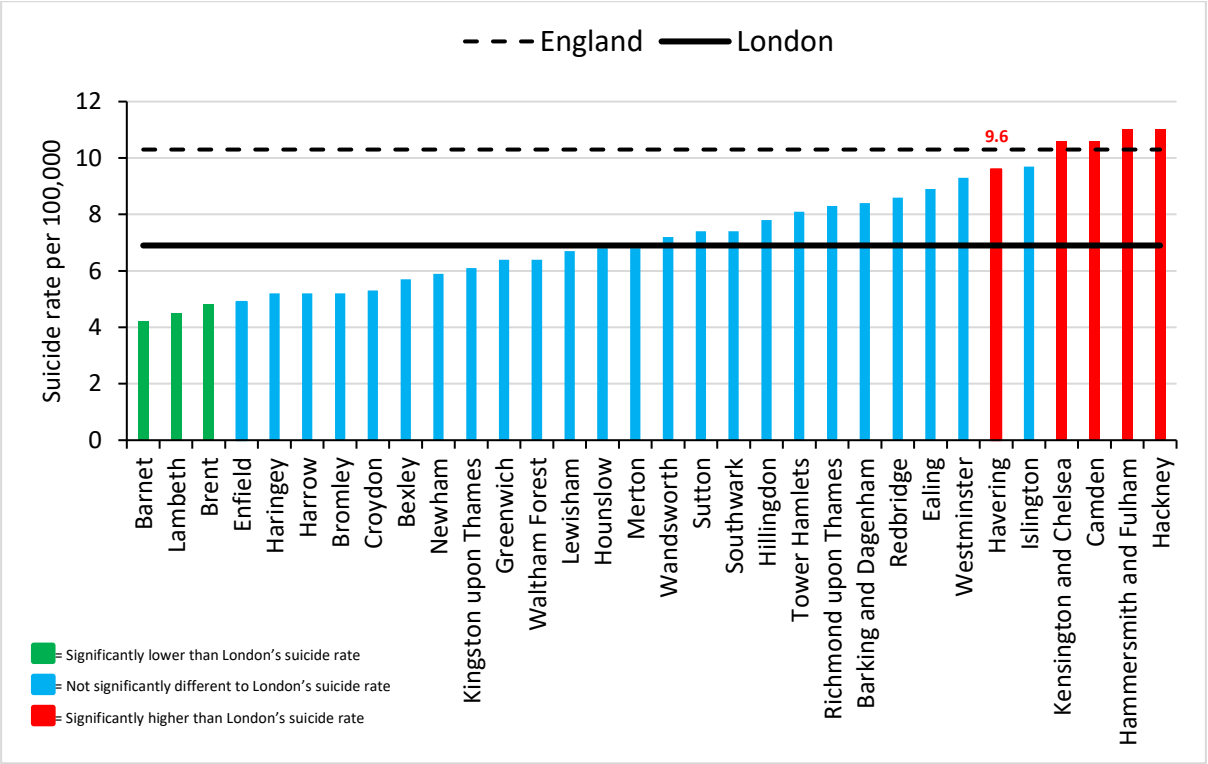


Figure 1 Three-year aggregate age-standardised suicide rates in London boroughs, London and England, 2020-2022*. Source: Office for National Statistics (2022). Suicides in the United Kingdom: 2022 Registrations.*

Risk factors for suicide

Suicide is rarely the result of a single cause. Instead, a complex mix of social, cultural, psychological and economic factors interact to increase an individual's level of risk (Figure 2). Factors are rarely experienced in isolation and often influence one another; for example, loss of employment may lead to debt and financial problems, increasing vulnerability to experiencing and acting upon suicidal thoughts.

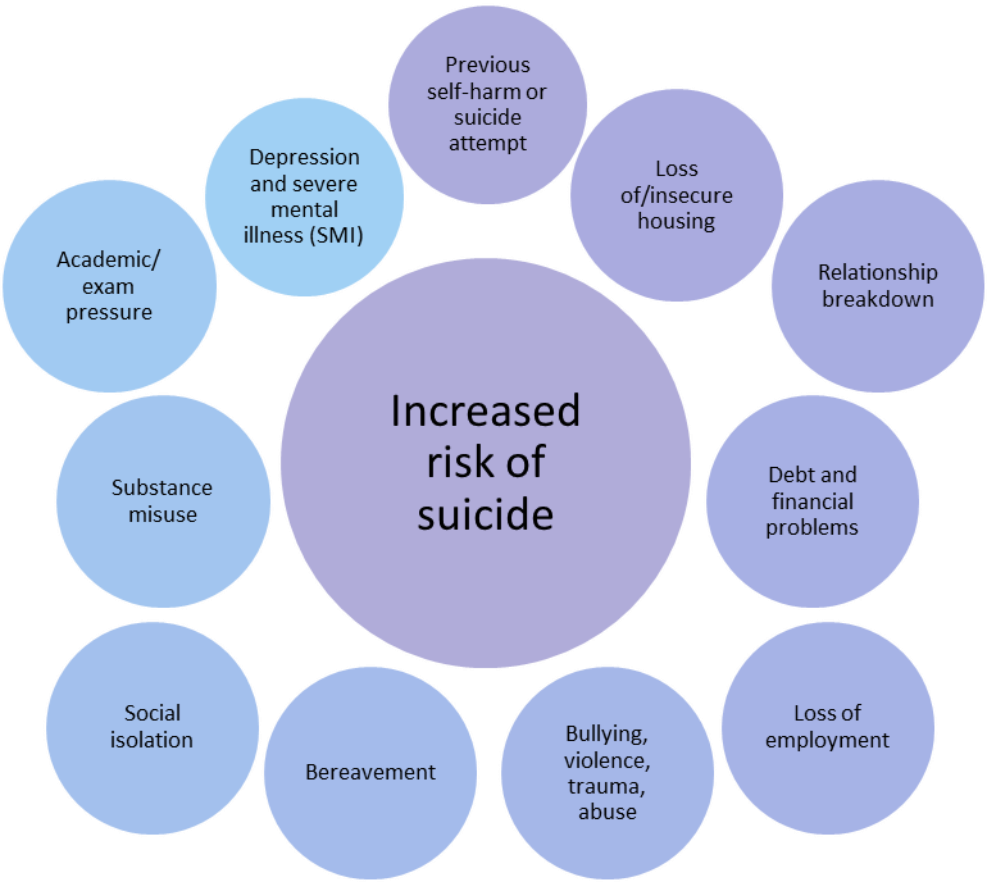


Figure 2 Multiple factors that have been linked to an increased risk of suicide[9]. *Examples of SMI include psychosis and paranoid schizophrenia. NB: Each of the factors can be experienced along with any of the others listed.*

Inequalities

As is the case with most health and wellbeing outcomes, the risk and frequency of suicide are unevenly distributed across the population. Socioeconomic deprivation, unemployment, housing insecurity and social isolation are factors that heighten suicide risk by increasing stress and reducing access to supportive resources. These also contribute to disparities in access to services and differences in risk factors within Havering's population. The accompanying Equality and Health Impact Assessment (EHIA) outlines these inequalities.

It is important to consider the impact of comorbidities, such as the co-occurrence of mental health disorder, chronic physical illnesses or substance misuse, can further increase suicide risk. When conditions overlap, they can compound challenges and create additional barriers to accessing timely and effective support. Other key insights from local, national and international data include:

- Age
    - Suicide affects all age groups, with middle-aged individuals (40-59 years) most at risk in Havering, reflecting national trends. [10].
    - Nationally, suicide rates among younger people, while lower overall, have seen an increase in recent years[10].

[9] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028
[10] Office for National Statistics (ONS), 2022

    - Given these trends, both middle-aged people and children and young people are priority groups for suicide prevention efforts in Havering, aligning with the national suicide prevention strategy.
- Disability
    - Disabled women are over four times more likely to die by suicide compared to non-disabled women, while disabled men are three times more likely to die by suicide than non-disabled men[11].
    - Suicide is a leading cause of early death for autistic people without co-occurring learning disabilities; autistic people are seven times more likely to die by suicide than allistic (non-autistic) individuals[12].
    - Up to 66% of autistic adults have considered suicide[13]. Autistic people are around 7 times more likely than non-autistic people to die by suicide, and this gap is even larger for certain groups, such as autistic people without a co-occurring learning disability and autistic women[14].
    - Undiagnosed autistic people are at higher risk of suicide and suicidal behaviours than non-autistic people[14].
    - Adults with ADHD are five times more likely to die by suicide[15].
- Gender identity and sexual orientation
    - Men are three times more likely to die by suicide than women[16].
    - Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and those who are part of the LGBTQ+ community are at a higher risk of death by suicide compared to those who do not identify as LGBTQ+[17].
- Ethnicity
    - Although there is limited evidence of statistically significant differences in suicide rates between ethnic groups, racism and discrimination impact wellbeing and suicide risk[18].
- Religion or Faith
    - In the UK, people belonging to any religious group generally have lower suicide rates compared to those with no religion, with the lowest rates in the Muslim group[19].
    - The rates of suicide were highest in the Buddhist group and religions classified as "Other"[19].
    - For men and women, the rates of suicide were lower across the Muslim, Hindu, Jewish, Christian and Sikh groups compared with the group who reported no religion.
- Maternity
    - Maternal suicide remains the leading cause of pregnancy-related deaths in the year after childbirth in the UK[20].
    - Almost a quarter of all deaths of women during pregnancy or up to a year after the end of pregnancy were from mental health-related causes[20].

[11] Disabled people far more likely to die by suicide than non-disabled people | Disability Rights UK
[12] https://www.autistica.org.uk/our-research/research-projects/understanding-suicide-in-autism#:~:text=Autistic%20people%20are%20much%20more,alarming%2035%25%20have%20attempted%20suicide.
[13] High Suicide Rates among Neurodiverse Individuals: Why it matters and what can be done about it • Government Events
[14] London Region Learning Disabilities and Autism NSH Futures, Community of Practice.
[15] https://www.berkshirehealthcare.nhs.uk/media/109514702/suicide-in-adhd-adhd-bekrshire-healthcare.pdf
[16] Suicide rate in England & Wales by gender 2000-2022 | Statista
[17] Self-harm and suicidality among LGBTIQ people: a systematic review and meta-analysis. Marchi et al. (2022)
[18] https://www.samaritans.org/about-samaritans/research-policy/ethnicity-and-suicide/
[19] Jacob, L., Haro, J.M. and Koyanagi, A., 2019. The association of religiosity with suicidal ideation and suicide attempts in the United Kingdom. Acta psychiatrica scandinavica, 139(2), pp.164-173 and ONS sociodemographic inequalities in suicide
[20] Suicide remains the leading cause of direct maternal death in first postnatal year | Maternal Mental Health Alliance

    - A recent confidential enquiry reported that improvements in care might have made a difference in outcome for 67% of women who died by suicide[21].
- Deprivation
    - People living in the least advantaged areas have a 10 times higher risk of suicide than those living in the most advantaged areas[22].
    - Living in poverty increases the risk of poor mental health and death by suicide.
- Stigma of mental ill-health
    - Members of groups and communities where stigma of mental ill-health and suicide is more prevalent are at an increased risk due to lower engagement with preventative and support[23].

[21] MBRRACE-UK: Confidential Enquiry into Maternal Deaths in the UK and Ireland. "Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19"
[22] Inequality and suicide | Samaritans
[23] Mental illness stigma and suicidality: the role of public and individual stigma - PMC (nih.gov)

Priority Groups

Risk factors and resilience to the impact of risk factors are not distributed equally, meaning targeted suicide prevention actions are essential. Figure 3 highlights national and local priority groups identified for focused suicide prevention efforts.

National Priority Groups	Additional Local Priority Groups
•Middle-aged men •People who self-harm •Children and Young people (rising rates in recent years) •People in contact with mental health services •Autistic people and/or neurodivergent individuals •Pregnant women and new mothers •People in contact with criminal justice system	•People with economic risk factors* •People who misuse substances •People bereaved or impacted by suicide •Victims and perpetrators of domestic violence and abuse •People living with chronic pain and/or long term conditions •Veterans of the armed forces

Figure 3 National and local priority groups for targeted suicide prevention activity.
**Including those living in neighbourhoods of disadvantage, in debt, homeless or facing homelessness, unemployed, insecure or low quality housing*

Working Together

In the context of services often operating at full capacity, when an individual does not engage with care or services offered, they could be considered as “hard to reach” or even “beyond help”, resulting in client disengagement leading to case closure and withdrawal of support. However, this strategy advocates for disengagement to be seen as a symptom of unmet needs or systemic barriers rather than a failure of the individual to engage with a service offer. Suicide prevention requires coordinated, multi-agency response that integrates strategy, policy and service delivery, especially as partner agencies have their own strategies, policies and pathways relating to suicide prevention. By improving coordination across partners, this strategy can work to ensure that no one is left behind.

The strategy outlines key objectives to improve knowledge, prioritisation and collaboration around suicide prevention at sub-regional, London-wide and national levels. This joined up working will deliver a well-coordinated and effective preventative response. From promoting training for healthcare professionals on the safe management of high-risk medications to encouraging housing officers to undertake suicide prevention training, partners can play their part in supporting prevention efforts for those at highest risk. Initiatives like these foster community resilience and empower individuals with the skills to recognise when someone is in need and connect them to appropriate support resources.

Stigma remains a barrier, discouraging individuals experiencing mental ill health, facing suicidal thoughts or experiencing bereavement due to suicide from seeking support. Creating safe, inclusive spaces where people feel encouraged to speak openly and access support is necessary. A key strategy priority is reducing stigma associated with suicide and bereavement by suicide. This will be achieved through education, training and engagement initiatives with the local, system-wide workforce and the broader Havering community,

addressing fear and fostering societal acceptance for both professionals and public to speak about and support suicide prevention.

Multi-agency case review panel

Upon notification of a death by suspected suicide, Public Health will lead the initial review and information gathering to determine whether a comprehensive review is required by partner agencies within the wider system (e.g. domestic homicide review). For cases not covered by other reviews, Public Health will lead the identification of lessons learned, patterns of risk factors and develop case-specific recommendations for actions to be shared across the wider system.

Aim

Every death by suicide is preventable, so this strategy aims to improve the success of suicide prevention activities within Havering; leading to a reduction in the number of deaths by suicide over the next five years[24]. This will be done through implementing objectives focused on identification, prevention and support (Figure 4).

Objectives

The strategy outlined objectives and key high-level actions to achieve its aims. A separate detailed action plan will enable the suicide prevention steering group to monitor implementation.

The local delivery plan will be flexible to accommodate emerging government initiatives, such as updates to the national curriculum, publication of the upcoming Major Conditions Strategy (expected in 2024) and implementation of the Department of Work and Pensions 'alert service to identify people who raise suicidal thoughts when using DWP helplines and services.

Why an All-Age Strategy?

An all-age strategy addresses the suicide risk factors that arise at different life stages. Whilst deaths by suicide amongst children are thankfully rare, the life course approach recognises that experiences throughout life, from childhood to old age, affect suicide risk. For example, children who have been suicide-bereaved, or experienced another adverse childhood experience (ACE) have an increased lifetime risk of death by suicide and need specific support.

Early childhood is a critical time when children develop foundational skills, such as emotional regulation, resilience and coping mechanisms that can protect them from mental health challenges later in life. Resilience factors include children feeling they belong in the community, have support networks, and trusted relationships with adults and peers. From teaching young children positive self-talk and self-esteem to fostering socio-emotional life skills in adolescents[25], suicide prevention starts in early childhood and flows into adulthood and later life, especially as young people face suicide risk factors like bullying including cyberbullying. When children and young people struggle to manage stress and emotions, it can lead to self-harm as a coping mechanism and increase their risk of suicide. Addressing self-harm in age-appropriate ways during adolescence can help young people understand

[24] Suicide rate data is aggregated for three year rolling periods. As such the impact from the suicide prevention strategy would not be seen until 2025-27 (Y1), 2026-28 (Y2) and 2027-29 (Y3) data is released.
[25] https://www.who.int/news-room/fact-sheets/detail/suicide

and manage their emotions safely, reducing the likelihood of harmful behaviours in the future.

In the Strategy's consultation, young people themselves highlighted the importance of these conversations. The young people also communicated that they encounter these topics on social media platforms, where content can often be misinformed or dangerous. Failing to address these issues with young people leaves them alone to navigate themselves, making it even more critical for adults to provide informed, supportive discussions that foster understanding and resilience.

Quote from Youth Council member: ***"Schools could treat students a bit more like adults, as how can a young people be expected to talk about grown-up issues in an environment where they're treated like a child?"***

Another member wanted ***"interactive sessions with students about self-harm and suicide to engage them in learning how to deal and support those struggling in these situations."***

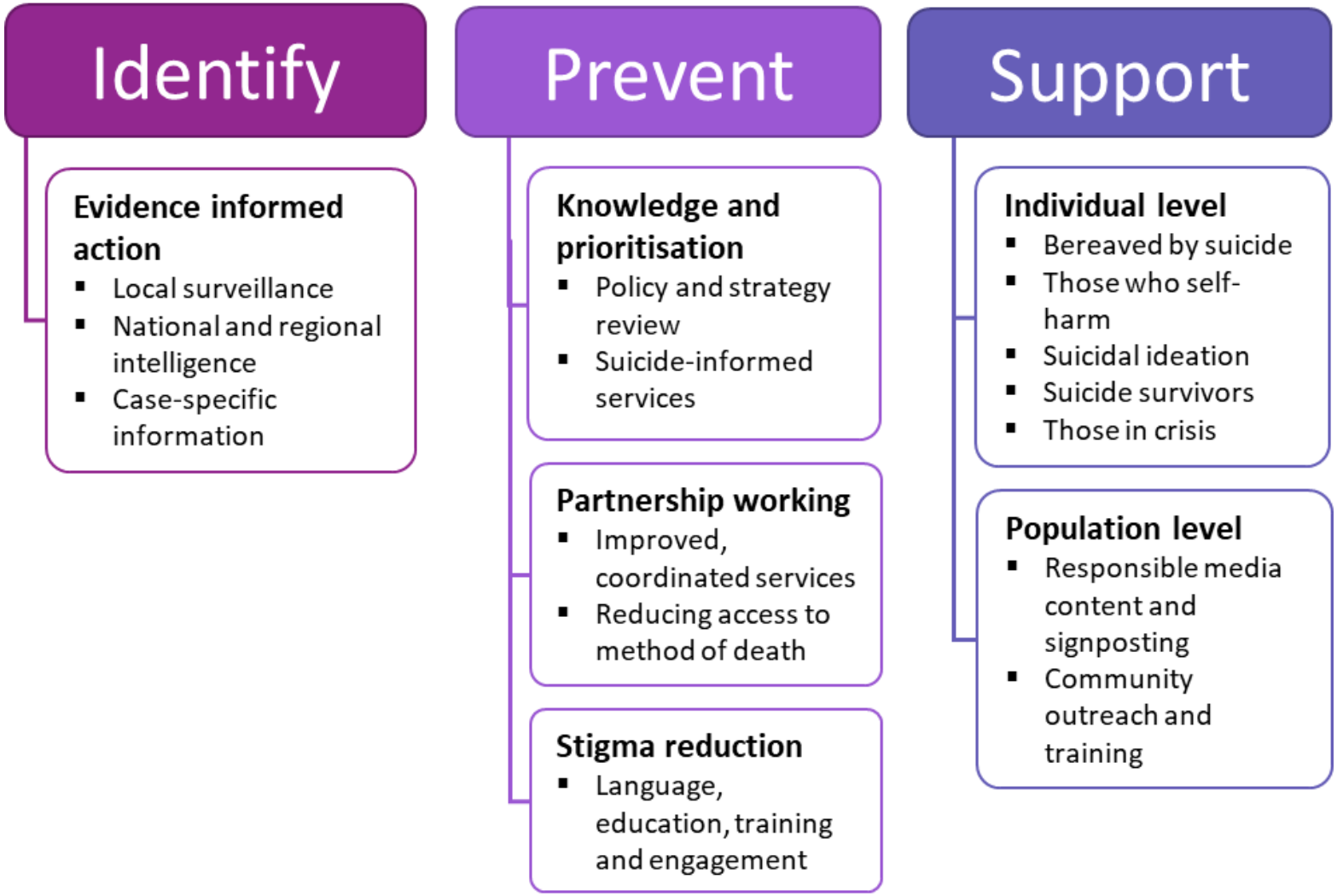


Figure 4 Overview of objectives

Identify

Objective 1: We will ensure local preventative actions are evidence-informed, effective, timely and responsive to local need. This will be achieved by:

- Conducting an annual review of local surveillance data through the Real Time Suspected Suicide Surveillance System (RTSSS) to identify trends/patterns in both risk factors and the method/location of death.
- Incorporating insights from national and regional data and intelligence, including Office of National Statistics reports and information shared by partners, such as British Transport Police.
- Improving our understanding of the local picture of self-harm and attempted suicide using the RTSSS, working with partners and local engagement.
- Identifying those bereaved by suicide through the RTSSS to improve pathways for people bereaved by suicide.
- Gathering qualitative information through multi-agency reviews performed upon notification of a suspected suicide led by Public Health or partner agencies, to generate actionable recommendations for both short- and long-term improvements.

The **Real Time Suspected Suicide Surveillance System** (RTSSS) gives an early opportunity to understand local trends in suspected suicide before Coronial inquest has occurred, and supports timely intervention for people who have been bereaved or affected by suicide; providing links to effective postvention support.

Prevent

Objective 2: We will ensure knowledge and prioritisation of suicide prevention will be strengthened across the system. This will be achieved by:

- Reviewing relevant Council, NHS and partners' policies, strategies, and service provision from a suicide prevention perspective.
- Embedding and/or strengthening appropriate action for suicide prevention to take into account nationally identified priority groups, local priority groups, and known suicide risk factors.
- Educating healthcare professionals about high-risk medications, raising awareness among parents and carers about the safe custody of medications and improving monitoring of children and young people prescribed antidepressants. The support of effective medicine choice and management should take into account suicide risk.
- Ensuring named leads responsible for Council and NHS policies, strategies and service provision provide updates of improvements to the Suicide Prevention Steering Group.
- Encouraging the adoption of learning from multi-agency reviews to inform ongoing suicide prevention efforts for services and partners.
- Increasing uptake of suicide prevention training and mental health first aid among Council and NHS frontline workforces, and commissioned services' workforces.
- Promoting training to other local employers, as per the 2023 National Suicide Prevention Strategy.

Objective 3: We *will strengthen partnership working at sub-regional, London-wide and national levels. This will be achieved through:*

- Facilitating joined up working across organisations to improve service delivery to residents.

- Implementing evidence-based preventative measures, such as reducing access to means and method of suicide (e.g. modifying public places and effective medicines management of high-risk medications, such as antidepressants, hypnotics and anxiolytics and controlled drugs, in collaboration with patients, carers and medical colleagues as appropriate).
- Working with regional partners to address multi-borough and borough-specific suicide prevention priorities, coordinating strategies and policies across agencies.

Objective 4: We will work to reduce stigma surrounding suicide and bereavement by suicide. This will be achieved by:

- Collaborating with Council services, the NHS and voluntary and community sector partners to tackle stigma surrounding mental ill health and suicide, focusing on inequality.
- Providing information, education and training on suicide prevention for the local workforce, including those who are self-employed.
- Providing information and increasing awareness of suicide prevention efforts and resources among local communities and residents, including through public awareness campaigns and events.

Support

Objective 5: We will strengthen, coordinate and ensure equitable access to support key groups across the system, including:

- Individuals bereaved by suicide
- Individuals who engage in self-harm
- Staff of anchor institutions whose work exposes them to the effect of suicide (e.g. those responding to deaths by suicide or impacted by the loss of someone who died by suicide)
- Individuals who express suicidal ideation, including at A&E
- Individuals who are experiencing a mental health crisis
- Individuals who have survived attempted suicide
- Priority groups (both national and local) listed in Figure 3

Objective 6: We will ensure early intervention and tailored support for those with common risk factors at a population level. We will do this by:

- Collaborating to ensure responsible media content to reduce harm, improve support and signposting (both digital and physical), and promote helpful messages about suicide and self-harm.
- Making promotion of information more accessible to address both digital exclusion and cultural differences.
- Targeting training to organisations and community groups work with at-risk populations and priority groups.
- Supporting voluntary, community and social enterprise organisations in accessing government funding for these efforts.
- Collaborating with partners to identify and implement strategies to reduce waiting times, prevent premature discharges and provide targeted support for individuals awaiting services.

Governance

Suicide Prevention Steering Group

A steering group with representatives from the Council, the NHS, Safeguarding (adults and children), mental health charities, and people with lived experience will ensure progress against the action plan by:

- monitoring the action plan performance
- updating the action plan in response to learning from surveillance data and emerging national initiatives
- producing an annual report

The Suicide Prevention Steering Group will be responsible to the Havering Place Based Partnership and the Havering Health and Wellbeing Board, and accountable to the Council's Cabinet (Figure 5).

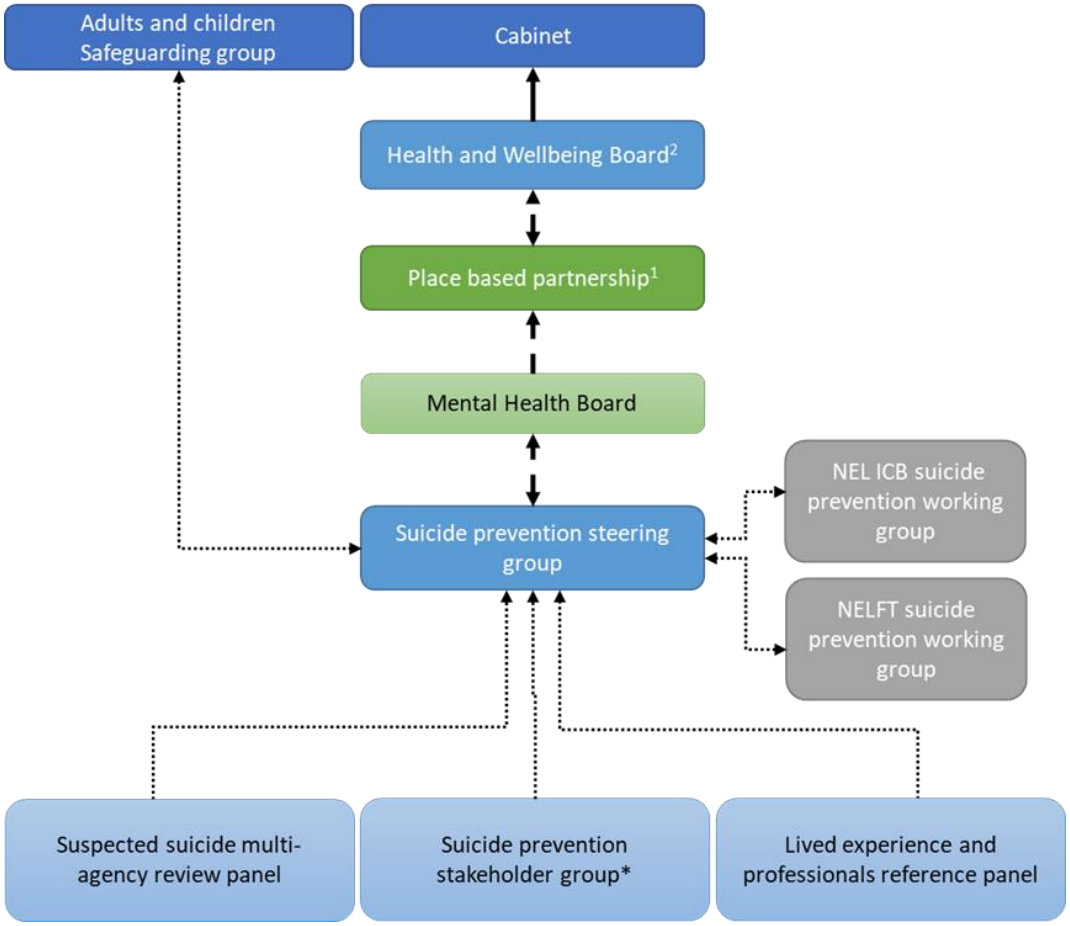


Figure 5 Proposed accountability structure for the Public Health led Suicide Prevention Steering Group. *Solid arrows indicate accountability, dashed arrows indicate responsibility and dotted arrows indicate sharing of information between groups. [1]Responsible for implementation.[2]Adoption of strategy. *Locally based stakeholders include those working in areas affecting the wider determinants of health that are known to be associated with increased risk of death by suicide. See Appendix 1*: High-level action plan, developed by organisations/representatives of the Havering Suicide Prevention Stakeholder Group.

High-Level Action	Actions

Identify those at increased risk and applying the most effective evidence-based interventions for our local population and setting	1.a Public Health will establish a systematic review panel and protocol, defining clear roles, responsibilities and meeting frequency.
	1.b Public Health and relevant partners will conduct comprehensive reviews of suspected suicides in Havering. From these, the panel will produce case-specific recommendations and lessons learned to develop a comprehensive understanding of the context and potential preventive measures.
	1.c Public Health will engage with MET Police colleagues and THRIVE London colleagues annually to review the suicide prevention panel and to improve data sharing.
	1.d Public Health will produce an Annual Suicide Prevention Report (ASPR), incorporating both epidemiology and gathered recommendations from suicide panel reviews, and findings from any relevant SARs and progress for the suicide prevention action plan.
	1.e Public Health will update and maintain mapping exercise to identify key strategies, policies, work areas and commissioned services to strengthen suicide prevention efforts.
	1.f All stakeholders will conduct thorough review of existing policies, strategies and service provision to ensure that suicide prevention is included.
	1.g Public Health will collaborate with relevant stakeholders to investigate and address gaps in referral pathways throughout services and organisations.
	1.h Children and Young People's Emotional Wellbeing and Mental Health Strategy will be developed, and to include young adults who are care experienced (up to age 25) in transition to adults services.
	1.i Safeguarding Team will conduct a retrospective exercise to consolidate findings and recommendations from past reviews of suicides. Then, Public Health will review the information extracted and consider how to disseminate findings.
Prevention activities across the system including increasing knowledge and reducing stigma	2.a From suicide review panel, immediate preventive measures will be implemented based on review findings, engaging with local authorities and stakeholders to enhance safety in high-risk and/or public areas.
	2.b Partners will promote Havering's Suicide Prevention Training Directory.
	2.c Public Health will work with PCN Leads to increase uptake of suicide prevention training among primary care staff.
	2.d Partners will promote suicide prevention training for community members that support people who have an increased risk of suicide or self-harm, or that provide support to people around distressing life events.
	2.e Public Health will investigate integrating suicide prevention into Community Engagement work (Health Champions).
	2.f Public Health will develop and improve approach to increase training uptake in Havering, including consulting with other Boroughs and NEL Training Hub.
	2.g As part of a Health in All Policies approach, Council services will integrate suicide prevention measures into the Council workforce by providing internal suicide prevention training and incorporating these measures into new or existing Council policies, for example, creating a staff guidance/protocol following a death of a service user by suicide.
	2.h Public Health will maintain up-to-date, brief resource that clearly directs individuals to self-harm and suicide prevention services, covering early intervention, prevention and postvention services.
	2.i Havering Communications and Public Health will develop a digital (QR code) and printable signposting guide for suicide risk factors, distributing it digitally to key partners and across the Borough, including libraries/community hubs, council services, places of worship, and incorporating the QR code on relevant Council materials.

	2.j Public Health will maintain and update suicide prevention council webpage.
	2.k Public Health will develop a communications and engagement plan to amplify national campaigns locally, coordinate activities for World Suicide Prevention Day and World Mental Health Day, and deliver an annual webinar on World Suicide Prevention Day. This plan will include involvement of people with lived experience.
Support at both individual and population levels, including those at risk of suicide and the bereaved	3.a Relevant services will recognise and put in place measures to support the specific needs of at risk and/or vulnerable groups in need of additional support.
	3.b Anchor organisations (e.g., the NHS, schools, police, fire service) will ensure that frontline staff receive sustained and evaluated support for dealing with the impact of suicide in their profession.
	3.c Public Health will form a reference group comprised of selected professionals and individuals with lived experience ("Expert by Experience") to provide feedback on various actions as part of the Havering Suicide Prevention Strategy such as reviewing an input into documents published by the suicide prevention public health team, leveraging existing connections with established groups, and amplifying the voice of those with lived experience.

for a complete list of stakeholder groups.

Informed by those with lived experience

We will ensure to continue incorporating the voices, perspectives and insights of people with lived experience, including people with experience of suicidal ideation, those who have made previous suicide attempts, and people who are bereaved by suicide. They will inform the planning, design and decisions at all levels of suicide prevention activity.

Glossary

Age-adjusted	Age adjustment enables meaningful comparisons to be made between two populations that vary in age structure.
Allistic	A person not affected by autism.
Consultation	A consultation for the public is a process by which members of the public are asked for input on public issues.
Domestic homicide review	A Domestic Homicide Review (DHR) is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.
EqHIA	The Equality and Health Impact Assessment (EqHIA) is a legal requirement under the Equality Act 2010 and aims to improve the work of the council by making sure it does not discriminate in providing services and employment and that it does all it can to promote equality and good relations for the community and various socio-demographic groups that are typically underrepresented.
ICB	Integrated Care Board; an NHS organisation responsible for planning health services for their local population.
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and those who are part of the community
Major Conditions	Major conditions refer to the main causes of ill-health that contribute to disease in England, specifically: cancers, cardiovascular diseases (including stroke and diabetes), chronic respiratory diseases, dementia, mental ill health and musculoskeletal disorders.
Needs assessment	A needs assessment is a systematic approach to understanding the needs of a population. It can identify the unmet health and healthcare needs of a population, and what changes are required to meet those unmet needs.
NELFT	North East London Foundation Trust; NELFT provides an extensive range of integrated community and mental health services for people living in the London boroughs of Barking & Dagenham, Havering, Redbridge and Waltham Forest and community health services for people living in the south west Essex areas of Basildon, Brentwood and Thurrock.
Neurodiversity	Neurodiversity describes the idea that people experience and interact with the world around them in many different ways; there is no one “right” way of thinking, learning, and behaving, and differences are not viewed as deficits. The word neurodiversity refers to the diversity of all people, but it is often used in the context of autism spectrum disorder (ASD), as well as other neurological or developmental conditions such as ADHD.
Office of National Statistics (ONS) data	The ONS main responsibilities are collecting, analysing and disseminating statistics about the UK's economy, society and population. ONS produce a range of economic, social and population statistics that are published in over 600 releases a year.
Primary Care Network (PCN)	A primary care network is a structure which brings general practitioners together on an area basis, along with other clinicians.
QR code	A QR code is a machine-readable code consisting of an array of black and white squares, typically used for storing

	URLs or other information for reading by the camera on a smartphone.
Real-time suspected suicide surveillance system (RTSSS)	The RTSSS provides more up-to-date data on suicides locally compared to ONS data which has time lags of approx. 12-18 months to be published because of the time taken to complete an inquest; with the caveat that the suicide is only suspected and has not been confirmed as the cause of death by a coroner. RTSSS data Includes suspected suicides of any Havering resident including those where the suicide took place outside of the borough, it does not include suspected suicides by people who are not Havering residents even when the suicide occurs in the borough. The RTSSS provides the following data the individual's name, demographics, place of suicide, method, circumstances, warning signs, mental health issues however information on risk factors including finances, employment and family circumstances can often be less complete. The RTSSS was developed by Thrive LDN and utilises data on suspected suicides collected by the Metropolitan Police, the British Transport Police (BTP) and the City of London Police. Our level of surveillance will focus on the London Borough of Havering however; we work closely with the North-East London (NEL) suicide prevention working group who we expect to focus on surveillance across all seven NEL boroughs.
Severe Mental Illness (SMI)	Examples include psychosis and paranoid schizophrenia.
Sub-regional	Sub-regional refers to the subdivision of a region.
Suicidal ideation	Suicidal ideation, or suicidal thoughts, is the thought process of having ideas, or ruminations, with taking one's own life.

Appendices

Appendix 1: High-level action plan, developed by organisations/representatives of the Havering Suicide Prevention Stakeholder Group.

High-Level Action	Actions
Identify those at increased risk and applying the most effective evidence-based interventions for our local population and setting	1.a Public Health will establish a systematic review panel and protocol, defining clear roles, responsibilities and meeting frequency.
	1.b Public Health and relevant partners will conduct comprehensive reviews of suspected suicides in Havering. From these, the panel will produce case-specific recommendations and lessons learned to develop a comprehensive understanding of the context and potential preventive measures.
	1.c Public Health will engage with MET Police colleagues and THRIVE London colleagues annually to review the suicide prevention panel and to improve data sharing.
	1.d Public Health will produce an Annual Suicide Prevention Report (ASPR), incorporating both epidemiology and gathered recommendations from suicide panel reviews, and findings from any relevant SARs and progress for the suicide prevention action plan.
	1.e Public Health will update and maintain mapping exercise to identify key strategies, policies, work areas and commissioned services to strengthen suicide prevention efforts.
	1.f All stakeholders will conduct thorough review of existing policies, strategies and service provision to ensure that suicide prevention is included.
	1.g Public Health will collaborate with relevant stakeholders to investigate and address gaps in referral pathways throughout services and organisations.
	1.h Children and Young People's Emotional Wellbeing and Mental Health Strategy will be developed, and to include young adults who are care experienced (up to age 25) in transition to adults services.
	1.i Safeguarding Team will conduct a retrospective exercise to consolidate findings and recommendations from past reviews of suicides. Then, Public Health will review the information extracted and consider how to disseminate findings.
Prevention activities across the system including increasing knowledge and reducing stigma	2.a From suicide review panel, immediate preventive measures will be implemented based on review findings, engaging with local authorities and stakeholders to enhance safety in high-risk and/or public areas.
	2.b Partners will promote Havering's Suicide Prevention Training Directory.
	2.c Public Health will work with PCN Leads to increase uptake of suicide prevention training among primary care staff.
	2.d Partners will promote suicide prevention training for community members that support people who have an increased risk of suicide or self-harm, or that provide support to people around distressing life events.
	2.e Public Health will investigate integrating suicide prevention into Community Engagement work (Health Champions).
	2.f Public Health will develop and improve approach to increase training uptake in Havering, including consulting with other Boroughs and NEL Training Hub.
	2.g As part of a Health in All Policies approach, Council services will integrate suicide prevention measures into the Council workforce by providing internal suicide prevention training and incorporating these measures into new or existing Council policies, for example, creating a staff guidance/protocol following a death of a service user by suicide.

	2.h Public Health will maintain up-to-date, brief resource that clearly directs individuals to self-harm and suicide prevention services, covering early intervention, prevention and postvention services.
	2.i Havering Communications and Public Health will develop a digital (QR code) and printable signposting guide for suicide risk factors, distributing it digitally to key partners and across the Borough, including libraries/community hubs, council services, places of worship, and incorporating the QR code on relevant Council materials.
	2.j Public Health will maintain and update suicide prevention council webpage.
	2.k Public Health will develop a communications and engagement plan to amplify national campaigns locally, coordinate activities for World Suicide Prevention Day and World Mental Health Day, and deliver an annual webinar on World Suicide Prevention Day. This plan will include involvement of people with lived experience.
Support at both individual and population levels, including those at risk of suicide and the bereaved	3.a Relevant services will recognise and put in place measures to support the specific needs of at risk and/or vulnerable groups in need of additional support.
	3.b Anchor organisations (e.g., the NHS, schools, police, fire service) will ensure that frontline staff receive sustained and evaluated support for dealing with the impact of suicide in their profession.
	3.c Public Health will form a reference group comprised of selected professionals and individuals with lived experience ("Expert by Experience") to provide feedback on various actions as part of the Havering Suicide Prevention Strategy such as reviewing an input into documents published by the suicide prevention public health team, leveraging existing connections with established groups, and amplifying the voice of those with lived experience.

Appendix 1 Main sources of evidence used as key references for this strategy in gathering evidence for identifying risk factors and vulnerabilities.

Source documentation	Link
Havering All Age Autism Strategy	All age autism strategy Final 140722 002.pdf (havering.gov.uk)
Havering Substance Misuse Strategy	Havering Combating Substance Misuse Strategy
Havering Homelessness Strategy 2020-25	Havering Council Prevention of Homelessness and Rough Sleeping Strategy 2020 - 2025
Havering Community Safety Partnership Plan 2022-25	Appendix 1- HCSP Partnership Plan 2022- 25 V3.pdf (havering.gov.uk)
Gambling Policy 2020-23	App 1 Statement of Gambling Policy 2019-2022 Draft for Consultation.pdf (havering.gov.uk)
Supported Housing Strategy 2022-25	Supported Housing Strategy.pdf (havering.gov.uk)
Havering Housing Services Domestic Abuse Policy	Housing Domestic Abuse Policy (havering.gov.uk)
Adult social care support planning policy	Adult Social Care Support Planning Policy (havering.gov.uk)
Local suicide prevention planning: a practice resource	PHE_LA_Guidance_25_Nov.pdf (publishing.service.gov.uk)
National Suicide prevention in England: 5-year cross-sector strategy	Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)
The NHS Long Term Plan	NHS Long Term Plan

The five year forward view for mental health	The Five Year Forward View for Mental Health (england.nhs.uk)
National Institute for Health and Care Excellence (NICE) Guidelines	Overview | Suicide prevention | Quality standards | NICE

NB: The above is not an exhaustive list and additional resources to cross cutting-issues and key documents the suicide prevention strategy were included in a Map of Suicide Priority Groups and Risk Factors as part of the suicide prevention needs assessment.

Appendix 3: Member organisations/representatives of the Havering Suicide Prevention Stakeholder Group, 2023-24.

LBH Public Health	BHRUT
LBH Elected member for Health and Wellbeing	Healthwatch
London Fire Brigade	Community Connectors
Mind	Local area coordinators
Samaritans	Health champions
Havering Carer's hub	Jobcentre plus / DWP
LBH Community Safety	LBH Housing
NELFT	LBH Adult Social Care
Metropolitan Police	LBH Children's Services
NHS NEL ICB	CAMHS
GP Representative	LBH Early Help
LBH Communications	LBH Education
People with lived experience / "Experts by Experience"	Safeguarding Adults Board
LBH CTax & Benefits, Exchequer & Transactional Services	LGBTQ+ forum / LGBTQ freelance trainer
Peabody	LBH Planning
Havering Integrated Team	Network Rail
Imago	ELFT
Community hubs	CGL
NEL Training Hub	LBH Workplace Health
PSHE Network	LBH Communities
Street pastors	LBH Social work
Town centres Manage	Havering Compact
Age UK	

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Public Consultation Report

Havering All-age Suicide Prevention Strategy 2025-2030

Working together to save lives

December 2024

London Borough of Havering

Isabel Grant-Funck, Public Health Strategist
Samantha Westrop, Assistant Director of Public Health

Content warning: The content of this needs assessment may be emotionally challenging as it discusses suicidality and self-harm.
Support is available:
Samaritans – a listening service which is open 24/7 for anyone who needs to talk. #
Campaign Against Living Miserably (CALM) - CALM's confidential helpline and live chat are open from 5pm to midnight every day.
Shout – a free confidential 24/7 text service offering support if you're in crisis and need immediate help.

Executive Summary

Citizen Space Survey

The Citizen Space Survey received responses from 66 participants, with 56% being Havering residents and 14% having lived experience of suicidal ideation and/or suicide attempts. An overwhelming 97% of respondents expressed support the Havering Suicide Prevention Strategy, its priorities and its objectives.

Key concerns raised included the need for greater inclusion of specific populations, such as autistic and neurodivergent individuals. Respondents also called for improved crisis and bereavement support services and pathways, alongside improvements in mental health services. Additionally, many suggested strengthening the strategy's focus on children and young people, particularly around the life-course and self-harm to create a more comprehensive "all-age" approach. Accessibility and inclusivity were also areas requiring further attention.

Focus Groups

To ensure the strategy addresses both its role in primary care and the needs of all age groups, focus groups were conducted with Primary Care Networks, the Havering Youth Council and schools. This engagement sought specific feedback from these key stakeholders to bridge gaps in support.

Summary of Findings

Public Consultation on Citizen Space

Local actions to focus on, based on feedback::

- Open Discussions, Safe Spaces and Stigma Reduction
- Crisis Support and Immediate Response
- Improving Services and Reducing Barriers to Care
- Preventive and Proactive Support
- Addressing Broader Contexts and Risk Factors

Main changes to strengthen strategy, based on feedback:

- Scope of strategy and role of public health
- Fill in missing attention areas, groups and risk factors
- Expand sections on crisis support and prevention
- Strengthen children and young people and self-harm sections

Focus Groups

- Primary Care Networks engagement highlighted the need for better training, resources and crisis pathways in primary care.
- Young people expressed a need for more empathetic support and accessible mental health resources.
- Schools highlighted the importance of tailored training for both parents and teacher, as well as the need to normalise stress and help students build resilience.

Introduction

Havering is refreshing its Suicide Prevention Strategy for 2025-2030, aiming to improve effectiveness of suicide prevention efforts within the borough and reduce the number of deaths by suicide over the next five years. The strategy's goals will be achieved through objectives that focus on:

- Identifying those at increased risk and applying the most effective, evidence-based interventions
- Promoting prevention activities across the system, including increasing knowledge and reducing stigma
- Providing support at both individual and population levels, addressing the needs of those at risk of suicide and the bereaved

To develop this strategy, the Suicide Prevention Stakeholder Group was established, which sharped the strategy and defined the actions aligned with the key objectives.

A public consultation was conducted to gather feedback from residents and suicide prevention stakeholders before the strategy is finalised. This consultation included a public online survey and focus groups with key groups: primary care networks, youth and primary and secondary school networks and the Havering Youth Council.

The results and key themes of the consultation are discussed below. The final strategy will be updated to reflect the concerns raised in the survey and feedback from the focus groups.

Methodology

The public consultation was carried out via Citizen Space – an online survey platform used by the London Borough of Havering. The survey was open from September 10th, 2024 to October 18th, 2024. The questions were designed by the suicide prevention team, with a mix of quantitative questions and space for qualitative follow-ups.

Citizen Space generated the survey results. Themes were captured from each question. In addition, themes from the focus groups, which included two primary care networks, a primary school network, a secondary school network and the Havering Youth Council, are included in this report.

Summary from Public Consultation

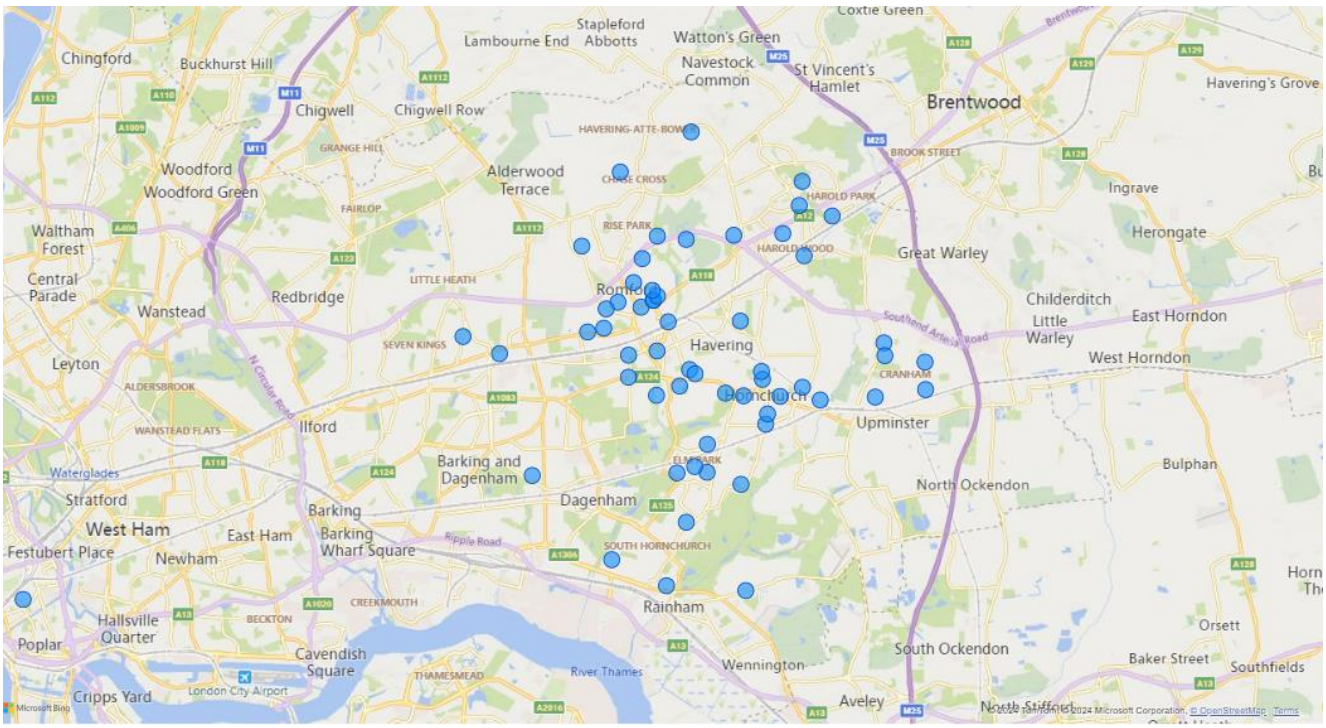
Citizen Space Survey

This section of the report will detail the response counts to each question, share analysis of questions and highlight relevant themes. 66 survey responses were received.

Questions

Question 1. Please tell us your postcode (either where you live, or where you work in the borough)

100% of respondents answered this question.



- 57/66 (86.4%) of the provided postcodes within the borough of Havering.
- 5/66 (7.6%) respondents listed postcodes associated with Havering Town Hall (RM1 3BB, RM1 4GR, RM1 3BD, RM1 3BB), suggesting these responses may be from council employees who do not reside in the borough.
- No respondents provided postcodes from hospitals.

Question 2. Please tell us in what capacity you are completing this consultation:

100% of respondents answered this question.

- 56% of respondents were residents.
- 1 respondent was a Councillor.
- 36% of respondents worked for a public sector organisation

- 17% of respondents worked for a community group or charity.
- 5% of respondents represented a public sector organisation.
- 8% of respondents represented a community group or a charity.

Question 3. What capacity are you responding in?

100% of respondents answered this question.

- 14% of respondents have living experience.
- 36% are responding as a close friend or family member relating to suicide.
- 3% of respondents (two individuals) were carers.
- 15% are responding as a neighbour/acquaintance/work colleague relating to suicide.
- 9% have witnessed a death by suicide.
- 24% work in suicide prevention.
- 21% have not been personally affected.

Question 4: Do you think it is important to have an approach that focuses on preventing suicide, such as this strategy?

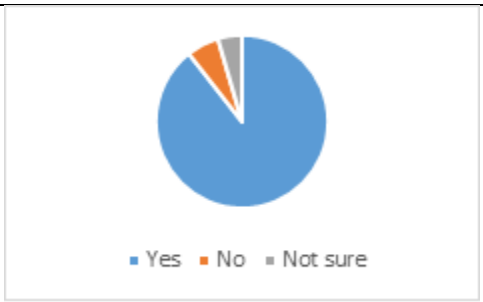
100% of respondents answered this question.

- 64/66 (97%) respondents believed it is important to have an approach that focuses on preventing suicide, such as this strategy.
- 2 respondents (3%) were not sure.
- 0 respondents (0%) answered no or somewhat.

Questions 5, 6, 7, 8: Do you support the following in Havering?

100% of respondents answered these questions.

Question	Action	Responses	Chart
5	Increasing suicide prevention awareness and knowledge	59 (89%) respondents said yes. 5 (8%) respondents said no. 2 (3%) respondents were not sure.	

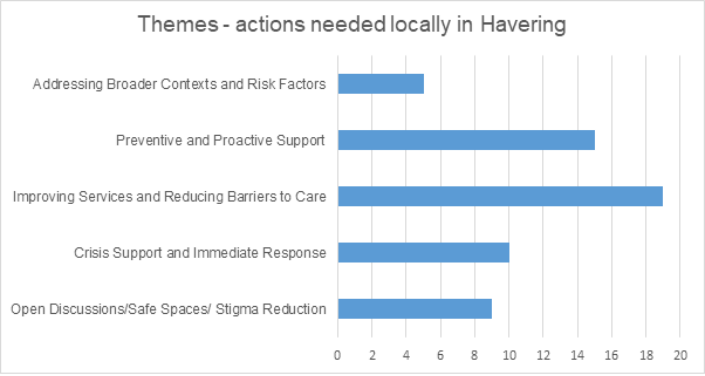
6	Reducing stigma (Making it easier to talk about suicide and help others)	59 (89%) respondents said yes. 5 (8%) respondents said no. 2 (3%) respondents were not sure.	
7	Helping people (those bereaved, those engaging in self-harm, those with suicidal thoughts, those who have survived suicide attempts) early and with the right support for them	58 (88%) respondents said yes. 5 (8%) respondents said no. 3 (5%) respondents were not sure.	
8	Improving signposting and messaging about suicide prevention	59 (89%) respondents said yes. 4 (6%) respondents said no. 3 (5%) respondents were not sure.	

Follow-up to Questions 5, 6, 7, 8: ***You can use this space for any additional actions that you feel are needed locally.***

50% of respondents answered this follow-up question.

Themes identified included:

- Open Discussions/Safe Spaces/ Stigma Reduction
- Crisis Support and Immediate Response
- Improving Services and Reducing Barriers to Care
- Preventive and Proactive Support
- Addressing Broader Contexts and Risk Factors



Overview of feedback from respondents:

1. **Open Discussions, Safe Spaces and Stigma Reduction**

- Have open discussions on suicide and mental health to create awareness and reduce stigma.
- Establish safe spaces for people to notice their feelings and manage them, especially during crises.
- Suicide can be a difficult subject to discuss; a positive framework needs to be established to enable people to understand, discuss, learn, and find support.
- Demystify the stigma of language around suicide.
- Establish 'listeners' in schools and workplaces—trained individuals whom students and employees can approach if experiencing suicidal thoughts.
- Raise awareness of cultural organizations for suicide prevention and assistance.
- Encourage community-wide responsibility, emphasizing that tackling suicide is everybody's business.

2. Crisis Support and Immediate Response

- Develop resources to help someone in crisis without referring them to ambulance or police services. Establish a dedicated team for mental health crises.
- Post-vention strategies for individuals who have attempted suicide or presented at A&E with suicidal ideations.
- Actions focused on those who have attempted suicide and survived—how to identify and support them.
- Establish alternative safe havens for those in crisis and their carers as an alternative to emergency departments.
- Provide crisis support hubs with robust funding and staffing.
- Address the lack of training in crisis teams; undertrained professionals can cause more harm than good.
- Act quickly to address stimuli that trigger suicidal ideation.
- Having severe OCD, many find that undertrained crisis teams can cause harm instead of helping.
- Significant waiting lists to access mental health support mean many cannot receive help until they reach a crisis.

3. Improving Services and Reducing Barriers to Care

- Non-engagement should be treated as a symptom requiring tailored support, not a reason for professional agencies to discharge patients.
- Address long waiting times for mental health services following a suicide attempt; people need immediate therapy, not delays of months or years.
- Mental health services are often too quick to discharge patients and may refuse to re-engage them when needed—this must change.
- Ensure NHS community services have adequate resources to reduce care coordinators' caseloads, which are often unmanageable.
- Improve quality and accessibility of free counselling for young adults.
- Ensure psychological teams are available specifically for those who have attempted suicide.
- Expand the network beyond volunteer-led services; provide more structured support for long-term conditions and challenges.
- Reduce digital exclusion to ensure equitable access to mental health services.
- Address issues with premature discharge and lack of re-engagement with patients.
- Join up charities to provide wider support and signpost to registered private therapists (e.g., BACP) and NHS services.
- Long waiting times for Talking Therapies are too long, and there is little to no interim advice or support.

- Increase resources to manage caseloads for care coordinators and primary workers in Mental Health and Wellness Teams, where typical caseloads exceed 30.
- Walk-in centres are needed to provide immediate mental health support.

4. Preventive and Proactive Support

- This needs a proactive, life-course approach that starts early—teaching what good mental and physical well-being is and is not.
- Implement early intervention education on mental health and coping mechanisms.
- Develop trained mental health champions in communities to identify those at risk.
- Join up charities to provide wider support and signpost individuals to registered therapists and NHS services.
- Make people aware of available support to reduce feelings of isolation and improve access to care.
- Reduce access to means of suicide by implementing preventive measures.
- Raise awareness of coping mechanisms (e.g., addictions, eating disorders) and their links to suicidality.
- Ensure specific support for people with life-limiting illnesses and those recently bereaved.
- Focus on societal stresses that lead to suicidal thoughts (e.g., housing, cost of living).
- More funds are required for free counselling services for young adults to ensure high quality and accessibility.

5. Addressing Broader Contexts and Risk Factors

- Suicide prevention policy must encompass all departments, including housing and socioeconomic services, to address systemic root causes.
- Ensure individuals with mental health challenges are not moved away from their support systems, families, or NHS teams due to housing policies.
- Living in unsuitable, poor-quality supported accommodation can exacerbate poor health and depression, contributing to suicide risk.
- Address local issues driving residents to the brink, such as anti-social behaviour, barking dogs, drug dens, and loud music disrupting sleep.
- Address societal stresses such as housing challenges, the cost of living, and access to affordable care.
- Provide more robust community services to engage and support individuals who may feel there is no other option than suicide.
- Consider diversity and ensure cultural sensitivity in all suicide prevention strategies.
- The diversity of communities, including those in Havering, should be considered when designing suicide prevention strategies.

6. Other

- Needs more than 200 characters to explain complex situations and interventions fully.

Question 9: In the strategy, we explain that some people have more risk factors for suicide, compared to others. Do you have any comments about how to reduce this inequality? If yes, please describe here:

25 responses (40% of participants) answered this follow-up question.

Overview of feedback from respondents:

1. **Specific Groups**

- Older people with undiagnosed conditions like dementia may struggle to manage their health and require focused support.
- Increase mental health support specifically targeted at groups like autistic individuals, with therapies tailored to their needs (e.g., autism-centred therapy instead of generic CBT).
- Be culturally aware and sensitive in designing strategies, considering how suicide is perceived differently across cultures.
- Address the lack of awareness and stigma toward middle-aged individuals at risk of suicide.
- Better understanding of autistic individuals' suicide ideation and the increased risks during perimenopause.
- Men-specific initiatives, such as BarberTalk and local walks, to engage men in conversations about mental health.
- Focus on prevention by targeting young people, as they will become adults, and early intervention can reduce risks.
- Develop equity in care to ensure all individuals receive proper attention regardless of circumstances, particularly those with conditions like autism or learning disabilities.

2. **Improving Services and Accessibility**

- Easier and earlier access to mental health counselling to reduce long wait times.
- Accept self-referrals for mental health services to make access easier for people with communication challenges.
- Provide highly private services, such as text-based crisis support, for individuals who prefer discreet access.
- Improve training for council staff across all departments to create a complete support package and improve accessibility.
- Increase mental health professionals in A&E to address crises related to addiction, self-harm, and anxiety.
- Enhance communication about services to meet the equality and diversity needs of the population (e.g., translations, varied formats).
- Ensure access to information on mental health services beyond unofficial channels like Facebook.
- Increase surveillance in colleges and other institutions to intervene swiftly and prevent contagion effects.
- Collaborate more effectively between services (e.g., learning disabilities and mental health) to provide holistic care.
- Ensure all groups have equitable access to culturally appropriate resources and services.

3. **Raising Awareness and Reducing Stigma**

- Promote targeted campaigns to normalise therapy and combat the stigma around mental health and suicide.
- Continual promotion of mental health services using all communication outlets, including in different languages.
- Organise events to bring communities together to discuss suicide and break taboos.

- Education and awareness campaigns tailored to specific cultural communities to encourage engagement.
- Include mental health discussions in "well-being" days in schools and workplaces, with an emphasis on high-risk industries like construction.
- Encourage faith leaders to demystify negative associations with mental health within their communities.
- Promote the idea that being in therapy is normal and that talking about mental health openly is vital.
- Focus on breaking inherent cultural imbalances and systemic inequalities that perpetuate stigma.

4. Expand Prevention

- Research to identify those most at risk of suicide and proactively create intervention plans.
- Deliver parenting courses to help families reduce stressors and provide better support for children.
- Expand community groups and initiatives, like Local Area Coordinators, to reduce loneliness and social isolation.
- Increase support and monitoring for postnatal women to identify mental health challenges early, beyond routine check-ups at health centres.
- Address underlying socioeconomic factors like poverty, housing, and inequality to reduce mental health risks.
- Provide support for those influenced by the suicide of a friend, relative, or celebrity, as this can increase the risk of imitation.
- Include parenting education for stressed parents of truanting children or those with behavioural issues to create healthier environments.
- Reduce life and health inequalities by focusing on vulnerable populations across services.
- Expand access to support networks, including groups for people expected to cope with significant life challenges.
- Ensure better housing options to reduce stress and improve mental health.

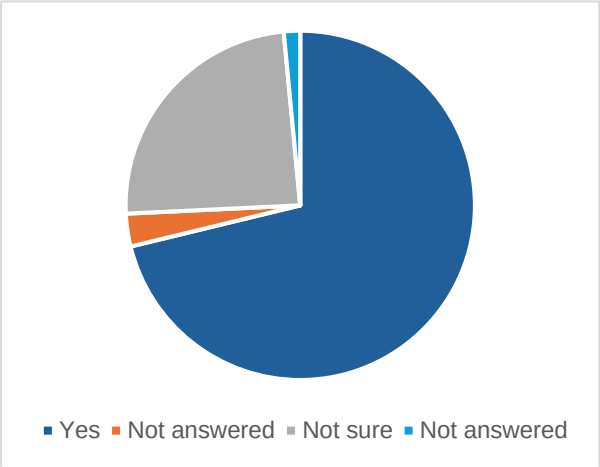
5. Other

- Graphics in maternity settings should address mental health (e.g., postpartum depression, anxiety) alongside physical health topics like breastfeeding.
- Bring all groups together for shared events to foster community and reduce inequality.
- Dependence on social media for support indicates a need for reliable and accessible formal support systems.
- Develop comprehensive and integrated solutions rather than siloed approaches to mental health care.

Question 10: Does the strategy clearly explain why suicide prevention is a priority for Havering and should be everyone's business?

100% of respondents answered this question.

- 47 (71%) respondents believe the strategy clearly explains why suicide prevention is a priority for Havering.
- 2 (3%) respondents believe the strategy does not clearly explain why suicide prevention is a priority for Havering and should be everyone's business.
    - "Needs more than 200 characters."
    - "No I'm still unclear."
- 16 (24%) of respondents were not sure if the strategy clearly explains why suicide prevention is a priority for Havering and should be everyone's business.



Question 11: There are 3 overarching objectives of the strategy, do you agree that these objectives are the right ones?

100% of respondents answered this question.

- 25 (38%) of respondents strongly agreed that the 3 overarching objectives were the right ones.
- 30 (45%) of respondents agreed that the 3 overarching objectives were the right ones.
- 6 (9%) of respondents neither agreed nor disagreed that the 3 overarching objectives were the right ones.
- 2 (3%) of respondents disagreed that the 3 overarching objectives were the right ones.
- 3 (5%) of respondents strongly disagreed that the 3 overarching objectives were the right ones.

Those who disagreed used the space to explain further.

11 responses (17% of participants) answered this text-box follow-up question.

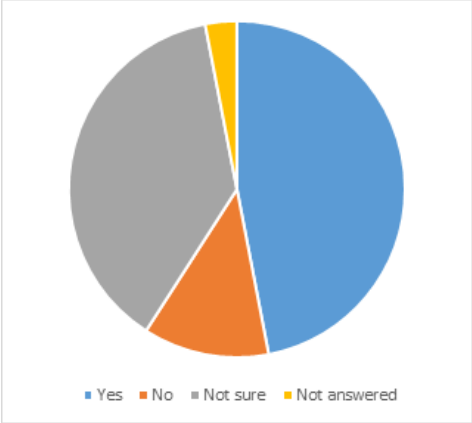
Overview of feedback from respondents:

- Did not understand how prevention works for stopping someone from harming or ending their life.
- Existing resources exist, such as bereavement support groups for those affected by suicide.
- Prevention may not be necessary if individuals receive timely and appropriate support.
- Broaden the identification process to include referrals from charities, friends, and family.
- Prioritise increased access to prompt and effective support over reducing access to means of harm.
- Clarify the ambiguous language around "reducing access to method of death" and focus on actionable solutions.
- Strengthen partnership working as a core element of all objectives within the strategy.

- Address gaps in support for individuals who have previously attempted suicide or those with comorbidities.
- Provide greater support for individuals already known to mental health services to avoid recurrence of crises.
- Ensure that the policy is implemented effectively and consistently by all stakeholders.
- Place more emphasis on supporting individuals before they reach a crisis stage—proactive, not reactive, interventions.
- Highlight the need for increased resources in NHS mental health services to meet demand effectively.
- Two respondents said there wasn't enough room to give detailed feedback with a 200 character limit.

Question 12: This is an all-age strategy. When we talk about "our population", we include children and young people, adults and older adults. Do you feel the strategy is clear about how it delivers for different age groups?

64 responses (97% of participants) answered this question.



- 31 (47%) of respondents felt that the strategy is clear in how it delivers for different age groups.
- 8 (12%) of respondents felt that the strategy is not clear in how it delivers for different age groups.
- 25 (38%) were not sure.
- 2 did not respond.

If participants answered, no, they could use a space to explain further.

15 responses (23% of participants) answered this text-box follow-up question.

Overview of feedback from respondents:

- High-risk groups are identified, but older adults are not explicitly mentioned.
- More specific details are needed to explain how the strategy plans to reach school-age children and those around them.
- The strategy mentions exploring children and young people but lacks set standards for prevention at present.
- Children are part of statistics but are not explicitly included in terms of preventative measures or support. For example, how can lived experience be integrated to support children?
- There is insufficient detail on self-harm among children and young people. More focus is needed on this issue.
- Children and young people (CYP) have different needs and ways of communicating compared to adults, including language and service access.
- The strategy is unclear regarding how it addresses the needs of children and the risks they face.
- A clear, all-ages policy is needed, with more information on which age groups or job roles are most affected.

- Uncertainty exists around how the strategy specifically addresses children's needs and risks.
- Consider support for children who experience multi-generational loss by suicide to help identify and provide appropriate support.
- The strategy lacks specified interventions for different age groups, especially under 18s.
- There should be more emphasis on under-18s in the strategy; it currently seems to be focused on adults.
- The language used may not be reader-friendly for younger children. The strategy should be accessible to children as young as 10, particularly those who may be self-harming.
- Schools may talk about compassion, but they do not always model it. Yellow Days are a good start, but therapists should be brought in to educate and speak at assemblies.

Question 13: Please use this space below if you have any further comments about suicide prevention in Havering or the draft strategy - additional comments

37 responses (56% of participants) answered this text-box follow-up question.

Overview of feedback from respondents:

1. **Awareness**
   - Work with schools to encourage self-worth among pupils and combat bullying, both in-person and online. Provide more support for RSHE (Relationships, Sex, and Health Education) that addresses prevention and support for all three main objectives.
   - More awareness and local promotional campaigns aimed at prevention rather than focusing only on support following suicide. Work on preventing suicide from becoming an option for the local community.
   - Awareness raising is key to reducing people's fear of discussing the topic of suicide.
   - Public events to talk about the topic more openly and change the approach to discussing suicide.
   - Advice for employers to know what warning signs to look out for in employees at risk of suicide.
   - The wider the circulation of this strategy, the better. There needs to be greater communication within organisations to ensure information about mental health strategies is accessible.

2. **Inclusive and comprehensive support**
   - We need a service that helps people in crisis and has a clear route to referring individuals to longer-term care that isn't an overstretched charity, with enough resources to follow up.
   - Not everyone can or wants to travel to group settings. There needs to be more person-centred care. Not everyone who is suicidal is unemployed or unwell—stop generalizing.
   - Menopause support centres in relation to mental health, particularly understanding links between hormones and mental health, as well as addressing intrusive thoughts and suicidal thoughts.
   - High-risk groups have been identified, but older adults are not explicitly mentioned in the strategy.

- More specific detail is needed to explain how the strategy plans to reach school-age children and those around them.

3. Improving services and reducing barriers

- NHS needs to employ more mental health professionals to minimise waiting times, which can have detrimental effects on individuals in crisis.
- People need to know that if they reach out for help, there is a facility available—many people are currently sent to A&E and then released a few hours later with little to no follow-up support.
- The strategy should address the need for better training of mental health support staff. Many professionals in the field lack experience in dealing with individuals at risk of suicide.
- There's a need for more consistent services that focus on the individual's needs.
- You can have all the strategies and policies in place, but without increased funding and a significant reduction in waiting lists, it won't make a meaningful difference.
- When my parent was suffering, they were not previously known to mental health services. This was used as an excuse, and the crisis team refused to visit. They later took their own life.

4. Collaboration

- The discourse around "voluntary" sectors undermines the importance of paid professionals who have the knowledge and experience to support the community and provide feedback.
- Each sector should review their input when a person dies by suicide, but why don't we have joint reviews for shared learning and breaking barriers down across sectors?
- This is a critical area that requires the whole health and care team working as one, alongside the community, ensuring co-design with users.

5. Other

- Difficult to comment due to lived experience.
- I was a Samaritan and am now a therapist, so I would be happy to get involved in supporting this initiative.
- It is difficult to give feedback in 200 characters.
- Tackle growing neurodivergent excuses for emotional distress. Teach more life skills and encourage resilience. Not everyone’s hardship is life threatening—it is important to support realistic coping mechanisms.
- There needs to be more focus on learning from local experiences and ensuring that services reach the right people.
- Add more detail is needed about how the voice of the child will be incorporated into the plan.
- Isolation and loneliness need to be reduced to provide better support for vulnerable individuals.

Changes to Strategy and Action Plan

Feedback from the Citizen Space Survey has resulted in the following changes.

1. **Scope of strategy and role of public health**

- Improved clarity around the scope of the strategy versus a detailed implementation plan.
- Clearly defined the roles of Public Health and Local Authority compared to NHS and clinical service provision.
- Clarified public health's role in collaboration with relevant suicide prevention partners, including encouraging partners, especially in reviews, to treat non-engagement with services as a symptom, not a reason to discontinue professional involvement.

2. **Missing Attention Areas, Groups and Risk Factors**

- Attention Areas
    - Addressed support for individuals already known to mental health services.
    - Linked to both premature discharge discussions and waiting lists.
    - Added action to address digital exclusion and cultural differences by making promotional information available in multiple languages and accessible formats.
    - Added more detail of self-harm association and support measures.
- Groups
    - Expanded focus from autistic to neurodivergent individuals (including ADHD).
    - Strengthened children and young people section and life-course approach.
    - Added to target self-employed individuals, including construction workers.
- Risk Factors
    - Added section on comorbidities.
    - Explicitly mentioned partnerships addressing wider determinants of health (housing, council tax, etc.).
    - Addressed social isolation and loneliness.
    - Added substance misuse.

3. **Crisis support**

- Added action to support NELFT with implementation of Crisis Hub, which aligns with the Adult Mental Health JSNA Recommendation.
- Discussed the need for support for those identified at A&E or who survive attempted suicide.
- Added action to improve pathways for bereavement support for those affected by suicide.

4. **Children and Young People**

- Strengthened "all-age" aspect of the strategy by clarifying the life course approach.
- Mentioned risks of both bullying and cyberbullying.
- Added detail on mental health support in schools for action plan: self-worth training for younger children and resources for teachers and parents.
- Highlighted the involvement of the child's voice via the youth council engagements and quotes.
- Added the promotion of accessibility for children and young people through easy-read version.

5. **Prevention**

- Made prevention objectives clearer using a primary/secondary/tertiary prevention framework.
- Highlighted prevention strategies before crises, including public awareness campaigns and events.
- Clarified plans for reducing access to means and the role public health can have in that (e.g., modifying public places).

Focus Groups

Primary Care Networks (PCNs)

The Havering Crest PCN meeting allowed for extended engagement with detailed questions posed for three objectives (see Appendix A). The Liberty PCN meeting had a shorter engagement time, so only objective was focused on (see Appendix B).

Key points from Havering Crest PCN included:

- General practitioners (GPs) expressed uncertainty about their role in suicide prevention.
- Some GPs felt suicidal individuals or their families might not approach GPs, making tools like posters in practices more relevant.
- Questions were raised about operational feasibility and confidentiality around the suspected suicide review panel; GPs were sceptical about the relevance of suicide review panels to their work and concerns over confidentiality were raised.
- None of the attendees had formal suicide prevention training and acknowledged a need for guidance; GPs suggested a suicide prevention education session during monthly meetings or practice manager meetings but emphasised keeping sessions concise.
- GPs reported patients with suicidal ideation often return multiple times while on mental health waiting lists, leaving GPs unsure of next steps.
- Referrals to crisis teams or A&E are common but lack follow-up mechanisms to ensure effective support.
- Suggestions for improvement:
    - Use existing forums such as practice managers' meetings and the social prescribing network for collaboration and education.
    - Provide more direct tools and training for GPs to handle patients in crisis and improve signposting to relevant services.
    - Distribute posters and educational materials in practices to raise awareness for both patients and their families.

Key points from Havering Liberty PCN included:

- GPs noted A&E is often viewed as a "safe option" by the health system but not suitable for mental health crises; this creates a chaotic experience where patients can easily feel lost or self-discharge to long waiting times.
- GPs emphasised the need for updated suicide prevention training to handle initial management and support effectively.
- GPs felt capable of providing initial support but identified gaps in where they know to signpost patients to.

- Primary care staff expressed feeling excluded from discussions about suicide prevention despite their role in patient care; they suggested being part of roundtable events and emphasised the need for support when they lose a patient to suicide.
- Some GPs receive coronial emails requesting data but are unsure of their purpose or how to respond.
- One participant noted that many patients feel GPs provide little beyond referrals, often leaving them feeling let down and worsening their mood.
- Positive feedback was shared about the LBH suicide prevention information session on World Suicide Prevention Day and requested more sessions like that to be conducted.

Youth Council

The Havering Youth Council participated in a session where the suicide prevention team presented a summary of the draft Havering Suicide Prevention Strategy. Following the presentation, the Youth Council was asked a series of questions and used sticky notes to record their responses. These answers were then discussed collectively. For a detailed list of questions posed to the Youth Council and their quoted responses, please refer to Appendix C.

Key points from the engagement with the Youth Council include:

1. **Impact of loss and needed support**

- Loss of a loved one leaves young people feeling confused, angry, isolated, and potentially lost in life.
- Can lead to long-term effects, including mental health issues like anxiety and depression.
- Support should include validating their feelings, ensuring they don't feel alone or to blame, and fostering a culture of empathy.
- Young people benefit from understanding friends, reassurance, and counseling to help them cope.
- Many young people lack awareness of available support services, and their diverse needs make a one-size-fits-all approach ineffective.

2. **Communicating with young people**

- Use comforting, direct, and non-judgmental language to avoid undermining or pressuring young people.
- Destigmatise mental health by avoiding language that implies abnormality or weakness.
- Education should start at a younger age and include frequent, open discussions to normalise the topics.
- Balance is key—sugarcoating can lead to misunderstanding, but severity should be communicated appropriately.

3. **Preferred sources for seeking help self-harm and/or suicidal thoughts**

- Young people often turn to trusted friends, close family members, or school wellbeing teams for help.
- Online platforms and resources provide comfort through anonymity and reduce fear or shame.
- Conversations via messaging, calls, or video platforms are also seen as helpful.

4. **What schools can do better**

- Schools should create systems for anonymous help-seeking and better advertise mental health services.
- Teachers should adopt a welcoming and supportive attitude, treating students with empathy and understanding.
- Educate both students and parents about mental health, providing tools, statistics, and workshops to reduce stigma.
- Create peer-support systems to help students feel less isolated and more connected.
- Acknowledge the impact of academic stress on mental health and address it openly.
- Offer interactive sessions on self-harm and suicide to actively engage students.
- Schools should proactively discuss these topics to counter toxic and unhealthy narratives often encountered online.

Primary and Secondary School Networks

As part of the consultation process, the suicide prevention team met with both the primary school network (PSHE network) and secondary school network (BAP network). The suicide prevention team presented the draft Havering Suicide Prevention Strategy-on-a-page, discussed the importance of mental health and suicide prevention for children and young people, and shared key insights from the engagement with the Havering Youth Council. Please refer to Appendix D for the PSHE questions and Appendix E for BAP questions.

Primary School Network: PSHE Meeting

Key points:

- **Resilience and Emotional Support**
  - Teachers find it challenging to address resilience in students while managing other responsibilities.
  - Emotional literacy support is currently offered to students with greater concerns only, but teachers feel that this support would benefit all students.
- **Positive self-talk and body image**
  - Positive self-talk is covered in PSHE lessons for older students. Body image awareness is starting earlier, with related lessons in Years 5 and 6 promoting positive perceptions.
- **Need for training**
  - Teachers feel underprepared to address mental health and resilience; they would welcome additional training and support.
  - Schools often rely on teaching assistants, learning mentors or external emotional support teams to handle these areas.

Secondary School Network: BAP Meeting

Key points:

- **Training for parents and teachers**
    - Head teachers highlighted that students who engage in self-harm often form trusting relationships with staff members who provide harm-reduction support, such as wound care. However, challenges arise when communicating with parents, who may struggle to understand or respond effectively. It was suggested that a tailored training package for parents be developed to assist with self-harm prevention and equip them to handle difficult conversations.
    - External training for parents was seen as valuable, as it provides information from experts rather than internal school sources.
    - Teachers already conduct online safety training but additional external training could be valuable.
    - It was emphasised that training for teachers should be separate from training for parents, as their needs differ.
- **Student Mental Health**
    - Head teachers noted that students often view stress and anxiety as abnormal and overthink negative feelings; there is a need to normalise such emotions and promote healthy coping mechanisms early in students' education.

Conclusion

Overall, there was broad agreement with the draft strategy, though several areas of concern were raised that will be addressed by the suicide prevention team. Although the survey received a relatively small number of responses, and therefore cannot be considered fully representative of all residents, it provides valuable feedback that will inform future actions. The Citizen Space survey helped identify gaps and areas for strengthening, while the focus group engagements highlighted additional opportunities to improve suicide prevention efforts.

GPs stressed the need for better training and improved crisis pathways, while the Youth Council emphasised empathetic, accessible support for young people. Schools pointed to the significance of resilience-building, mental health education and tailored training for both parents and teachers. As the strategy is developed and implemented, ongoing engagement with key stakeholders will continue.

Appendix

Appendix A: Questions for Havering Crest PCN

Questions on Objective 1

We have initiated a process where when there is a death by suspected suicide, we reach out to relevant stakeholders to see what services they were known to, and to deem then if a pre-coronial review is necessary.

We want to know what GP practice each case was registered to. Relevant stakeholders including contact from PCN, Housing Services, Community Safety, Change Grow Live (addiction services), Adult Social Care

-What do you think about this objective?
-Is this feasible?

Questions on Objective 2

-What are your views on the current partnership working?
-How often do you engage with partners across NE London?
-In what ways do you think this subregional partnership could be strengthened?

Questions on Objective 3

-Do you have any feedback on the current access to services for those expressing suicidal ideation or clearly at risk?

Appendix B: Questions for Liberty PCN

Questions on Objective 5:

-Do you have any feedback on the current access to services for those expressing suicidal ideation or clearly at risk?
-Have you been trained in suicide prevention?
-Do you think suicide prevention is relevant in GP practices? If yes, how? If no, why not?

Appendix C: Questions to Youth Council with quoted answers

1. How do you think the loss of a friend or family member affects young people? What support do they need most during this time?

- The young person should know their feelings are valid and they are not to blame.
- It affects young people as it could leave them feeling confused and angry. To support them you should let them know you support them no matter what.

- That they are not alone although they are going through a difficult time there are always people to support them
- You should ensure that they know that they will get past this bereavement and it is not the end of the world.
- The loss of a loved one changes you as a person.
- There should be an ongoing, widespread culture of empathy, as not all of those around us may have good understanding of empathy, especially in those situations.
- The young people mourning for a loved one may feel lost. They may find it difficult to live their life without their loved one
- They need a close understanding friend to talk about how they feel
- I think it would make them feel isolated as they would be overcome with negative emotions. I think they need to be reassured
- Confusion, lack of understanding of what happened
- Excluded from conversations about death or person of loss
- Some young people don't know about services
- Young peoples needs are diverse so its hard to pinpoint support
- Young people will struggle to cope and deal with the loss of a friend or family member as they won't know how to cope with it and I would suggest that if a young person is ever in that situation then they should go counselling to learn how to cope with it
- The loss of a friend or family member would affect a young person for the rest of their lives and could possibly even lead to mental health issues such as depression or anxiety. I also feel like its most overwhelming for young people as when your young you don't expect it

2. What are the most effective ways to communicate to young people about sensitive topics like suicide and mental health? [Any preferred language?]

- I think the best way to communicate to young people about sensitive topics is by talking to the young people in a comforting and enthusiastic manner because young people may feel undermined or told off when being asked to speak about these topics, and shouldn't feel pressured when speaking about how they feel
- Education on these topics from a younger age
- Some way of having a discussion with young people
- Educate people through school, can be spoke about more frequently so people are more aware and can feel comfortable talking and speaking out if ever struggling as they will then know support is there.
- The most effective way to communicate to young people about sensitive subjects is being direct as sugarcoating may lead to them misunderstanding the seriousness of the situation.
- I think trying to destigmatise mental health with the language we use to describe it is very important eg ensuring young people don't feel they are abnormal when they are going through something
- Sometimes you may need to stress the severity of the situation as some young people may not take it seriously enough

3. Where do you think young people feel most comfortable in seeking help if having thoughts of self-harm or suicide?

- Friends which they trust
- I think that the easiest way for young people feel most comfortable in seeking help is through talking to close family/friends and young people would find it easier to get professional help from a wellbeing team at school
- Young people feel most comfortable in seeking help from their friends if having thoughts of self-harm or suicide. Maybe would also seek help from family or the school dependent on the person or the situation
- I think young people feel most comfortable talking to their friends about mental health as they do not feel judged
- Conversations through a screen –message –calls –Zoom –etc
- I think we would feel most comfortable talking to our friends or trusted adult. I think online resources are good too because it removes the aspect of fear and possible shame that comes along with talking about your situation
- Many people may feel a lot more comfortable talking about their feelings online because they do not feel as exposed as it can be more anonymous

4. What can schools do better to educate and communicate with young people about the risks of self-harm/suicide and the importance of seeking help?

- Speaking to young people before parents
- Having a way to anonymously seek help
- Advertising mental health services
- Teachers should be less strict and more welcoming. Reminding children that they are humans too and are willing to support and be there for them
- Educate parents on mental health. Show statistics to children to highlight the reality of it. Have a support system in place. Have conversations about these topics
- Inform children of what to do if struggling, give them alternative resources. Speak more about mental health, making it more important
- Emphasise to us that they are not alone and they should not suffer in silence. Maybe they could volunteer to lend an ear to other pupils so that they can get comfort and guidance from someone who is more similar to them than a teacher
- Schools could treat students a bit more like adults as how can a young person be expected to talk about grown up issues in an environment where they're treated like a child?
- Schools can acknowledge how academic stress can lead to worse mental health as feeling seen helps a lot
- Schools can acknowledge how academic stress can lead to worse mental heath as feeling seen helps a lot
- Parents should be informed on how to encounter such situations, whether it is though a workshop or open discussion at school. As our parent's generation may have a stigma, or especially from when they grew up, they may have been taught little knowledge about mental health

- Schools should have interactive sessions with students about self-harm and suicide to engage them in learning how to deal and support those struggling in these situations

5. Other things mentioned

- They're seeing these conversations on the Internet (eg Tik Tok) anyway; so having teachers not talk about it at all makes them only see these conversations, in mostly toxic and unhealthy ways

Appendix D: Questions for the PSHE (primary school) Network:

-How comfortable are you with discussing emotional health or difficult feelings with your students? Do you feel you have adequate training in this area?

-How do you incorporate activities or lessons that promote self-esteem and confidence in your classroom?

-How do you help students manage and cope with failure or frustration?

-Do you use specific programmes or tools to promote positive self-talk? If not, is this something you'd be interested in if we provided it?

Appendix E: Questions for the BAP (secondary school) Network:

-Do you have initial thoughts based on the feedback from these young people?

-What do you think schools can do to better education and communicate with young people about the risks of self-harm and suicide and the importance of seeking help?

-What strategies and pathways are already in place to help young people regarding self-harm and suicide? How can these be improved?

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Suicide Prevention Needs Assessment

November 2024

Content warning: The content of this needs assessment may be emotionally challenging as it discusses suicidality and self-harm.

Support is available:

- Samaritans – a listening service which is open 24/7 for anyone who needs to talk.
- Campaign Against Living Miserably (CALM) - CALM's confidential helpline and live chat are open from 5pm to midnight every day.
- Shout – a free confidential 24/7 text service offering support if you're in crisis and need immediate help.

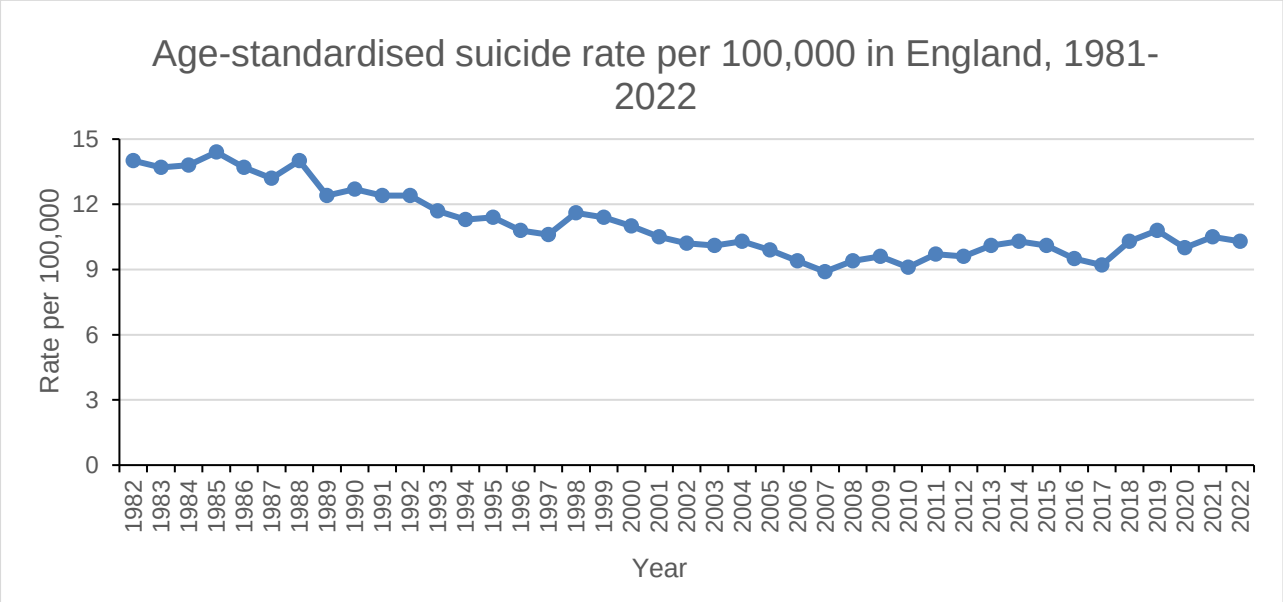
1. Introduction

1.1 Every suicide is preventable

Every suicide is a tragedy that leaves long-lasting effects on loved ones, colleagues, witnesses and frontline responders. For every suicide, individuals who are bereaved often experience suicidal thoughts or attempts themselves because of the loss[1]. The risk of suicide is unequally distributed throughout the population. Many different sociodemographic factors correspond risk of death by suicide, and inequalities unequally distributed throughout the population. Many different sociodemographic factors correspond to risk of death by suicide, and with people living in the most disadvantaged communities facing the highest risk of dying by suicide[2].

While death by suicide is a significant contributor to years of life lost amongst the population, suicides are not inevitable. Public health interventions aimed at limiting access to means and improving care for at-risk individuals have contributed to a decline in national suicide rates since the 1980s (See Figure 1)[3] and suicides are not inevitable. Suicidal incidents are complex and involve many factors, showing the need for a system-wide approach to prevention that involves services, communities, individuals and society as a whole.

Figure 1. Age-standardised suicide rate per 100,000 in England, 1981-2022.



Source: Office for National Statistics (ONS), 2022

[1] McDonnell, S., Flynn, S., Shaw, J., Smith, S., McGale, B., & Hunt, I. M. (2022). Suicide bereavement in the UK: Descriptive findings from a national survey. *Suicide & life-threatening behavior*, *52*(5), 887–897. https://doi.org/10.1111/sltb.12874

[2] Samaritans. *Inequality and suicide*. Retrieved from https://www.samaritans.org

[3] Office for Health Improvement and Disparities (OHID). *Fingertips data: Suicide rates per 100,000 in England compared to London & Havering*.

1.2 Policy Context

National Context

Since April 2019, all local authorities in England have implemented suicide prevention strategies aligned with the National Suicide Prevention Strategy (recently refreshed Suicide Prevention Strategy for England: 2023 to 2028)[4]. Supported by a £57 million investment in suicide prevention through the NHS Long Term Plan[5], these strategies ensure every local area has multi-agency suicide prevention plans in place. Moving forward, these plans must be tailored to tailored the specific demographics of the populations they serve, including considerations of ethnicity, age, gender identity and sexuality to meet local needs, and responsive to changes over time.

Havering Context

In 2018, a suicide prevention strategy was agreed upon between the London Boroughs of Barking and Dagenham, Havering, and Redbridge (BHR), along with the local NHS, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and North-East London NHS Foundation Trust (NELFT). The BHR Suicide Prevention Strategy[6] was due to be refreshed in 2022, but then each borough developed separate strategies. Havering's refresh was delayed by the pandemic, leading to an extension of the 2018-2022 strategy to cover 2023 at the time of writing this document.

Havering Public Health coordinates the *Havering Suicide Prevention Stakeholder Group* with members including:

- Havering Council
- MET Police
- National Rail
- BHRUT
- VCS – Samaritans, Mind, Safe Connections
- NELFT
- ELFT
- PCN (Primary Care Network) leads, GPs and other medical professionals
- Individuals with lived experience

1.3 Purpose and Process

The Suicide Prevention Needs Assessment's informs the development of the Havering Suicide Prevention Strategy for 2025-2030. The Needs Assessment serves to identify at-risk populations, analyse suicide prevalence and provide recommendations for action. Key sources of information include the Office for National Statistics, the Office for Health Improvement and Disparities (OHID), the Northeast London Suicide Prevention Dashboard and the Primary Care Mortality Database (PCMD). Appendix A includes further details on interpreting suicide data and methodologies.

[4] Department of Health and Social Care. (2023). *Suicide prevention strategy for England 2023-28*.
[5] National Health Service. (2019). *The NHS Long Term Plan*.
[6] Barking and Dagenham, Havering, and Redbridge Councils. 2018, *Suicide prevention strategy*.

1.4 Who is at risk and why?

There is no single reason cause for why people take their own lives. A complex mix of social, cultural, psychological and economic factors interact to increase an individual's level of risk (Figure 1: Multiple factors that have been linked to an increase risk of suicide**. Examples of SMI include psychosis and paranoid schizophrenia. NB: Each of the factors can be experienced along with any of the others listed.**). Often, these risk factors intersect, and some have a direct causal link to others; for example, loss of employment leads to debt and financial problems.

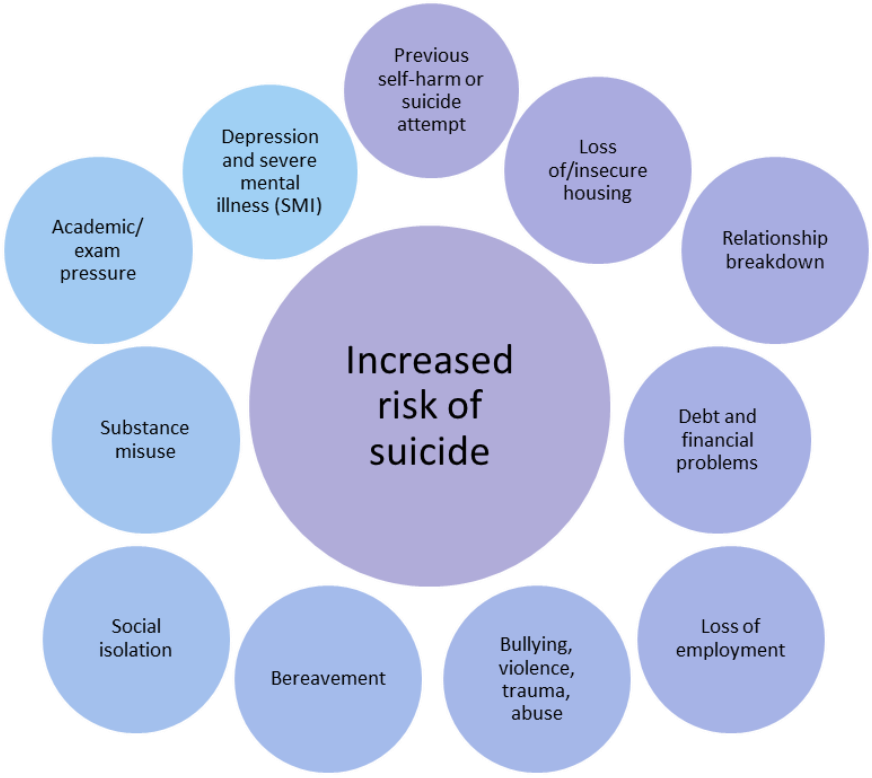


Figure 1: Multiple factors that have been linked to an increase risk of suicide[7]***. Examples of SMI include psychosis and paranoid schizophrenia. NB: Each of the factors can be experienced along with any of the others listed.***

1.5 The impact of suicide

For every death by suicide, on average 135 people are impacted, meaning that nearly 900,000 people a year are affected by suicide across the UK per year[8].	People bereaved by the sudden death of a friend or family members are 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural causes[9].

[7] Centers for Disease Control and Prevention. *Risk and protective factors*. Retrieved November 29, 2024, from https://www.cdc.gov/suicide/risk-factors/index.htm
[8] Samaritans. *The economic cost of suicide in the UK*. Retrieved from https://www.samaritans.org
[9] University College London. (2016). 1 in 10 suicide attempt risk among friends and relatives of people who die by suicide. Retrieved from https://www.ucl.ac.uk/news/2016/jan/1-10-suicide-attempt-risk-among-friends-and-relatives-people-who-die-suicide

The death of a patient by suicide has an effect on the personal and professional life of health professionals, affecting recruitment, retention, quality of professional life and patient care[10]. 	One death by suicide cost at average £1.46 million to society. Employment productivity losses account for one third of all suicide costs in 2022 in England, reaching £2.48 billion[8]. 

1.6 Inequalities

Inequalities exist in the distribution of risk factors associated with suicide. The impact of suicide cannot be discussed without acknowledging that national and international trends reveal that inequalities exist in the distribution of risk factors associated with suicide, for example:

- **Age**
    - Suicide affects individuals across all age groups, with certain age-related risk factors warranting particular attention.
    - In Havering, the highest suicide rates between 2013 and 2023 were among middle-aged people, specifically those aged 40-49 years and 50-59 years. This trend aligns with national data for England and Wales.
    - While the overall number of suicides among younger populations is comparatively lower, recent years have seen a relative increase in suicide rates nationally[11].
    - Given these trends, both middle-aged people and children and young people have been identified as priority groups for suicide prevention efforts, aligning with the national suicide prevention strategy.

- **Disability**
    - Disabled women are over four times more likely to die by suicide compared to non-disabled women[12]. Disabled men are three times more likely to die by suicide than non-disabled men[12].
    - Suicide is a leading cause of early death for autistic people without co-occurring learning disabilities; autistic people are seven times more likely to die by suicide than non-autistic individuals[13].

- **Gender identity and sexual orientation**
    - Men are on average twice as likely to die by suicide than women.
    - Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and those who are part of the community (LGBTQ+) are at a higher risk of death by suicide compared to those who do not identify as LGBTQ+[14].
- **Ethnicity**

[10] Royal College of Psychiatrists. *College report CR229: Self-harm and suicide*. Retrieved from https://www.rcpsych.ac.uk
[11] Office for National Statistics (ONS), 2022
[12] Disability Rights UK. Disabled people far more likely to die by suicide than non-disabled people. Retrieved from https://www.disabilityrightsuk.org
[13] Autistica. *Understanding suicide in autism*. Retrieved from https://www.autistica.org.uk/our-research/research-projects/understanding-suicide-in-autism
[14]Marchi, M., Arcolin, E., Fiore, G., Travascio, A., Uberti, D., Amaddeo, F., Converti, M., Fiorillo, A., Mirandola, M., Pinna, F., Ventriglio, A., Galeazzi, G. M., & Italian Working Group on LGBTIQ Mental Health (2022). Self-harm and suicidality among LGBTIQ people: a systematic review and meta-analysis. *International review of psychiatry (Abingdon, England)*, *34*(3-4), 240–256.

    - Although there is not enough data to give a full picture of suicide rates between ethnic groups, racism and discrimination can have significant impact on wellbeing and suicide risk[15].
- **Religion or Faith**
    - People belonging to any religious group generally have lower suicide rates compared to those with no religion, with the lowest rates in the Muslim group (5.14 per 100,000 males and 2.15 per 100,000 females).[16]
    - The rates of suicide were highest in the Buddhist group (26.58 per 100,000 males and 31.05 per 100,000 females) and religions classified as "Other" (33.19 per 100,000 males and 28.95 to 38.06 females).
    - For men and women, the rates of suicide were lower across the Muslim, Hindu, Jewish, Christian and Sikh groups compared with the group who reported no religion.
- **Maternity**
    - Maternal suicide is still the leading cause of direct (pregnancy-related) death in the year after pregnancy.
    - Almost a quarter of all deaths of women during pregnancy or up to a year after the end of pregnancy were from mental health-related causes.
    - A recent confidential enquiry reported that improvements in care might have made a difference in outcome for 67% of women who died by suicide[17].
- **Deprivation**
    - People living in the least advantaged areas have a 10 times higher risk of suicide than those living in the most advantaged areas.
    - Living in poverty increases the risk of poor mental health and death by suicide.
- **Stigma of mental ill-health**
    - Members of groups and communities where stigma of mental ill-health and suicide is more prevalent are at an increased risk as a result of lack of engagement with services that offer support to prevent death by suicide.

[15] Samaritans. *Ethnicity and suicide*. Retrieved from https://www.samaritans.org/about-samaritans/research-policy/ethnicity-and-suicide/
[16] Jacob, L., Haro, J.M. and Koyanagi, A., 2019. The association of religiosity with suicidal ideation and suicide attempts in the United Kingdom. Acta psychiatrica scandinavica, 139(2), pp.164-173 and ONS sociodemographic inequalities in suicide
[17] MBRRACE-UK, Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22. Retrieved from https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports

2. Key Findings

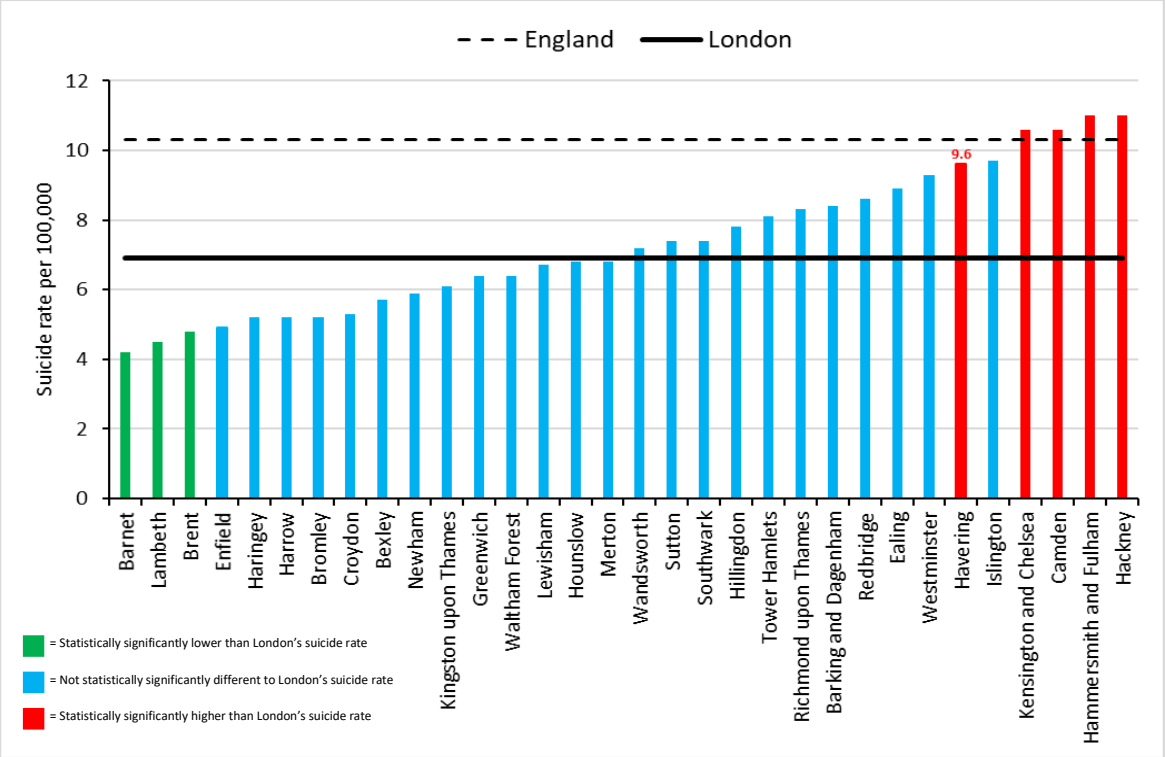
This section presents data on suicide prevalence, sociodemographics, methods and risk factors in Havering, contextualised with national data. While national data shows higher suicide risk among certain population groups, local data is insufficient to identify these differences due to small sample sizes. Consequently, local data for specific risk groups is presented where available. For more detail on high-risk groups, see Appendix B. Appendix C compares risk factors for suicide in Havering versus England.

2.1 Suicide Prevalence

Between 2015 and 2022, 139 lives were lost to suicide an additional 230 attempted suicides were registered among Havering residents[18]. Three-year rolling averages are used to detail the rate of suicide to ensure reliable rates can be produced and visibility of trends improved, and is especially useful when data can exhibit large changes in proportions owing to relatively small absolute numbers of occurrences each year. The average rate of suicide between 2020 and 2022 was 9.6 per 100,000 population [95%CI:7.4 – 12.3]. This is statistically significantly higher than the London rate of 6.9 deaths by suicide per 100,000 population [95%CI:6.6 – 7.3] and not different as the England rate of 10.3 per 100,000 [95%CI: 10.2 – 10.5][15]. Havering is now among one of the few boroughs with a notably higher age-adjusted suicide rate[4].

Figure 3. Three-year aggregate age-standardised suicide rates in London boroughs, London and England, 2020-2022.

[18] NEL Suicide Prevention Data Dashboard

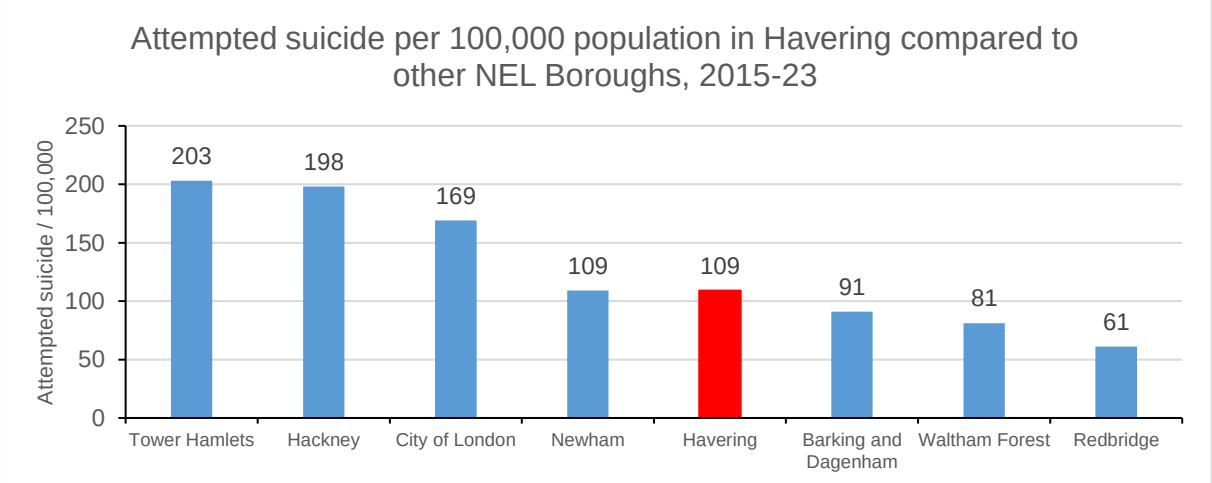


Source: Office for National Statistics (ONS), 2022. **Error! Bookmark not defined.**

2.2 Attempted Suicide

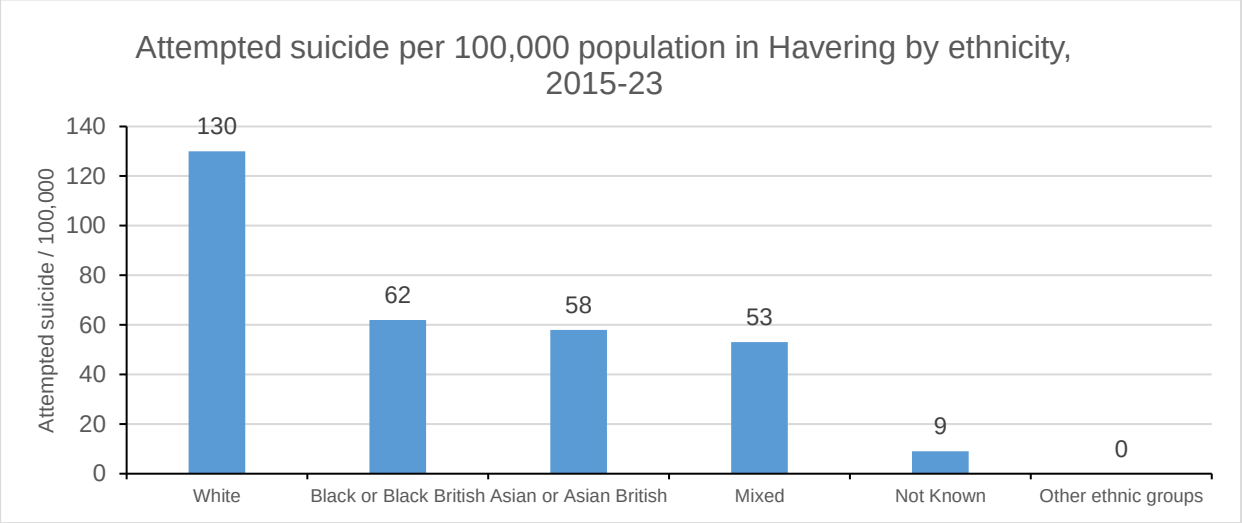
From 2015 to 2023, Havering reported an overall attempted suicide rate of 109 per 100,000, higher than neighbouring NEL boroughs (Barking & Dagenham, Redbridge and Waltham Forest). In Havering, the attempted suicide rate per 100,000 population between 2015 and 2023 was highest in the White population (130 per 100,000), the 13-19 age group (174 per 100,000) and 20-34 age group (217 per 100,000). Males accounted for 75% of attempted suicides and females accounted for 25% of attempted suicides from 2015 to 2023.

Figure 4. Attempted suicide per 100,000 population in Havering compared to other NEL Boroughs, 2015-23.



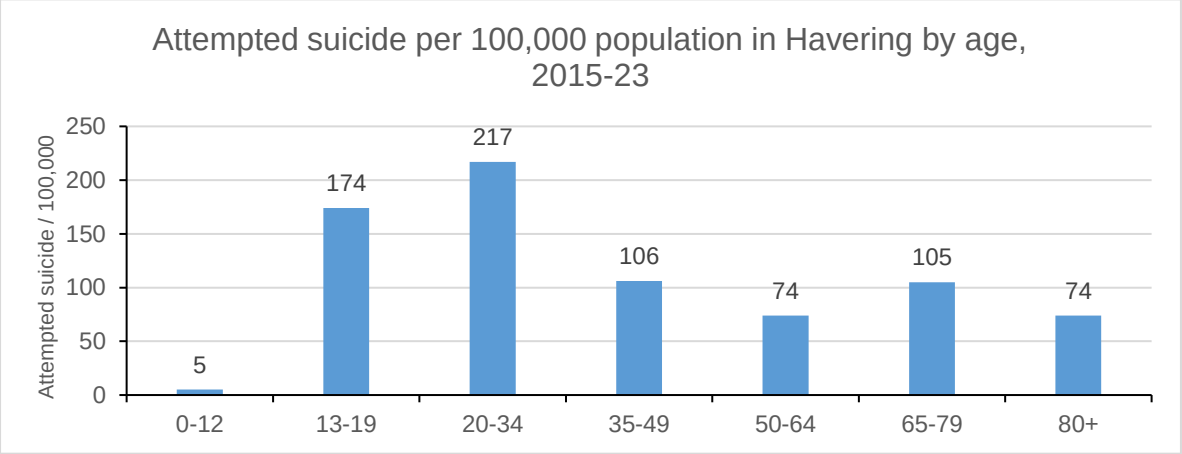
Source: Primary Care Discovery Data Service from the Suicide Prevention NEL Data Dashboard, 2015-23. N.B. This data may not always reflect the actual date of the event, as it might correspond to the date of the encounter with the GP. The primary care observation uses SNOMED code 82313006 – Suicide attempt (event).

Figure 5. Attempted suicide per 100,000 population in Havering by ethnicity, 2015-23.



Source: Primary Care Discovery Data Service from the Suicide Prevention NEL Data Dashboard, 2015-23. N.B. This data may not always reflect the actual date of the event, as it might correspond to the date of the encounter with the GP. The primary care observation uses SNOMED code 82313006 – Suicide attempt (event).

Figure 6. Attempted suicide per 100,000 population in Havering by age, 2015-23.



Source: Primary Care Discovery Data Service from the Suicide Prevention NEL Data Dashboard, 2015-23. N.B. This data may not always reflect the actual date of the event, as it might correspond to the date of the encounter with the GP. The primary care observation uses SNOMED code 82313006 – Suicide attempt (event).

2.3 Prevalence by demographic

Suicide rate by gender

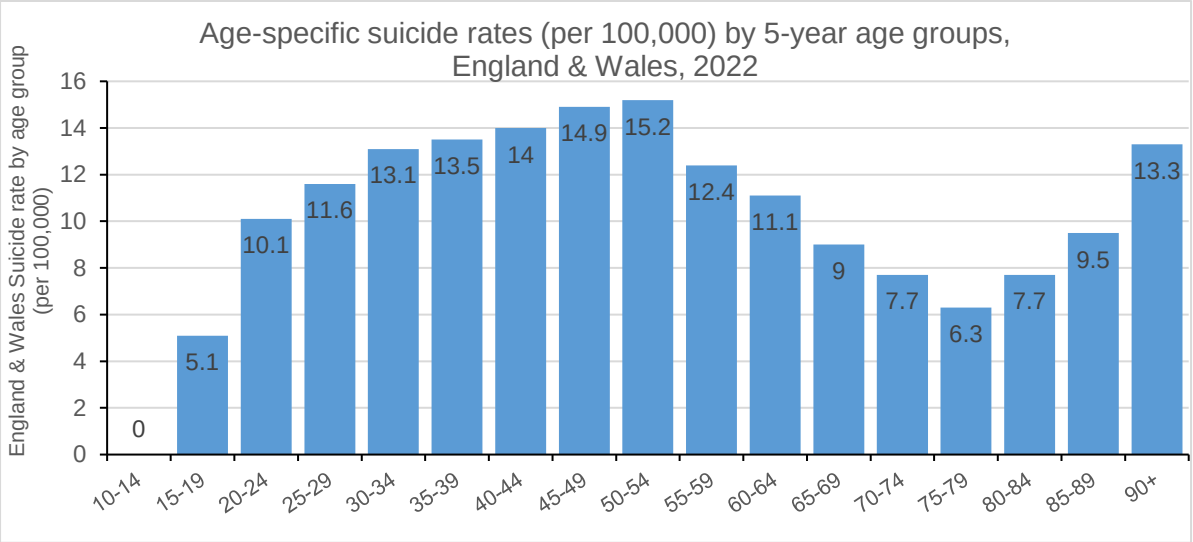
From 2015-16 to 2021-22, the average death by suicide by gender was 73.92% males and 26.08% females. This is similar to the England and Wales data, as three-quarters of suicides registered in England and Wales in 2022 were males (74.1%), equivalent to 16.4 deaths per 100,000[4].

Suicide rate by age

Between 2013 and 2023, Havering recorded the highest suicide rates seen among people aged 40-49 years and 50-59 years. This aligns with national data (England & Wales) where the highest suicide rates were among people aged 50 to 54 years in 2022, with those 45 to

49 as the second-highest age band[Error! Bookmark not defined.]. Males aged 45 to 64 have had the highest rate since 2010, with a rate of 20.4 per 100,000 in 2022[Error! Bookmark not defined.]. Suicide rates in Havering between 2013 and 2023 in younger age groups (18-29 years and 30-39 years) were lower than the national average[Error! Bookmark not defined.].

Figure 7. Age-specific suicide rates (per 100,000) by five-year age groups, England & Wales, 2022.



Source: Office for National Statistics (ONS), 2022[Error! Bookmark not defined.]

Suicide rates by occupation

A report by the ONS analysed suicide deaths in England from 2011 to 2015, focusing on differences across occupations[19]. Refer to Appendix D for the methodology and data description regarding suicide by occupation. Key findings included:

- Males employed in the lowest-skilled occupations faced a 44% higher risk of suicide compared to the male national average; the elevated risk among males in skilled trades was 35%.
- The risk of suicide among low-skilled male labourers, particularly those working in construction roles, was 3 times higher than the male national average.
- For males working in skilled trades, the highest risk was among building finishing trades; particularly, plasterers and painters and decorators had more than double the risk of suicide than the male national average, agricultural workers 1.7 times higher.
- The risk of suicide was elevated for those in culture, media and sport occupations for males (20% higher than the male average) and females (69% higher); risk was highest among those working in artistic, literary and media occupations.
- For females, the risk of suicide among health professionals was 24% higher than the female national average; this is largely explained by high suicide risk among female nurses.
- Male and female carers had a risk of suicide that was almost twice the national average.
- Females within the teaching and education profession had a lower risk of suicide but specifically for primary and nursery school teachers there was evidence of an elevated risk.
- Managers, directors and senior officials – the highest paid occupation group – had the lowest suicide risk.

[19] Office for National Statistics *Suicide by occupation, England*. Retrieved from https://www.ons.gov.uk

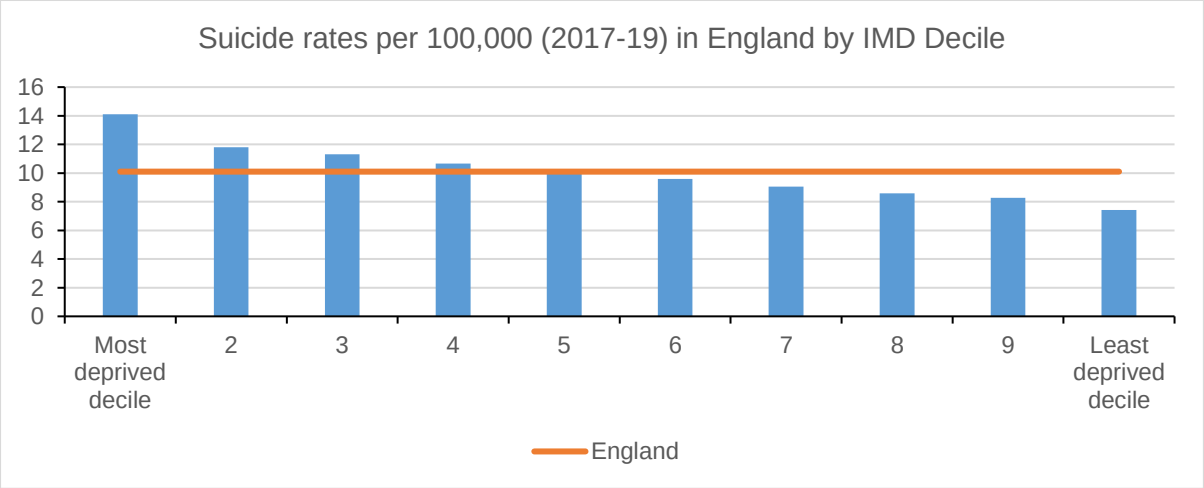
Suicide rates by ethnicity

A population level analysis compared the risk of dying by suicide across sociodemographic groups in adults in England and Wales[20]. It found that for ethnicity, rates of suicide were highest in the White and Mixed/Multiple ethnic groups for both men and women. Estimated rates of suicide were highest in the White (men: 21.03 per 100,000 people [95% CI: 20.56 to 21.51], women: 6.79 per 100,000 people [95% CI: 6.53 to 7.05]) and Mixed/Multiple ethnic groups (men: 23.56 per 100,000 people [95% CI: 21.32 to 26.04], women: 9.57 per 100,000 people [95% CI: 8.27 to 11.08])[20].

Suicide rates by deprivation

In Havering, the highest suicide rates were observed in the second most deprived quintile, while the lowest rates were in the least deprived quintile. This patterns contrasts with the national trend, which generally follows a social gradient for suicide rates: the more deprived the area, the higher the suicide rates. Across England, individuals living in the most deprived areas face a higher risk of suicide than those living in the least deprived areas. The suicide rate in the most deprived 10% of areas ('decile') in 2017-2019 was 14.1 per 100,000, nearly double the rate of 7.4 in the least deprived decile[21].

Figure 8. Suicide rates per 100,000 (2017-19) in England by IMD Decile (IMD 2019).



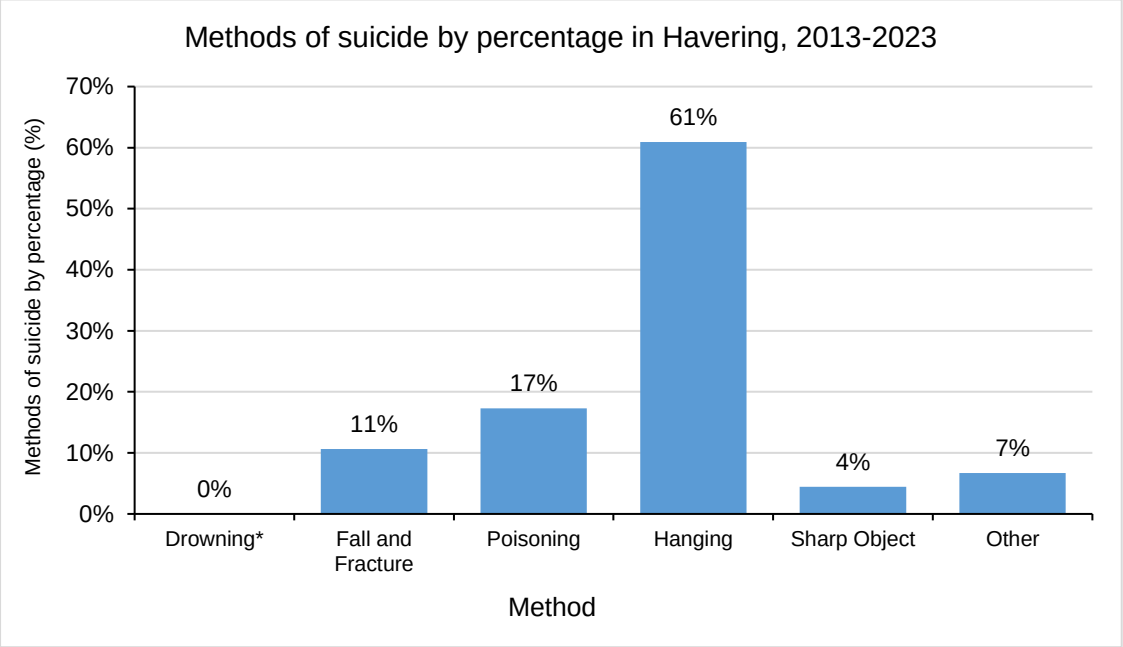
Source: OHID Fingertips Rates of suicide by deprivation decile in England, 2017-19.[22]

2.4 Prevalence of suicide by method

The most common method of suicide in Havering was hanging, accounting for 61% of all suicides from 2013 to 2023 (109 out of 180 registered deaths in this period, according to the PCMD). This is also the most common method of suicide in England and Wales for both males and females in 2022**Error! Bookmark not defined.**. The second most common method was poisoning, which accounted for 17% of all suicides (31 out of 180 deaths). This also mirrors England and Wales, as the second most common method continued to be poisoning and accounted for 19.9% of all suicides in 2022 (1,123 out of 5,642 deaths)**Error! Bookmark not defined.**. See Figure 10 below for more detailed method data.

[20] Office for National Statistics. *Sociodemographic inequalities in suicides in England and Wales*. Retrieved from https://www.ons.gov.uk
[21] Office for Health Improvement and Disparities (OHID). *Fingertips data: Rates of suicide by deprivation decile in England*.
[22] Office for Health Improvement and Disparities (OHID).*Rates of suicide by deprivation decile in England, 2017-19*.

Figure 10. Methods of suicide by percentage in Havering, 2013-2023.



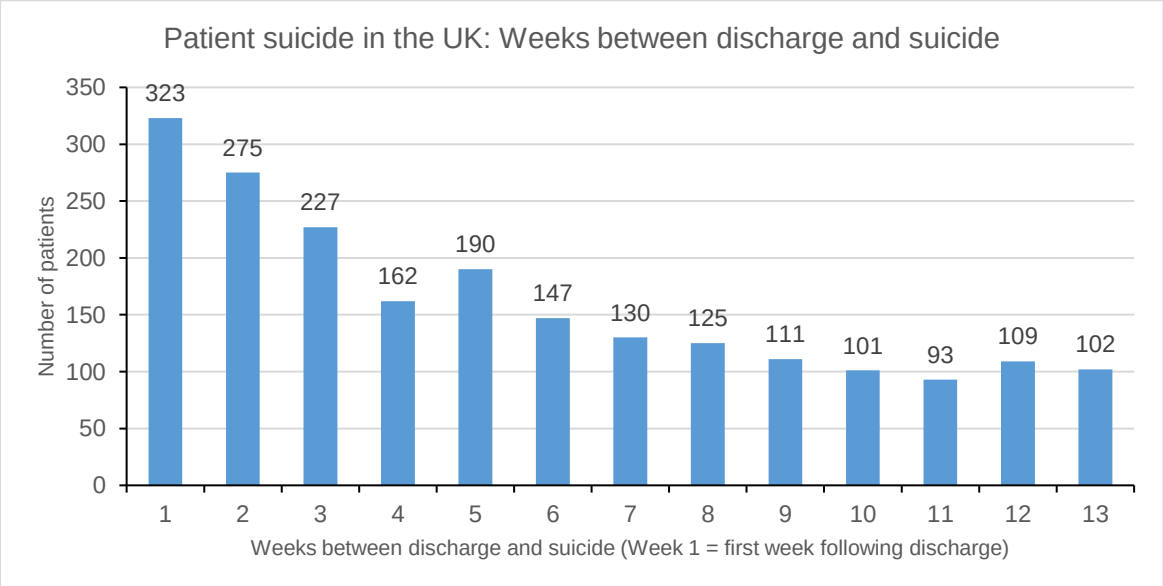
Source: PCMD. Produced by LBH PHI team. N.B. Data on suicides by drowning is suppressed due to the small number of cases (four or fewer) to prevent identification of individuals.

2.4 Prevalence by risk groups

Suicide among people in contact with mental health services

There were 18,403 suicide deaths by patients (i.e. people in contact with mental health services within 12 months of suicide) in the UK in 2010-2020, 27% of all general population suicides, an average of 1,673 deaths per year[23]. Post-discharge deaths by suicide were the most frequent in the first 1-2 weeks after leaving the hospital, see below.

Figure 11. Patient suicide in the UK: Weeks between discharge and suicide (Week 1 = first week following discharge, 2010-20.[10]



Source: National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), 2023 Annual Report.[20]

[23] Manchester University. *Understanding suicide in the UK*. Retrieved from https://www.manchester.ac.uk

Suicide among people who have self-harmed

Self-harm is defined as 'Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation' and there is strong evidence that the risk of suicide among those who have self-harmed is much greater than that of the general population, as is the risk of premature death[24]. Almost half of the general population and over half of the young people who die by suicide have previously harmed themselves. The risk of suicide is elevated by between 30 and 100-fold in the year following an episode of self-harm, compared to the general population[24].

Between 2018 and 2023, Havering had an overall A&E self-harm rate of 834 per 100,000, lower than all other NEL boroughs except for city of London, which had a rate of 607 per 100,000[25]. In Havering, the highest self-harm rates per 100,000 population between 2015 and 2023 were highest in the Other Ethnic Groups population (1,467 per 100,000), the 13-19 age group (2,953 per 100,000) the 20-34 age group (1,424 per 100,000), and among females, who represented 60% of self-harm A&E attendances. The A&E self-harm percentage for Havering residents was 61% in females and 39% in males[25].

Suicide among people diagnosed with severe health conditions

A diagnosis or first treatment for certain severe health conditions is associated with an elevated suicide rate when compared with similar socio-demographic characteristics (age, sex, ethnicity, religion, deprivation and region of residence)[26]. For example, one year after being diagnosed with COPD, the suicide rate for patients was 23.6 deaths per 100,000 people. This is 2.4 times higher than the suicide rate for the matched controls at 9.7 deaths per 100,000 people[23]. Similarly, one year after diagnosis for chronic ischemic heart conditions, the suicide rate for patients was 16.4 deaths per 100,000 people, nearly double the rate for the matched controls, which was 8.6 deaths per 100,000[23].

Suicide among people diagnosed with Autism

Despite comprising only about 1% of the population, autistic individuals account for 11% of suicides, making it the second-leading cause of death within this community[27]. Autistic adults with no learning disability are nine times more likely to die by suicide than the general population. Autistic women are also at twice the risk of death from suicide[28]. The average life expectancy for autistic people is just 54 years old[29]. Autistic people are at higher risk of mental health challenges, as research indicates that 70% of autistic individuals have one mental health disorder (such as anxiety or depression), and 40% have at least two mental health problems**Error! Reference source not found.**.

Suicide among those in the LGBTQ+ community

Lesbian, gay and bisexual individuals are more than twice as likely than straight peers to experience suicidal thoughts or engage in self-harming behaviours[30]. Experiences of

[24] Royal College of Psychiatrists. *College report CR229: Self-harm and suicide*. Retrieved from https://www.rcpsych.ac.uk
[25] North East London Suicide Prevention. (2018-2023). *Suicide prevention NEL data dashboard*.
[26] Office for National Statistics. *Suicides among people diagnosed with severe health conditions, England: 2017 to 2020*.
[27] Government Events. High suicide rates among neurodiverse individuals: Why it matters and what can be done about it.
[28] Cassidy S, Au-Yueng S, Robertson A, et al. Autism and autistic traits in those died by suicide in England. *The British Journal of Psychiatry.* 2022:221(5):683-691.
[29] T., Mittendorfer-Rutz, E., Boman, M., Larsson, H., Lichtenstein, P., & Bölte, S. (2016). Premature mortality in autism spectrum disorder. *The British journal of psychiatry : the journal of mental science*, *208*(3), 232–238.
[30] Kidd, G., Marston, L., Nazareth, I. *et al.* Suicidal thoughts, suicide attempt and non-suicidal self-harm amongst lesbian, gay and bisexual adults compared with heterosexual adults: analysis of data from two nationally representative English household surveys. *Soc Psychiatry Psychiatr Epidemiol* **59**, 273–283 (2024)

discrimination and bullying may play a role in increasing the risk of suicidality. Furthermore, a survey with lesbian, gay, bisexual and trans people across the England, Scotland and Wales[31] found that,

- One in eight LGBT young adults aged 18-24 (13%) reported surviving a suicide attempt in the past year.
- 46% of trans individuals and 31% of LGBT individuals who do not identify as trans have contemplated suicide in the last year.
- Almost half of LGBT young adults aged 18-24 (48%) reported self-harming in the past year. Additionally, 41% of non-binary individuals, 20% of LGBT women and 12% of LGBT men reported self-harming, compared to only 6% of adults in the general population.

Suicide among women in the perinatal period

There is an increase in suicide rates among women in the perinatal period in the UK and Ireland[32]. In 2020, 28 women died by suicide during pregnancy or within a year after pregnancy, a rate of 3.84 per 100,000 maternities[29]. The median age of these women was 30, with the majority (86%) being from white ethnic groups and 82% being UK or Irish citizens. Although pregnancy is usually considered a protective factor against death by suicide, there has been a statistically significant increase in the rate of suicide during pregnancy and up to six weeks postpartum in the UK, when comparing 2017-19 to 2020[329].

Suicide among those in contact with the criminal justice system

Individuals in prison in England and Wales are significantly more likely to die by suicide than those in the general population[33]. Over the last decade, the suicide rate in prisons in England and Wales has increased by over a third, making suicide the second leading cause of death in prisons.

This heightened risk continues post-release, with men being eight times more likely and women 36 times more likely to die by suicide within the first year after release compared to the general population. Additionally, people in prison are more likely to experience suicidal thoughts compared to the general population[33]**Error! Bookmark not defined.**.

2.6 Suicide prevention training uptake in Havering

The uptake of suicide prevention training courses in Havering was the lowest across the 7 NEL boroughs (Figure 13). According to the NEL Training Hub, the number of places taken up by Havering residents was 97 in April 2021/2022. This number more than doubled to 211 in April 2022/2023. This trend has continued into April 2023/2024, with 123 places already filled. As the current year progresses, more places are expected to fill, especially as the capacity of the NEL training hub grows. As a result, we anticipate that the uptake in 2023-24 will approach or surpass last year's figures.

[31] Stonewall. (2018). *LGBT in Britain - Health*.
[32] Confidential Enquiry into Maternal Deaths. *Unlocking the evidence: Understanding suicide in prisons*.
[33] Public Health England. *Local authority guidance on suicide prevention*. Retrieved from https://publishing.service.gov.uk

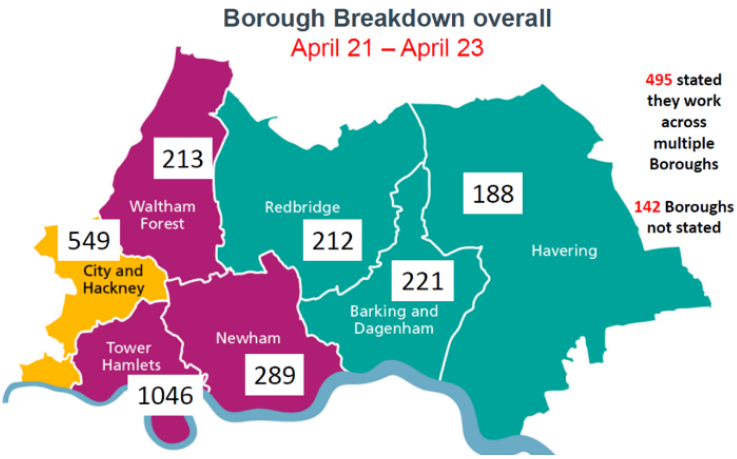


Figure 2: ***Uptake of NEL Training Hub suicide prevention training courses by NEL borough from April 2021-April 2023*** *Source: North East London Training Hub: Multi-Agency Mental Health & Suicide Prevention Training 2021-April 2023.*

3. NEL ICS Level

Northeast London (NEL) Integrated Care System (ICS) Level

Operating at the NEL level, the Suicide Prevention ICB working group collaborates with partners including:

- Public Health Suicide Prevention leads from the 7 NEL boroughs
- NELFT
- ELFT
- Network Rail
- Mind
- Safe Connections & Grief in Pieces
- Samaritans
- GP Care Group

The key priorities in the new Havering Suicide Prevention Strategy, aligned with the National Suicide Prevention Strategy, are outlined as follows:

1. Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
2. Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
3. Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.

4. Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
5. Providing effective crisis support across sectors for those who reach crisis point.
6. Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Providing effective bereavement support to those affected by suicide.
8. Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

The Suicide Prevention Stakeholder Group, launched in July 2023, provides input on the Havering Suicide Prevention Needs Assessment and the Suicide Prevention Strategy and Action Plan. Their efforts aim to raise awareness of suicide prevention, promote relevant services and training and enhance collaboration among partners to strengthen suicide prevention initiatives. See Table I below for member organisations.

Table I: Member organisations of the Havering Suicide Prevention Stakeholder Group, 2024

LBH Public Health	BHRUT	LBH CTax & Benefits, Exchequer & Transactional Services	LGBTQ+ forum / LGBTQ freelance trainer
LBH Elected member for Health and Wellbeing	Healthwatch	Peabody	LBH Planning
London Fire Brigade	Community Connectors	JCU	Network Rail
Mind	Local area coordinators	Imago	ELFT
Samaritans	Health champions	Community hubs	CGL
Havering Carer's hub	Jobcentre plus / DWP	NEL Training Hub	LBH Workplace Health
LBH Community Safety	LBH Housing	PSHE Network	LBH Communities
NELFT	LBH Adult Social Care	Street pastors	LBH Social work
Metropolitan Police	LBH Children's Services	Town centres Management	Havering Compact
NHS NEL ICB	CAMHS	Age UK	LBH Education
GP Representative	LBH Early Help	People with lived experience	Adults Safeguarding Board
LBH Communications			

Further details on the actions and the responsibilities at different geographical footprints i.e. borough, ICS and London level are in the Havering Suicide Prevention Strategy and Action Plan.

4. Recommendations

4.1 Adopt and implement a local all-age suicide prevention strategy to ensure best use of local data, intelligence and partnership working

4.2 Promoting suicide prevention across Havering

The council should continue to collaborate with stakeholders, to address the intersecting factors that lead to suicide and provide comprehensive support for at-risk individuals. This includes the Public Health Suicide Prevention team to contribute to the development of the Adult Mental Health Needs Assessment. By continuing to work closely and develop an action plan with stakeholders (healthcare workers, community organisations, council services, etc.), the council can promote a coordinated approach to suicide prevention.

4.3 Review each death by suspected suicide amongst Havering residents

The "Local Suicide planning: a practical resource[34]" from Public Health England (PHE) in partnership with the National Suicide Prevention Alliance recommends a local suicide audit for local implementation of the national strategy. Therefore, Having Council should ensure that each death by suspected suicide is reviewed regarding possible lessons learned and areas of improvement to prevent future deaths by suicide. Such review processes provide detailed insights into individual cases, methods used and interactions with services, each year. This data can help identify cohorts of local people who are at risk of suicide as well as

[34] Public Health England. (2020). *Local suicide prevention planning: A practice resource*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/939479/PHE_LA_Guidance_25_Nov.pdf

changes in the proportion of methods of death to indicate any particular preventative actions to be taken.

Completing a local suicide audit can help to identify inequalities by understanding the Havering-specific factors contributing to suicide within different demographic groups, such as socioeconomic status.

4.4 Continue to work with partners across the North East London Region and more widely (London and National)

Recognising a person's life experience is rarely contained in a single Local Authority geopolitical footprint, the need to work collaboratively with colleagues in suicide prevention efforts is crucial. In particular the response to potential clusters of deaths by suicide, when Havering residents die by suicide outside of the borough and when residents of other areas die by suicide within Havering (for example on our transport network). The need to be share an awareness and align, where appropriate, our response and processes should be continually considered along with shared learning that may help to improve the effectiveness of our work locally.

Contact Person

Public Health: publichealth@havering.gov.uk

References

1. McDonnell, S., Flynn, S., Shaw, J., Smith, S., McGale, B., & Hunt, I. M. (2022). Suicide bereavement in the UK: Descriptive findings from a national survey. *Suicide & life-threatening behavior*, *52*(5), 887–897. https://doi.org/10.1111/sltb.12874
2. Samaritans. *Inequality and suicide*. Retrieved from https://www.samaritans.org
3. Office for Health Improvement and Disparities (OHID). *Fingertips data: Suicide rates per 100,000 in England compared to London & Havering*.
4. Department of Health and Social Care. (2023). *Suicide prevention strategy for England 2023-28*.
5. National Health Service. (2019). *The NHS Long Term Plan*.
6. Barking and Dagenham, Havering, and Redbridge Councils. 2018, *Suicide prevention strategy*.
7. Centers for Disease Control and Prevention. *Risk and protective factors*. Retrieved November 29, 2024, from https://www.cdc.gov/suicide/risk-factors/index.html
8. Samaritans. *The economic cost of suicide in the UK*. Retrieved from https://www.samaritans.org
9. University College London. (2016). 1 in 10 suicide attempt risk among friends and relatives of people who die by suicide. Retrieved from https://www.ucl.ac.uk/news/2016/jan/1-10-suicide-attempt-risk-among-friends-and-relatives-people-who-die-suicide
10. Royal College of Psychiatrists. *College report CR229: Self-harm and suicide*. Retrieved from https://www.rcpsych.ac.uk
11. Office for National Statistics (ONS), 2022
12. Disability Rights UK. Disabled people far more likely to die by suicide than non-disabled people. Retrieved from https://www.disabilityrightsuk.org
13. Autistica. *Understanding suicide in autism*. Retrieved from https://www.autistica.org.uk/our-research/research-projects/understanding-suicide-in-autism
14. Marchi, M., Arcolin, E., Fiore, G., Travascio, A., Uberti, D., Amaddeo, F., Converti, M., Fiorillo, A., Mirandola, M., Pinna, F., Ventriglio, A., Galeazzi, G. M., & Italian

Working Group on LGBTIQ Mental Health (2022). Self-harm and suicidality among LGBTIQ people: a systematic review and meta-analysis. *International review of psychiatry (Abingdon, England)*, *34*(3-4), 240–256.
15. Samaritans. *Ethnicity and suicide*. Retrieved from https://www.samaritans.org/about-samaritans/research-policy/ethnicity-and-suicide/
16. Jacob, L., Haro, J.M. and Koyanagi, A., 2019. The association of religiosity with suicidal ideation and suicide attempts in the United Kingdom. Acta psychiatrica scandinavica, 139(2), pp.164-173 and ONS sociodemographic inequalities in suicide
17. MBRRACE-UK, Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22. Retrieved from https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports
18. North East London Suicide Prevention. *Suicide prevention data dashboard*.
19. Office for National Statistics *Suicide by occupation, England*. Retrieved from https://www.ons.gov.uk
20. Office for National Statistics. *Sociodemographic inequalities in suicides in England and Wales*. Retrieved from https://www.ons.gov.uk
21. Office for Health Improvement and Disparities (OHID). *Fingertips data: Rates of suicide by deprivation decile in England*.
22. Office for Health Improvement and Disparities (OHID).*Rates of suicide by deprivation decile in England, 2017-19*.
23. Manchester University. *Understanding suicide in the UK*. Retrieved from https://www.manchester.ac.uk
24. Royal College of Psychiatrists. *College report CR229: Self-harm and suicide*. Retrieved from https://www.rcpsych.ac.uk
25. North East London Suicide Prevention. (2018-2023). *Suicide prevention NEL data dashboard*.
26. Office for National Statistics. *Suicides among people diagnosed with severe health conditions, England: 2017 to 2020*.
27. Government Events. High suicide rates among neurodiverse individuals: Why it matters and what can be done about it.
28. Cassidy S, Au-Yueng S, Robertson A, et al. Autism and autistic traits in those died by suicide in England. *The British Journal of Psychiatry.* 2022:221(5):683-691.
29. Hirvikoski, T., Mittendorfer-Rutz, E., Boman, M., Larsson, H., Lichtenstein, P., & Bölte, S. (2016). Premature mortality in autism spectrum disorder. *The British journal of psychiatry : the journal of mental science*, *208*(3), 232–238. https://doi.org/10.1192/bjp.bp.114.160192
30. Kidd, G., Marston, L., Nazareth, I. *et al.* Suicidal thoughts, suicide attempt and non-suicidal self-harm amongst lesbian, gay and bisexual adults compared with heterosexual adults: analysis of data from two nationally representative English household surveys. *Soc Psychiatry Psychiatr Epidemiol* **59**, 273–283 (2024). https://doi.org/10.1007/s00127-023-02490-4
31. Stonewall. (2018). *LGBT in Britain - Health*.
32. Confidential Enquiry into Maternal Deaths. *Unlocking the evidence: Understanding suicide in prisons*.
33. Public Health England. *Local authority guidance on suicide prevention*. Retrieved from https://publishing.service.gov.uk
34. Public Health England. (2020). *Local suicide prevention planning: A practice resource*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/939479/PHE_LA_Guidance_25_Nov.pdf
35. Appleby, L., Kapur, N., Turnbull, P., Rodway, C., Graney, J. and Tham, S.G., 2021. Suicide in middle-aged men.

36. Royal College of Physicians: self harm and suicide in adults - final report of the patient safety group (July, 2020)
37. National Child Mortality Database. (2021). *Suicide in children and young people*. National Child Mortality Database. Retrieved from https://www.ncmd.info/publications/child-suicide-report/
38. Tham, S.G., Hunt, I.M., Turnbull, P., Appleby, L., Kapur, N. and Knipe, D., 2023. Suicide among psychiatric patients who migrated to the UK: a national clinical survey. EClinicalMedicine, 57.https://doi.org/10.1016/j.eclinm.2023.101859
39. SMI Adviser & Suicide Prevention Resource Center. *Suicide and serious mental illness: An overview of considerations, assessment, and safety planning*. Zero Suicide. Retrieved from https://zerosuicide.edc.org/resources/resource-database/suicide-and-serious-mental-illness-overview-considerations-assessment
40. Healthcare Quality Improvement Partnership. (2019). *Suicide by people in contact with substance misuse services: Feasibility study*. HQIP. Retrieved from https://www.hqip.org.uk/wp-content/uploads/2019/08/Suicide-by-people-in-contact-with-substance-misuse-service-feasibility-study-FINAL.pdf
41. Samaritans. (2024). *Alcohol and suicide*. Samaritans. Retrieved from https://www.samaritans.org/about-samaritans/research-policy/alcohol-suicide/
42. Just Like Us. (2021). *LGBT+ young people are twice as likely to contemplate suicide, research finds*. Just Like Us. Retrieved from https://www.justlikeus.org/blog/2021/11/25/lgbt-young-people-twice-likely-suicide/
43. Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., Silverman, M. M., Fisher, P. W., Hughes, T., Rosario, M., Russell, S. T., Malley, E., Reed, J., Litts, D. A., Haller, E., Sell, R. L., Remafedi, G., Bradford, J., Beautrais, A. L., Brown, G. K., … Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *Journal of homosexuality*, *58*(1), 10–51. https://doi.org/10.1080/00918369.2011.534038
44. Stonewall. (2018). *LGBT in Britain: Health*. Stonewall. Retrieved from https://www.stonewall.org.uk/resources/lgbt-britain-health-2018
45. Khalifeh, H., Hunt, I.M., Appleby, L. and Howard, L.M., 2016. Suicide in perinatal and non-perinatal women in contact with psychiatric services: 15 year findings from a UK national inquiry. The Lancet Psychiatry, 3(3), pp.233-242.
46. Jacob, L., Haro, J.M. and Koyanagi, A., 2019. The association of religiosity with suicidal ideation and suicide attempts in the United Kingdom. Acta psychiatrica scandinavica, 139(2), pp.164-173.
47. Office for National Statistics. (2023). *Sociodemographic inequalities in suicides in England and Wales: 2011 to 2021*. Office for National Statistics. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/sociodemographicinequalitiesinsuicidesinenglandandwales/2011to2021
48. O'reilly, D. and Rosato, M., 2015. Religion and the risk of suicide: longitudinal study of over 1 million people. The British Journal of Psychiatry, 206(6), pp.466-470.
49. Public Health Agency. *Health intelligence briefing on Travellers*. Public Health Agency. Retrieved from https://www.publichealth.hscni.net/sites/default/files/Health%20Intelligence%20briefing%20on%20Travellers.pdf
50. The Traveller Movement. (2019). *Policy briefing addressing mental health and suicide among Gypsy, Roma and Traveller communities in England*. The Traveller Movement.
51. McDonnell, S., Flynn, S., Shaw, J., Smith, S., McGale, B., & Hunt, I. M. 2022. Suicide bereavement in the UK: Descriptive findings from a national survey. Suicide & Life-Threatening Behavior, 52(5), 887-897. https://doi.org/10.1111/sltb.12874
52. Probert-Lindström, S., Berge, J., Westrin, A, Öjehagen, A., & Skogman Pavulans, K. (2020). Long-term risk factors for suicide in suicide attempters examined at a medical emergency inpatient unit: Results from a 32-year follow-up study. *BMJ Open, 10*(10).

53. World Health Organization. (2014). *Preventing suicide: A global imperative*. World Health Organization. Retrieved from https://www.who.int/publications/i/item/9789241564779
54. West Midlands Police & Crime Commissioner. (2020). *Domestic abuse links to suicide: Rapid review, fieldwork, and quantitative analysis report*. West Midlands Police & Crime Commissioner. Retrieved from https://www.westmidlands-pcc.gov.uk/
55. D'Arrigo, T. (2023, June). One-fifth of suicide deaths linked to relationship problems. *Psychiatric News, 58*(6). https://doi.org/10.1176/appi.pn.2023.06.6.7
56. Dangar, S., Munro, V. E., & Young Andrade, L. (2023). *Learning legacies: An analysis of domestic homicide reviews in cases of domestic abuse suicide*. Advocacy After Fatal Domestic Abuse (AAFDA) and University of Warwick.
57. Henson, K.E., Brock, R., Charnock, J., Wickramasinghe, B., Will, O. and Pitman, A., 2019. Risk of suicide after cancer diagnosis in England. JAMA psychiatry, 76(1), pp.51-60.
58. National Confidential Inquiry into Suicide and Safety in Mental Health. (2023). *Annual report 2023: UK patient and general population data 2010-2020*.
59. Samaritans. (2019). *Prisons data report 2019*. Samaritans. Retrieved from https://media.samaritans.org/documents/Samaritans_PrisonsDataReport_2019_Final.pdf
60. Office for National Statistics. (2017). *Suicide by occupation, England: 2011 to 2015*. Office for National Statistics. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015
61. Care Inspectorate. *Suicide prevention for looked after children and young people*. Care Inspectorate. Retrieved from https://hub.careinspectorate.com/media/1630/suicide-prevention-for-looked-after-children-and-young-people.pdf
62. Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by
People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.
63. Fox, V., Dalman, C., Dal, H., Hollander, A.-C., Kirkbride, J. B., & Pitman, A. (2021). Suicide risk in people with post-traumatic stress disorder: A cohort study of 3.1 million people in Sweden. *Journal of Affective Disorders, 279*, 609–616. https://doi.org/10.1016/j.jad.2020.10.009
64. Institute of Health Equity. (2020). *The impact of adverse experiences in the home on the health of children and young people, and inequalities in prevalence and effects*. Institute of Health Equity. Retrieved from https://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf
65. Mental Health Foundation. (n.d.). *Refugees and asylum seekers: Statistics*. Mental Health Foundation. Retrieved from https://www.mentalhealth.org.uk/explore-mental-health/statistics/refugees-asylum-seekers-statistics
66. Rodway, C., Ibrahim, S., Westhead, J., Bojanić, L., Turnbull, P., Appleby, L., Bacon, A., Dale, H., Harrison, K. and Kapur, N., 2022. Suicide after leaving the UK Armed Forces 1996-2018: a cohort study. medRxiv, pp.2022-12.
67. Shaw, R.J., Cullen, B., Graham, N., Lyall, D.M., Mackay, D., Okolie, C., Pearsall, R., Ward, J., John, A. and Smith, D.J., 2021. Living alone, loneliness and lack of emotional support as predictors of suicide and self-harm: A nine-year follow up of the UK Biobank cohort. Journal of Affective Disorders, 279, pp.316-323.
68. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (2015). *Suicide in primary care in England, 2002–2011*. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
69. O'Dwyer, C. (2017). *Unpaid carers and their mental health: Policy brief*. University of Exeter. Retrieved from

https://www.exeter.ac.uk/media/universityofexeter/research/policy/briefs/ODwyer_Unpaid_carers_Policy_Brief.pdf
70. Autistica. (2020). *Personal tragedies, public crisis: Autism and suicide*. Autistica. Retrieved from https://www.autistica.org.uk/downloads/files/Personal-tragedies-public-crisis-ONLINE.pdf
71. Murray, R. M., Conroy, E., Connolly, M., Stokes, D., Frazer, K., & Kroll, T. (2021). Scoping Review: Suicide Specific Intervention Programmes for People Experiencing Homelessness. *International journal of environmental research and public health*, *18*(13), 6729. https://doi.org/10.3390/ijerph18136729
72. Samaritans. (2023). *Insights from experience: Economic disadvantage, suicide, and self-harm*. Samaritans. Retrieved from https://media.samaritans.org/documents/Samaritans_InsightsFromExperience_EconomicDisadvantageSuicideSelfharm_2023_WEB.pdf
73. Eric B Elbogen, Megan Lanier, Ann Elizabeth Montgomery, Susan Strickland, H Ryan Wagner, Jack Tsai, Financial Strain and Suicide Attempts in a Nationally Representative Sample of US Adults, *American Journal of Epidemiology*, Volume 189, Issue 11, November 2020, Pages 1266–1274,
74. Meltzer H, Griffiths C, Brock A, Rooney C, Jenkins R. Patterns of suicide by occupation in England and Wales: 2001–2005. *British Journal of Psychiatry*. 2008;193(1):73-76. doi:10.1192/bjp.bp.107.040550

Appendices

Appendix A: Important considerations for interpreting suicide data, Office for National Statistics (ONS) Methodology

The Office for National Statistics (ONS) publishes national data on deaths registered as suicides during that year, not deaths occurring in each calendar year. Because of the time taken to complete an inquest, it can take months, sometimes years, for a suicide to be registered. ONS data describes the date a death was registered, as opposed to the date of death. Because of the length of time of coroners' inquests, only a proportion of deaths registered in a given year would have occurred in the same year.

For example, for England and Wales, 56% of suicides registered in 2017 also occurred in 2017; most remaining suicides (41%) occurred in 2016. In England and Wales, data on suicide concern all deaths that were assigned underlying cause of intentional self-harm (for those aged 10 years and above). Also included are those deaths cause by injury or poisoning of undetermined intent (for those aged 15 years and above), based on the assumption that the majority will be suicide.

ONS figures used for England, region and local authority describe postcode of residence (not place of death). The suicide rate is an age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aggregated populations for the three years) in people aged 10+. ONS reported counts are totals for the three-year period (January 2020 to December 2022).

Data from the Primary care mortality (PCMD) database has been used to examine deaths recorded as suicides, with the data broken down by age group, method of suicide, and deprivation decile. Comparing suicide rates by age group between Havering and national data presents challenges due to differences in age band categorisation between the PCMD and ONS data.

Appendix B: Comprehensive Overview of High-Risk Groups for Suicide Risk Factors

Vulnerable and at risk groups	Take home message
Middle aged men[35]	• Men aged 40-54 have the highest suicide rates in the UK. • Key risk factors for middle-aged men include unemployment, living in deprived areas, substance misuse, mental health conditions, social isolation, and economic instability. • Men are less likely to seek or complete therapy compared to women.
People who self-harm[36]	• Self-harm greatly increases suicide risk, particularly in the year following an episode (30-100x higher risk than the general population). • Nearly half of those who die by suicide have a history of self-harm.
Children and Young People (CYP) [37]	• There are rising suicide rates in under-20s, especially among girls. • Risk factors for CYP include significant personal losses, bullying, and undiagnosed neurodevelopmental conditions (e.g., autism). • Over one-third of CYP who die by suicide were not in contact with mental health services.
People with Severe Mental Illness (SMI) [38] [39]	• 50% of suicide cases had a diagnosed mental health condition, with schizophrenia and bipolar disorder associated with significantly elevated risk. • The suicide rate is 25 times higher in mood disorders.

[35] Appleby, L., Kapur, N., Turnbull, P., Rodway, C., Graney, J. and Tham, S.G., 2021. Suicide in middle-aged men.
[36] Royal College of Physicians: self harm and suicide in adults - final report of the patient safety group (July, 2020)
[37] National Child Mortality Database. (2021). *Suicide in children and young people*. National Child Mortality Database. Retrieved from https://www.ncmd.info/publications/child-suicide-report/

[38] Tham, S.G., Hunt, I.M., Turnbull, P., Appleby, L., Kapur, N. and Knipe, D., 2023. Suicide among psychiatric patients who migrated to the UK: a national clinical survey. EClinicalMedicine, 57.https://doi.org/10.1016/j.eclinm.2023.101859
[39] SMI Adviser & Suicide Prevention Resource Center. *Suicide and serious mental illness: An overview of considerations, assessment, and safety planning*. Zero Suicide. Retrieved from https://zerosuicide.edc.org/resources/resource-database/suicide-and-serious-mental-illness-overview-considerations-assessment

Vulnerable and at risk groups	Take home message
Substance misuse including alcohol[40] [41]	• 22% of drug-related deaths receive a conclusion of suicide or undetermined intent at coroner's inquest, and this is likely an underestimate. • People who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population. • In England, 45% of all patients under the care of mental health services who die by suicide have a history of alcohol misuse.
LGBTQ+ [42] [43] [44]	• LGBT+ young people are twice as likely to contemplate suicide than non-LGBT+ young people, and Black LGBT+ young people are three times more likely. • 13% of people identifying as LGBTQ+ aged 18-24 have attempted to take their own life in the last year; almost half of trans people have thought about taking their own life in the last year. • 14% of people identifying as LGBTQ+ have avoided treatment for fear of discrimination because they're part of the LGBTQ+ community.
Women in the perinatal period[45] [17]	• Perinatal suicidality is considered one of the leading causes of maternal mortality in the first 12 months postpartum. • Perinatal suicide occurs mainly through more violent methods compared to suicide in non-pregnant women and at a higher rate among women with a previous or current mental illness.
Those not belonging to faith groups [46] [47]	• Religion generally lowers suicide risk, though stigma can deter help-seeking. • The highest rates of deaths by suicide are among Buddhist and "Other" religious groups.
Gypsy, Roma & Traveller (GRT) communities [48] [49]	• Travellers experience a 6.6 times higher suicide rate when compared with non-Travellers, accounting for approximately 11% of all Traveller deaths. • When disaggregated by gender and age, this rate was 7 times higher for men and most common in young Traveller men aged 15-25 and 5 times higher for Traveller women than in the general population. • GRT populations are rarely recognised in local or national suicide prevention plans.
Those bereaved or impacted by suicide [50]	• Around 38% of bereaved individuals reported suicidal thoughts, with 8% attempting suicide, often within a year of the loss. • The most common relationships to the deceased in those who reported a suicide attempt were parent (23%); friend (22%); spouse/partner (19%); sibling (13%); and child (11%).

[40] Healthcare Quality Improvement Partnership. (2019). *Suicide by people in contact with substance misuse services: Feasibility study*. HQIP. Retrieved from https://www.hqip.org.uk/wp-content/uploads/2019/08/Suicide-by-people-in-contact-with-substance-misuse-service-feasibility-study-FINAL.pdf

[41] Samaritans. (2024). *Alcohol and suicide*. Samaritans. Retrieved from https://www.samaritans.org/about-samaritans/research-policy/alcohol-suicide/

[42] Just Like Us. (2021). *LGBT+ young people are twice as likely to contemplate suicide, research finds*. Just Like Us. Retrieved from https://www.justlikeus.org/blog/2021/11/25/lgbt-young-people-twice-likely-suicide/

[43] Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., Silverman, M. M., Fisher, P. W., Hughes, T., Rosario, M., Russell, S. T., Malley, E., Reed, J., Litts, D. A., Haller, E., Sell, R. L., Remafedi, G., Bradford, J., Beautrais, A. L., Brown, G. K., … Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *Journal of homosexuality*, *58*(1), 10–51. https://doi.org/10.1080/00918369.2011.534038

[44] Stonewall. (2018). *LGBT in Britain: Health*. Stonewall. Retrieved from https://www.stonewall.org.uk/resources/lgbt-britain-health-2018

[45] Khalifeh, H., Hunt, I.M., Appleby, L. and Howard, L.M., 2016. Suicide in perinatal and non-perinatal women in contact with psychiatric services: 15 year findings from a UK national inquiry. The Lancet Psychiatry, 3(3), pp.233-242.

[46] Jacob, L., Haro, J.M. and Koyanagi, A., 2019. The association of religiosity with suicidal ideation and suicide attempts in the United Kingdom. Acta psychiatrica scandinavica, 139(2), pp.164-173.

[47] O'reilly, D. and Rosato, M., 2015. Religion and the risk of suicide: longitudinal study of over 1 million people. The British Journal of Psychiatry, 206(6), pp.466-470.

[48] Public Health Agency. *Health intelligence briefing on Travellers*. Public Health Agency. Retrieved from https://www.publichealth.hscni.net/sites/default/files/Health%20Intelligence%20briefing%20on%20Travellers.pdf

[49] The Traveller Movement. (2019). *Policy briefing addressing mental health and suicide among Gypsy, Roma and Traveller communities in England*. The Traveller Movement.

[50] McDonnell, S., Flynn, S., Shaw, J., Smith, S., McGale, B., & Hunt, I. M. 2022. Suicide bereavement in the UK: Descriptive findings from a national survey. Suicide & Life-Threatening Behavior, 52(5), 887-897. https://doi.org/10.1111/sltb.12874

Vulnerable and at risk groups	Take home message
People who have attempted suicide [51] [52]	• A prior suicide attempt is the single most important risk factor for suicide in the general population. • Long-term studies of mortality among those with previous suicide attempts have found that between 2% and 13% have died by suicide after 20–37 years after the first suicide attempt.
Those subjected to DV [53] [54] and those in relationship breakdown [55]	• Among survivors of abuse, 24% reported suicidal ideation, particularly in cases of prolonged or multiple abuse forms. • Women experiencing intimate partner violence showed a strong dose-response relationship with suicidality. • One in five deaths by suicide is related to problems with current or former intimate partners, such as divorce, separation, romantic breakups, conflicts and intimate partner violence.
People with LTCs and/or recently diagnosed with a life changing illness (terminal) [56]	• Cancer patients, especially those with low-survival cancers, and individuals with COPD or heart conditions face elevated suicide risks, particularly within the first year-post diagnosis.
People with history of MH issues, in contact with MH services, after discharge from hospital [57]	• During 2006-2016, 28% of deaths by suicide in the UK were by mental health patients. • For patient suicides after hospital discharge, the highest risk was in the first two weeks after discharge and the highest number of deaths occurred on day 3 post-discharge.
People in contact with criminal justice system[58]	• Suicide is the second leading cause of death in prisons. • This risk remains high even after release from prison – in England and Wales, men have been shown to be 8 times and women 36 times more likely to die by suicide than others in the community, in the first year after their release from prison. • People in prison are also more likely to have suicidal thoughts.
Specific occupational groups, such as doctors, nurses, veterinary workers, agricultural workers, police.[59]	• Males in lowest skilled occupations, labourers, construction, skilled trades were at an elevated risk of suicide. • Job-related features such as low pay and low job security increase risk. • Between 1991 and 2000, occupational mortality in England and Wales indicated that doctors, dentists, nurses, vets and agricultural workers such as farmers were at increased risk of suicide.
Looked after children/children leaving care [60] [61]	• Transition periods, such as moving from one placement to another or leaving care, can increase trauma and suicide risk. • There is increased prevalence of suicidal ideation among looked after children.

[51] Probert-Lindström, S., Berge, J., Westrin, A, Öjehagen, A., & Skogman Pavulans, K. (2020). Long-term risk factors for suicide in suicide attempters examined at a medical emergency inpatient unit: Results from a 32-year follow-up study. *BMJ Open, 10*(10).
[52] World Health Organization. (2014). *Preventing suicide: A global imperative*. World Health Organization. Retrieved from https://www.who.int/publications/i/item/9789241564779
[53] West Midlands Police & Crime Commissioner. (2020). *Domestic abuse links to suicide: Rapid review, fieldwork, and quantitative analysis report*. West Midlands Police & Crime Commissioner. Retrieved from https://www.westmidlands-pcc.gov.uk/
[54] Dangar, S., Munro, V. E., & Young Andrade, L. (2023). *Learning legacies: An analysis of domestic homicide reviews in cases of domestic abuse suicide*. Advocacy After Fatal Domestic Abuse (AAFDA) and University of Warwick.
[55] D'Arrigo, T. (2023, June). One-fifth of suicide deaths linked to relationship problems. *Psychiatric News, 58*(6). https://doi.org/10.1176/appi.pn.2023.06.6.7
[56] Henson, K.E., Brock, R., Charnock, J., Wickramasinghe, B., Will, O. and Pitman, A., 2019. Risk of suicide after cancer diagnosis in England. JAMA psychiatry, 76(1), pp.51-60.
[57] National Confidential Inquiry into Suicide and Safety in Mental Health. (2023). *Annual report 2023: UK patient and general population data 2010-2020*.
[58] Samaritans. (2019). *Prisons data report 2019*. Samaritans. Retrieved from https://media.samaritans.org/documents/Samaritans_PrisonsDataReport_2019_Final.pdf
[59] Office for National Statistics. (2017). *Suicide by occupation, England: 2011 to 2015*. Office for National Statistics. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015
[60] Care Inspectorate. *Suicide prevention for looked after children and young people*. Care Inspectorate. Retrieved from https://hub.careinspectorate.com/media/1630/suicide-prevention-for-looked-after-children-and-young-people.pdf
[61] Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.

Vulnerable and at risk groups	Take home message
People with PTSD/trauma[62]	• PTSD is associated with increased suicide rates, with individuals diagnosed with PTSD twice as likely to die by suicide than those without PTSD.
People with Adverse Childhood Experiences (ACEs) [63]	• Childhood trauma increases the risk of suicide and self-harm in children and young people. • Emotional adversities, such as parental death or separation and living in care, had an association with risk of suicide. • The presence of multiple ACEs heightens this risk even further.
Refugees and asylum seekers [64]	• Research suggests that asylum seekers are five times more likely to have mental health needs than the general population, and more than 61% will experience severe mental distress. • Data shows that they are less likely to receive support than the general population; poor mental health, PTSD, mental health conditions, economic conditions including housing and income instability, lack of support will all contribute to increased suicide risk.
People leaving the armed forces [65]	• Suicide risk was two to four times higher in male and female veterans aged under 25 years than in the same age groups in the general population.
People who live on their own [66]	• For men, both living alone and living with non-partners were associated with death by suicide, independently of loneliness, which had a modest relationship with suicide. • For women, there was no evidence that living arrangements, loneliness or emotional support were associated with death by suicide.
Individuals who visit their GP more than 24 times a year [67]	• 37% of people who died by suicide had not seen their GP in the previous year. • Risk was increased by 67% in non-attenders. • Suicide risk also increased with increasing number of GP consultations, particularly in the 2 to 3 months prior to suicide. In those who attended more than 24 times, risk was increased 12-fold.
Unpaid carers [68]	• More than 45 studies have reported suicidal thoughts and behaviours in unpaid carers; the number of carers reporting suicidal ideation varies across studies, with some estimates as high as 71% and most likely to be an underestimate. • Among those who have contemplated suicide, research suggests that 1 in 6 carers are likely to attempt suicide in the future and 1 in 10 have already attempted suicide.
Disability, including autism and other neurodevelopmental conditions and learning disabilities [12] [69]	• Disabled women are over four times more likely to die by suicide compared to non-disabled women. Disabled men are three times more likely to die by suicide than non-disabled men. • Autistic adults with no additional learning disability are over 9 times more likely (relative to a general population) to die by suicide. • Multiple studies suggest that between 30% and 50% of autistic people have considered taking their own live.

[62] Fox, V., Dalman, C., Dal, H., Hollander, A.-C., Kirkbride, J. B., & Pitman, A. (2021). Suicide risk in people with post-traumatic stress disorder: A cohort study of 3.1 million people in Sweden. *Journal of Affective Disorders, 279*, 609–616. https://doi.org/10.1016/j.jad.2020.10.009
[63] Institute of Health Equity. (2020). *The impact of adverse experiences in the home on the health of children and young people, and inequalities in prevalence and effects*. Institute of Health Equity. Retrieved from https://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf
[64] Mental Health Foundation. (n.d.). *Refugees and asylum seekers: Statistics*. Mental Health Foundation. Retrieved from https://www.mentalhealth.org.uk/explore-mental-health/statistics/refugees-asylum-seekers-statistics
[65] Rodway, C., Ibrahim, S., Westhead, J., Bojanić, L., Turnbull, P., Appleby, L., Bacon, A., Dale, H., Harrison, K. and Kapur, N., 2022. Suicide after leaving the UK Armed Forces 1996-2018: a cohort study. medRxiv, pp.2022-12.
[66] Shaw, R.J., Cullen, B., Graham, N., Lyall, D.M., Mackay, D., Okolie, C., Pearsall, R., Ward, J., John, A. and Smith, D.J., 2021. Living alone, loneliness and lack of emotional support as predictors of suicide and self-harm: A nine-year follow up of the UK Biobank cohort. Journal of Affective Disorders, 279, pp.316-323.
[67] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (2015). *Suicide in primary care in England, 2002–2011*. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
[68] O'Dwyer, C. (2017). *Unpaid carers and their mental health: Policy brief*. University of Exeter. Retrieved from https://www.exeter.ac.uk/media/universityofexeter/research/policy/briefs/ODwyer_Unpaid_carers_Policy_Brief.pdf
[69] Autistica. (2020). *Personal tragedies, public crisis: Autism and suicide*. Autistica. Retrieved from https://www.autistica.org.uk/downloads/files/Personal-tragedies-public-crisis-ONLINE.pdf

Vulnerable and at risk groups	Take home message
	• One study found that 14% of autistic children experience suicidal thoughts compared to 0.5% of non-autistic children.
Individuals who rough sleep[70]	• Attempted suicides is up to 5.3 times higher among individuals who rough sleep compared to the general population.
Individuals financial strain [71] [72]	• Accumulated financial strain, including a debt crisis mixed with unemployment, past homelessness or lower income, significantly predicts suicide attempts and suicidal ideation. • Individuals facing multiple financial stressors show up to 20 times higher likelihood of attempted suicide compared to those without such strain. • Men in lower social classes and deprived areas face up to 10 times higher suicide risk compared to affluent counterparts.

Appendix C: Risk factors associated with an increased risk for suicide, comparing Havering rates with England.

Risk Factor	Havering rate	England rate
Alcohol-related hospital admissions (narrow): directly age standardised rate per 100,000 persons (2022/23)	334 per 100,000	475 per 100,000
Hospital admissions due to substance misuse per 100,000 in 15-24 year olds (2020/21-22/23)	171.4 per 100,000	58.3 per 100,000
Self-harm hospital admissions per 100,000 by age group 10-14 (2022/23)	90.7 per 100,000	251.2 per 100,000
Self-harm hospital admissions per 100,000 by age group 15-19 (2022/23)	203.4 per 100,000	468.2 per 100,000
Self-harm hospital admissions per 100,000 by age group 20-24 (2022/23)	180.6 per 100,000	244.4 per 100,000
Emergency hospital admissions for intentional self-harm per 100,000 (all ages) (2022/23)	66.7 per 100,000	126.3 per 100,000
Deprivation Score (IMD 2019)	16.8 per 100,000	21.7 per 100,000

[70] Murray, R. M., Conroy, E., Connolly, M., Stokes, D., Frazer, K., & Kroll, T. (2021). Scoping Review: Suicide Specific Intervention Programmes for People Experiencing Homelessness. *International journal of environmental research and public health*, *18*(13), 6729. https://doi.org/10.3390/ijerph18136729

[71] Eric B Elbogen, Megan Lanier, Ann Elizabeth Montgomery, Susan Strickland, H Ryan Wagner, Jack Tsai, Financial Strain and Suicide Attempts in a Nationally Representative Sample of US Adults, *American Journal of Epidemiology*, Volume 189, Issue 11, November 2020, Pages 1266–1274,

[72] Samaritans. (2023). *Insights from experience: Economic disadvantage, suicide, and self-harm*. Samaritans. Retrieved from https://media.samaritans.org/documents/Samaritans_InsightsFromExperience_EconomicDisadvantageSuicideSelfharm_2023_WEB.pdf

Domestic abuse related incidents and crimes recorded by the police per 100,000 (age 16+) (2021/22)	35.5 per 100,000	30.7 per 100,000
Unemployment (Percentage of the working age population claiming out of work benefit) (2022/23)	5%	5%
Long term unemployment (+ 12 months) rate per 1,000 working age population (16+) (2021/22)	1.8 per 100,000	1.9 per 100,000
Households in temporary accommodation per 1,000 estimated total households (2022/23)	8.9 per 100,000	4.2 per 100,000
Children entering the youth justice system (10-17 yrs) (2020/21)	2.6 per 100,000	2.8 per 100,000
Percentage of looked after children whose emotional wellbeing is a cause for concern aged 5-16 years (2021/22)	32%	37%
Proportion of the population (aged 18+) with GP diagnosed depression	10.85 per 100,000	12.3 per 100,000
The prevalence (%) of Severe Mental Illness (SMI) including psychosis (all ages)	0.72 per 100,000	0.95 per 100,000

Source: Office for Health Improvement and Disparities. Public health profiles. 2024.

Appendix D: Methodology and Data Description for suicide by occupation

The figures described in this bulletin include deaths registered in England between 2011 and 2015. The analysis is based on suicides registered in England between 2011 to 2015 as this represents the approach used when this analysis was previously completed.[14] This approach reduces the likelihood that sudden changes in occupational populations impact the analysis.

Of the 18,998 suicides among individuals aged 20 to 64 during this period, occupation data was approximately available for 70% (13,232) of these cases.

Suicide was defined using the National Statistics definition of suicide which includes deaths given an underlying cause of intentional self-harm or injury or poisoning of undetermined intent (ICD-10 codes: X60 to X84, Y10 to Y34). The informant reports occupation at the time of death registration. This information is coded using the Standard Occupation Classification (SOC 2010). This classification system has 4 levels of granularity, ranging from higher-level groupings (for example, those working in skilled construction and building trades) to specific occupations (for example, bricklayers and masons). The analyses were restricted to those aged 20 to 64 years. This approach improves the likely comparability between the occupation recorded at census and that at the time of death registration.[73]

It is important to note that while suicide counts by occupation are available for England and Wales from 2011-20, disparities in absolute numbers may not accurately reflect differences in suicide risk. Higher counts within specific occupations may be attributed to larger workforces rather than indicating an inherently higher risk of suicide in those fields.

[73] Patterns of suicide by occupation in England and Wales: 2001–2005

Equality & Health Impact Assessment (EHIA)

Document control

Title of activity:	*Havering Suicide Prevention Strategy 2025-2030*
Lead officer:	*Isabel Grant-Funck (Public Health Strategist), Public Health Service in the People Directorate*
Approved by:	*Samantha Westrop (Assistant Director of Public Health), Public Health Service in the People Directorate*
Version Number	**V0.1**
Date and Key Changes Made	*05/12/2024*
Scheduled date for next review:	*February 2030*

Content warning: The content of this needs assessment may be emotionally challenging as it discusses suicidality and self-harm.

Support is available:

- Samaritans – a listening service which is open 24/7 for anyone who needs to talk.
- Campaign Against Living Miserably (CALM) - CALM's confidential helpline and live chat are open from 5pm to midnight every day.
- Shout – a free confidential 24/7 text service offering support if you're in crisis and need immediate help.

Did you seek advice from the Corporate Policy & Legal?	No
Did you seek advice from the Public Health team?	Yes
Does the EHIA contain any confidential or exempt information that would prevent you publishing it on the Council's website? See Publishing Checklist.	No

1. Equality Health Impact Assessment Checklist

About your activity

1	**Title of activity**	*Havering Suicide Prevention Strategy 2025-2030*
2	**Type of activity**	*A refreshed strategy*
3	**Scope of activity**	*Every suicide is a tragedy that affects families and communities, and has long-lasting effects on the people left behind: families, friends, colleagues, and healthcare workers. Importantly, bereavement as a result of suicide is itself a risk factor; people bereaved by the sudden death of a friend or family member are 65% more likely to try to take their own life if the deceased died by suicide than if they died by natural causes.* *Public health measures to reduce access to means and improve care for those who are at risk of suicide have contributed to a reduction in the national suicide rate since the 1980s. Suicide is preventable and it is our collective responsibility to do all that we can to reduce deaths through suicide. To be successful, this must be through a multi-agency approach bringing together the Council, primary care and secondary care services, voluntary and community sector organisations as well as communities and individuals. A strategy that is to succeed in reducing suicide deaths needs to combine a range of integrated interventions that build wider community resilience as well as targeting groups of people at increased risk of suicide. We need to ensure that suicide prevention and mental health are everyone's business.* *The BHR strategy was extended to 2023 with approval from the health and wellbeing board, but is now out of date. The strategy covered the 3 boroughs of Havering, Barking & Dagenham, and Redbridge, and was jointly led by the three Councils, NELFT and Clinical Commissioning Groups. The BHR strategy continues to guide current actions – with some actions now being led elsewhere in the system.* *We are now working on a localised strategy redesign to cover 2025-30* *The development of a local suicide prevention strategy is recommended by government and supports the national Suicide Prevention Strategy (2012) - Preventing suicide in England: A cross government outcomes strategy to save lives. As of April 2019, all local authorities in England have had suicide prevention plans in place.* *Aims & objectives* *The overall aim of this strategy is to reduce the rate of suicide, suicidal behaviour and self-harm through the following objectives:*

		1. *We will ensure that our local preventative actions are evidence informed so that interventions are effective, timely and responsive to local need.* 2. *We will ensure that knowledge and prioritisation of suicide prevention will be strengthened across the system.* 3. *We will strengthen partnership working at sub-regional, London and national levels.* 4. *We will work to reduce stigma surrounding suicide and bereavement by suicide.* 5. *We will work across the sector with partners at sub-regional, London and national levels to strengthen, coordinate and ensure equity and accessibility of the support offered.* 6. *We will ensure local provision of early intervention and tailored support at a population level to those with common risk factors.*			
4a	**Are you changing, introducing a new, or removing a service, policy, strategy or function?**	Yes	If the answer to <u>either</u> of these questions is **'YES'** Continue to question **5**.		If the answer to <u>all</u> of the questions (4a, 4b & 4c) is **'NO'** Go to question **6**.
4b	**Does this activity have the potential to impact (either positively or negatively) upon people from different backgrounds?**	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	Use the *Screening tool* before you answer this question.	If you answer **'YES'** Continue to question **5**.	
5	**If you answered YES:**	**Please complete the EHIA in Section 2 of this document.** Please see Appendix 1 for Guidance.			
6	**If you answered NO:**	*N/A*			

Completed by:	*Isabel Grant-Funck (Public Health Strategist) from the Public Health Service in the People Directorate* *Samantha Westrop (Assistant Director of Public Health) from the Public Health Service in the People Directorate*
Date:	*05/12/2024*

2. The EHIA – How will the strategy, policy, plan, procedure and/or service impact on people?

Background/context:

Between 2015 and 2023, 194 lives were lost to suicide in Havering. Every suicide is a tragedy that deeply affects families and communities, leaving long-lasting impacts on loved ones, colleagues, witnesses and healthcare workers. The aftermath of a suicide often leads to affected individuals experiencing suicidal thoughts or attempts themselves due to the emotional toll of the loss. The risk of suicide is closely linked to broader inequalities, with disadvantaged communities experiencing higher rates of suicide.

Recent data from 2022, shows that the recent reduction in London-wide suicide rate has lead to the rate in Havering rate now being significantly higher than London as a whole, and outer London (9.6 per 100,000 population).

Suicide is a significant contributor to years of life lost amongst our population and deaths by suicide are not inevitable. Public health interventions aimed at limiting access to means and improving care for at-risk individuals have contributed to a decline in the national suicide rate since the 1980s. Suicidal incidents typically involve various contributing factors, underscoring the need for a comprehensive, system-wide approach to prevention involving services, communities, individuals and society as a whole.

Who will be affected by the activity?

While anyone can be at risk of suicide, certain groups are at higher risk and will be prioritised in the suicide prevention strategy. The likelihood of someone dying by suicide is influenced by broader inequalities, with significant differences in suicide rates based on individuals' social and economic circumstances. For example, people living in the most deprived areas of the country are ten times more at risk of suicide than those in the most affluent areas. Factors such as experiencing homelessness, being in debt, facing unemployment or living in poverty increase the risk of poor mental health and suicide, a concern that is especially relevant during the cost of living crisis we are currently experiencing.

Several factors further increase the risk of suicide. The strongest predictor of suicide risk is a history of self-harm or previous suicide attempts. Other high-risk groups include men, young and new mothers, people in contact with the criminal justice system, individuals in the LGBTQIA+ community, teens and young adults, people with depression and severe mental illness (e.g. psychosis, paranoid schizophrenia) and those who misuse substances. Addressing the needs of these vulnerable groups is crucial for suicide prevention.

Protected Characteristic - Age: Consider the full range of age groups

If there is an impact on under 18s, how have you / will you ensure their views are gained to inform decision making?

Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	The Havering Suicide Prevention Strategy takes into account the needs of different age groups, addressing age-related vulnerabilities associated with suicide, as well as the proportional years of life lost when a younger person dies by suicide. Actions from the strategy will have a positive impact on all age groups, with one of the focuses being on preventing suicide and self-harm in children and young people, who are a national priority group due to the years of lives lost. Whilst deaths by suicide amongst children are thankfully rare, the life course approach recognises that experiences throughout life, from childhood to old age, affect suicide risk. For example, children who have been suicide-bereaved, or experienced another adverse childhood experience (ACE) have an increased lifetime risk of death by suicide and need specific support.
Neutral		
Negative		

		Public Health's engagement with stakeholders working with children and young people, such as Education, the PHSE network, the Havering Youth Council, The VCS (Papyrus, Mind, Samaritans), ensures that the strategy is informed by those directly working with CYP. Recognising the role of economic factors in suicide risk, particularly among middle-aged individuals, the Strategy's Action Plan includes targeted promotion of suicide prevention services and training opportunities targeting specific services and organisations (e.g. schools/colleges, council workforce including housing, food banks, citizen's advice bureau, financial support services in community hubs, social prescribers). The Strategy commits to review new guidance and evidence-based initiatives to adapt and improve.

Evidence:
Suicide affects individuals across all age groups, with certain age-related risk factors warranting particular attention. In Havering, the highest suicide rates between 2013 and 2023 were among middle-aged people, specifically those aged 40-49 years and 50-59 years. This trend aligns with national data for England and Wales, where the highest suicide rates in 2022 were among people aged 50 to 54 years, followed by those aged 45 to 49 years.

Furthermore, national data indicates a concerning trend among younger age groups. While the overall number of suicides among younger populations is comparatively lower, recent years have seen a relative increase in suicide rates. Notably, suicide and injury or poisoning of undetermined intent remained the leading cause of death in 2017. This accounted for an increased proportion of deaths in this age group compared with the previous year, with a notable rise among females, where it accounted for 13.3% of deaths at this age, compared with 9.6% in 2016.

Given these trends, both middle-aged people and children and young people have been identified as priority groups for suicide prevention efforts, aligning with the national suicide prevention strategy.

Sources used:
Office for National Statistics (ONS), 2022

Protected Characteristic - Disability: Consider the full range of disabilities; including physical, mental, sensory, progressive conditions and learning difficulties. Also consider neurodivergent conditions e.g. dyslexia and autism.

Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	**Overall impact:** The Havering Suicide Prevention Strategy will be published electronically to ensure that it is fully accessible to people who are partially sighted or blind. Accessibility standards to enable assisted technology will be considered and worked towards prior to publication of the final version of the strategy. An easy read version of the strategy will also be published. Furthermore, the Strategy includes considerations for suicide prevention concerning individuals living with disabilities and long-term conditions. Public health will raise awareness of suicide prevention to services that are working with different vulnerable groups, such as the Autism Hub in Liberty Mall (provided by Sycamore Trust) and the Havering Carer's Hub, which supports carers of autistic individuals. These services will then disseminate the information we share with those they support and work with. The distribution of suicide prevention training to the Havering workforce, especially those engaging with high-risk groups (including those with learning disabilities) will improve awareness of suicide and its associated risk factors.
Neutral		
Negative		

		Public Health will also emphasise the need for services to be tailored to individuals who are deaf, disabled or neurodivergent, based on evidence from Autistica and NSPA. This ensures that those in need of support for suicide or its risk factors are more likely to access services. Moreover, along with the Strategy, a mapping exercise has been conducted to identify opportunities for strengthening strategies, policies, work areas, and commissioned services to incorporate suicide prevention efforts. This includes the alignment with Havering's All Age Autism Strategy and Learning Disability Strategy. Continuous review of new guidance will inform the consideration of additional actions to mitigate the risk of suicide among those with disabilities and long-term conditions. Those with long-term conditions (LTCs) and those living with chronic pain are also a priority group, as chronic pain and LTCs are a risk factor for suicide. The suicide prevention team will work with organisations that interact those living with chronic pain and LTCs, like St Francis Hospice, to ensure that they have up-to-date, accurate information and bereavement support.

Evidence:
Individuals living with disabilities and long-term health conditions, such as COPD, heart conditions and cancer face an elevated risk of suicide. Research indicates that following a diagnosis or initial treatment for these conditions, the likelihood of death by suicide is notably higher compared to matched controls with similar socio-demographic characteristics (age, sex, ethnicity, religion, deprivation and region of residence).

For instance, within one year of being diagnosed with COPD, the suicide rate for patients was 2.4 times higher than that of matched controls, with 23.6 deaths per 100,000 individuals compared to 9.7 deaths per 100,000 individuals, respectively. Similarly, following a diagnosis of chronic ischemic heart conditions, the suicide rate for patients was nearly double that of matched controls, with 16.4 deaths per 100,000 individuals compared to 8.5 deaths per 100,000 individuals, respectively. A wider confidence interval for the suicide rate in the low survival cancer patients is largely because of the lower number of suicides recorded for this condition.

Additionally, autistic adults without learning disabilities are nine times more likely to die by suicide than the general population. Despite comprising approximately 1% of the population, autistic individuals account for 11% of suicides. Alarmingly, suicide is the second leading cause of death for autistics individuals, with an average life expectancy of just 54 years. Autistic women, in particular, face twice the risk of death by suicide.

Furthermore, a recent report from the Mental Health Taskforce identified autistic people as being at a higher risk of mental health issues. Research indicates that 70% of autistic individuals have at least one mental health disorder, such as anxiety or depression, and 40% have at two or more mental health disorders.

Chronic pain is a risk factor for suicide, with rates of suicidal ideation ranging from 18 to 50 percent among patients with chronic pain. A US study found that 8.8 percent of suicide deaths involved chronic pain and over half of those individuals noted pain as a factor in their suicide notes.

Sources used:
Autistica. Suicide and Autism. Retrieved from: https://www.autistica.org.uk/what-is-autism/suicide-and-autismand autism | Autistica

Office for National Statistics, based on mortality records linked to the 2011 Census and Hospital Episode Statistics (HES) known as the Public Health Data Asset (PHDA).

The Independent Mental Health Taskforce to the NHS in England (2016). The five year forward view for mental health.

Hirvikoski, T. et al. (2015). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207

Mental Defeat and Suicidality in Chronic Pain: A Prospective Analysis, Themelis, Kristy et al. The Journal of Pain, Volume 24, Issue 11, 2079 - 2092

Protected Characteristic – Sex / gender: Consider both men and women		
Please tick (✓) the relevant box:		**Overall impact:** The Havering Suicide Prevention Strategy is inclusive and beneficial all genders, with a particular focus on men due to their higher suicide prevalence. The strategy aims to raise awareness of services tailored to men, such as Havering Talking Therapies, and informal support options offered by the Voluntary and Community Sector (VCS), which some men may prefer. Suicide risk factors for men include economic challenges and relationship breakdowns. Consequently, promoting suicide prevention training, particularly to services and organisations in contact with financially struggling men, is essential. These include the council workforce (including housing services) food banks, Citizens Advice Bureau, financial support services in community hubs and social prescribers for socially isolated men. Additionally, services that promote social cohesion such as Mentell, will be promoted to men experiencing loneliness or social isolation. BarberTalk Live, a service commissioned by Public Health, trained six barbers in suicide prevention and will continue its funding in 2025 and 2026. This training equips them to recognize suicide-warning sides, engage in supportive conversations and confidently direct men to appropriate resources. This training will be expanded to cover other occupations across the borough that have a high proportion of men working in them. The strategy will also be inclusive of those of all genders, which will be highlighted later in the LGBTQIA+ section.
Positive	✓	
Neutral		
Negative		

Evidence:

There are differences in suicide prevalence depending on gender. From 2001 to 2022, the suicide rate per 100,000 in England amongst males is consistently three times that of females. In both London and Havering, suicide rates are also higher in males compared to females. In 2020-22, the suicide rate in Havering for males was 13.9 per 100,000 people and the suicide rate in females was 5.2 per 100,000.

Data shows that almost all (91%) middle-aged men had interacted with at least one frontline service, primarily primary care services (82%). Half had engaged with mental health services, and 30% with the justice system. This challenges the notion that men do not seek help. Public Health efforts should therefore encourage services to better recognize and respond to men's needs

through initiatives like Making Every Contact Count (MECC) and widespread suicide prevention training for frontline workers, particularly those interacting with at-risk individuals. For the minority (9%) of men not in contact with any support, several local and national third-sector initiatives aim to reach this group.
Sources used: Office for Health Improvement and Disparities (OHID) fingertips data, 2020-2022. NCISH Annual report 2023: UK patient and general population data 2010-2020

Protected Characteristic – Ethnicity / race / nationalities: Consider the impact on different minority ethnic groups and nationalities		
Please tick (✓) the relevant box:		**Overall impact:** There are notable differences in suicide prevalence across different ethnicities in Havering. While the Havering Suicide Prevention Strategy benefits all ethnicities, it does not specifically target individuals based on ethnicity. Racism has been linked to poor mental health, social isolation and loneliness. The BAME community are more likely to be impacted by poverty, which is an economic risk factor for suicide. The Strategy addresses the intersectionality of overlapping risk factors. For instance, an individual of mixed ethnicity and a member of the LGBTQIA+ community faces compounded suicide risks. To support ethnic groups, the Strategy will align with the national strategy and adopt a cross-sector approach to tackle different risk factors for suicide, some of which are more likely to impact the BAME community.
Positive	✓	
Neutral		
Negative		
Evidence: In 2021, the ONS published data on suicide rates among different ethnic groups in England and Wales for the first time looking at 2012 to 2019, although they did not take into account confidence intervals, so no statistically significant differences were found. Although there is not enough data to give a full picture of suicide rates between ethnic groups, racism and discrimination can have significant impact on well-being and suicide risk.		
Sources used: Office for National Statistics (ONS), 2022 Ethnicity and suicide | Samaritans		

Protected Characteristic – Religion / faith: Consider people from different religions or beliefs, including those with no religion or belief		
Please tick (✓) the relevant box:		**Overall impact:** The evidence on how religion/faith influences suicide risk is mixed. Being part of a religious/faith group can provide a sense of belonging and community, which may protect against suicide. However, stigmatizing beliefs within these groups (e.g., that suicide is an unforgivable sin) could deter help-seeking, thus increase suicide risk. Stigma can inhibit emotional vulnerability, further hindering help-seeking. Public Health will engage with religious/faith groups, such as street/rail pastors, Interfaith Forum and the VCS, to promote suicide prevention services and training opportunities. Raising awareness of different vulnerable groups and promoting evidence-based approaches to improving mental health in specific groups is crucial.
Positive		
Neutral	✓	
Negative		

Evidence:
The evidence of religion/faith on suicide risk varies. People belonging to any religious group generally have lower suicide rates compared to those with no religion, with the lowest rates in the Muslim group (5.14 per 100,000 males and 2.15 per 100,000 females). The rates of suicide were highest in the Buddhist group (26.58 per 100,000 males and 31.05 per 100,000 females) and religions classified as "Other" (33.19 per 100,000 males and 28.95 to 38.06 females). The religions which were included in the "Other" religious group included Pagan, Spiritualist, Mixed religion, Jain and Ravidassia. For men and women, the rates of suicide were lower across the Muslim, Hindu, Jewish, Christian and Sikh groups compared with the group who reported no religion.

Sources used:
ONS sociodemographic inequalities in suicide
Jacob, L., Haro, J.M. and Koyanagi, A., 2019. The association of religiosity with suicidal ideation and suicide attempts in the United Kingdom. Acta psychiatrica scandinavica, 139(2), pp.164-173.

Protected Characteristic - Sexual orientation: Consider people who are heterosexual, lesbian, gay or bisexual

Please tick (✓) the relevant box:	
Positive	✓
Neutral	
Negative	

Overall impact:
The Havering Suicide Prevention Strategy is inclusive of all sexual orientations and genders, recognising differences in suicide prevalence among different groups. It focuses on promoting suicide prevention services and training, particularly targeting organisations in contact with LGBTQIA+ individuals, such as schools, colleges, council workforce and sexual health clinics.

Public Health will raise awareness of different vulnerable groups and the services available for these groups and promote evidence-based approaches to improving mental health in specific groups as part of the Strategy. Distributing suicide prevention training widely, especially to those working with high-risk groups will promote awareness of suicide risk factors, build confidence to discuss suicide and help recognize warning signs to assist in a crisis.

LGBTQIA+ training, provided by Outhouse and TMT, is also promoted. This training equips organisations with the knowledge and skills to use inclusive language, forms and data systems, improving understanding of LGBTQIA+ issues and barriers, and their link to mental health and suicide.

Evidence:
Stonewall commissioned YouGov to conduct a survey involving over 5,000 lesbian, gay, bisexual and trans (LGBTQIA+) people across England, Scotland and Wales to gain insights into their lives in Britain.[17]
The survey revealed key findings related to mental health and suicide prevention within this cohort:

- Half of LGBTQIA+ respondents (52%) reported experiencing depression in the last year. This figure was even higher among trans people (67%) and non-binary individuals (70%).
- One in eight LGBTQIA+ young adults aged 18-24 (13%) reported surviving a suicide attempt in the past year.
- Almost half of trans individuals (46%) and 31% of LGBTQIA+ individuals who do not identify as trans have contemplated suicide in the last year.
- Almost half of LGBTQIA+ young adults aged 18-24 (48%) reported self-harming in the past year. Additionally, 41% of non-binary individuals, 20% of LGBTQIA+ women and 12% of LGBTQIA+ men reported self-harming, compared to only 6% of adults in the general population.

Sources used:
Stonewall YouGov survey
https://www.stonewall.org.uk/lgbt-britain-health

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:		**Overall impact:** The Havering Suicide Prevention Strategy's actions will benefit those seeking, undergoing or have receive gender reassignment surgery, as well as people whose gender identity is different from their gender at birth. As mentioned above, the Strategy will work closely with LGBTQIA+ organisations through distributing suicide prevention training to organisations and also promoting specific LGBTQIA+ training, which includes gender reassignment. The steering group will also include those will lived experience from the LGBTQIA+ community, so the action plan will be reviewed and amended by the steering group to inform inclusive actions. The London Borough of Havering is developing a suspected suicide review panel, chaired by public health, which will support our surveillance function by analysing information from the London RTSSS, as part of the Havering Suicide Prevention Strategy. Any learning from this panel should be shared with the transitions panel in the event that suspected suicide was an individual who identified as transgender.
Positive	✓	
Neutral		
Negative		
Evidence: People identify as non-binary or transgender are at an increased risk of suicide and self-harm. Almost half of trans people (46 per cent) have thought about taking their own life in the last year. This is compared to one in twenty adults in the general population who reported thoughts of taking their own life in the past year and fewer than one per cent said they attempted to take their own life in the last year (according to research for NHS Digital).Forty-one per cent of non-binary people said they harmed themselves in the last year compared to 20 per cent of LGBTQIA+ women and 12 per cent of LGBTQIA+ men. This is compared to around six per cent of adults in the general population who said they had self-harmed in the last year (according to research for NHS Digital).		
Sources used: Stonewall YouGov survey https://www.stonewall.org.uk/lgbt-britain-health		

Protected Characteristic – Marriage / civil partnership: Consider people in a marriage or civil partnership		
Please tick (✓) the relevant box:		**Overall impact:** The Strategy is inclusive of people of all relationship types. For those in stable marriages or civil partnerships are likely to experience a neutral impact from the suicide prevention strategy. However, someone going through the end of a marriage and civil partnership, or during relationship breakdown and divorce, has higher risk of death by suicide. The Strategy outlines how divorced and separated individuals exhibit a higher suicide risk.
Positive		
Neutral	✓	
Negative		
Evidence: One study using data from the Marriage and Family Therapy Practice Research Network (MFT-PRN) examined suicidal risk and relationship satisfaction in couples undergoing therapy. Among 27 same-sex couples, a quarter exhibited suicidal risk at the first session. However, no direct association was found between suicidal risk and relationship satisfaction or changes over time. Suicidal risk comes in with divorce, as multiple studies have identified a link between divorce and suicide risk, though the gender-related differences within this remain unclear. While some		

research suggests an increased risk for men following relationship breakdown, further studies are needed to compare suicide risk and gender in this context.
Sources used: Morgan, P. C., Love, H. A., Hunt, Q. A., & King, S. (2025). Dyadic Associations of Suicidal Risk Predicting Relationship Satisfaction in a Clinical Sample. *Journal of marital and family therapy*, *51*(1), e12757. https://doi.org/10.1111/jmft.12757 Evans, R., Scourfield, J., & Moore, G. (2016). Gender, Relationship Breakdown, and Suicide Risk: A Review of Research in Western Countries. *Journal of Family Issues*, *37*(16), 2239-2264. https://doi.org/10.1177/0192513X14562608

Protected Characteristic - Pregnancy, maternity and paternity: Consider those who are pregnant and those who are taking maternity or paternity leave		
Please tick (✓) the relevant box:		**Overall impact:** The Havering Suicide Prevention Strategy aims to address the needs of pregnant and postpartum women by promoting suicide prevention services and training opportunities, particularly targeting services/organisations with women during the perinatal period (e.g. GPs, midwives, council workforce incl. housing, health visitors). Public Health will also raise awareness of different vulnerable groups and the services available for women in the perinatal period e.g. Mums Matter (perinatal support provided by Mind).
Positive	✓	
Neutral		
Negative		
Evidence: Maternal suicide is still the leading cause of direct (pregnancy-related) death in the year after pregnancy. Almost a quarter of all deaths of women during pregnancy or up to a year after the end of pregnancy were from mental health-related causes. Assessors felt that improvements in care might have made a difference in outcome for 67% of women who died by suicide.		
Sources used: MBRRACE-UK published their latest Confidential Enquiry into Maternal Deaths in the UK and Ireland. “Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19"		

Socio-economic status: Consider those who are from low income or financially excluded backgrounds		
Please tick (✓) the relevant box:		**Overall impact:** The Havering Suicide Prevention Strategy will promote targeting services/organisations in contact with people in financial difficulties (e.g. Council workforce incl. housing, food banks, citizen’s advice bureau, DWP / Job Centres, community hubs financial support services and debt advice, housing associations). Public Health will raise awareness of different vulnerable groups and the services available for people in financial difficulties such as Harold Hill Community Hub and promote evidence-based approaches to improving mental health in specific groups e.g. alternative crisis support through housing team.
Positive	✓	
Neutral		
Negative		
Evidence: Suicide is complex and is rarely caused by one thing. However, there is strong evidence of associations between financial difficulties, mental health and suicide. Struggling to make ends meet can lead to feelings of anxiety and shame. These feelings can themselves affect our motivation and ability to manage our money, and some people may experience a sense of entrapment or loss of control. All of these feelings are associated with suicide. Not everyone will experience these stressors equally, with those already in lower income households or with pre-existing mental health conditions likely to be among those worst impacted. More specifically, we know that men in the lowest social class, living in the most deprived areas, are up to ten times more at risk of suicide than those in the highest social class, living in the most affluent areas.		

Economic risk factors that can increase someone's risk of suicide include living in areas of deprivation, being in debt, being homeless or facing homelessness, living in poor quality or insecure housing.

Sources used:
Samaritans report: Insights from experience: economic disadvantage, suicide and self-harm

Health & Wellbeing Impact:
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 Havering Suicide Prevention Strategy promotes health and wellbeing positively; it has short-term impacts: increased awareness, working with partners to increase crisis intervention, work with partners to increase access to services, reduce stigma and promote community resilience. Regarding long-term impacts, the strategy works for sustained mental health improvements and a reduction in suicide rates.

Do you consider that a more in-depth HIA is required as a result of this brief assessment? **Yes** ☐ **No** ✓

Evidence:
Public health measures aimed at limiting access to methods of suicide and enhancing care for individuals at risk have contributed to a reduction in the national suicide rate since the 1980s. Suicide is preventable and it is our collective responsibility to do all that we can to reduce deaths through suicide. This must be through a multi-agency approach bringing together the Council, primary care and secondary care services, voluntary and community sector organisations as well as communities and individuals. A strategy that is to succeed in reducing suicide deaths needs to combine a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. We need to ensure that suicide prevention and mental health are everyone's business.

Distributing suicide prevention training to the Havering workforce as widely as possible particularly to those working with high-risk groups will raise awareness of suicide and self-harm, the risk factors, provide people with the confidence to have important conversations around suicide, and ensure that those working with people who may be at risk of suicide can recognise warning signs and assist in a crisis.

Reduce suicide rates in priority groups by raising awareness of evidence based approaches, services and training opportunities tailored to improving mental health in specific groups providing people with crisis support and other forms of support they need around broader risk factors for suicide e.g. economic risk factors, reducing stigma & encouraging help seeking behavior. Tailored support is available to priority groups in times of need e.g. Grief in Pieces (bereavement support service for those impacted or bereaved by suicide in NEL).

Suspected suicides reviewed by the panel should identify if anything could have been done to reduce access to the means of suicide e.g. ligatures, medications especially if the individual was a service user. The panel could also identify if communication between services in contact with the individual could have been improved. Suspected suicides that occur in public places will be reviewed by the panel to identify any lessons that can be learnt with the involvement of Planning and Network rail. Making Havering a safer place through borough design to reduce access to means of suicide e.g. tall places and railways.

Suicides in Havering should be reported sensitively without personal identifiable information or information regard location or method of suicide to prevent imitational suicidal behaviour or contagion. Media reports should also be used as an opportunity to promote suicide prevention services and training.
Sources used: Office for National Statistics (ONS), 2022

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	☐ Amount of traffic congestion	☐ Solid waste management
☐ Road safety measures		☐ Public transport infrastructure

4. Outcome of the Assessment

The EHIA 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 EHIA. 2. The EHIA identified **no significant concerns** OR the identified **negative concerns** have already been **addressed**	→	**Proceed with implementation** of your activity
	3. The EHIA identified some **negative impact** which still needs **to be addressed**	→	**COMPLETE SECTION 5:** **Complete action plan** with measures to mitigate the and finalise the EHIA
	4. The EHIA 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 EHIA on the revised proposal.**

5. Action Plan

The real value of completing an EHIA 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 Disability Sex/Gender Ethnicity/Race Religion/faith Sexual orientation Gender reassignment Pregnancy Socioeconomic status	By 2030, we should expect to see an improvement in suicide prevention efforts relating to age, including for, but not limited to, middle-aged men and increased prevention efforts in schools for children and young people. By 2030, we should expect to see an improvement in suicide prevention efforts relating to disability, increased working with carers, working with different sexes, genders, religion groups, members of the LGBTQIA+	• Public Health will work with PCN Leads to increase uptake of suicide prevention training among primary care staff, making sure they know that middle-aged men are at highest risk and they understand inequalities that contribute to the distribution of suicide risk factors. • Public Health Team to ensure that anchor organisations (e.g., the NHS, schools, police, fire service) to ensure that frontline staff receive support for dealing with the impact of suicide in their profession. • Public Health Team to encourage partners to promote suicide prevention training for community members that support people who have an increased risk of suicide or self-harm, or that provide support to people around distressing life events.	Outcomes include: a) embedding changes in the Havering system through an all systems approach b) introducing an approach which makes suicide prevention everyone's business, tapping into professions that have not been prioritized before Monitoring: • Suicide rates by age group • Suicide rates by disability	5 years, annual reviews and suicide panel annual report	Sam Westrop, Assistant Director of Public Health

	community, those who are pregnant or have recently had a child, and those from lower socioeconomic statuses.	• Children and Young People's Emotional Wellbeing and Mental Health Strategy is planned and planned to include young adults who are care experienced (up to age 25) in transition to adults services. • Public Health to form a reference group comprising selected professionals and individuals with lived experience to provide feedback on documents produced and activities led by the suicide prevention public health team, leveraging existing connections with established groups. This group will aim to include members with disabilities, carers, those of different sex and genders, members of the LBGTQIA+ community, those who have experienced perinatal depression, those from all socioeconomic status to ensure diversity of insights and feedback.	• Suicide rates by ethnicity • Suicide rates by religion • Suicide rates by sexual orientation • Suicide rates in perinatal • Suicide rates by socioeconomic status		

6. Review

In this section you should identify how frequently the EHIA will be reviewed; the date for next review; and who will be reviewing it.

Review: The EHIA will be reviewed upon the refresh of the Suicide Prevention Strategy.

Scheduled date of review: February 2030

Lead Officer conducting the review: Suicide Prevention Lead, Public Health Team

Havering
LONDON BOROUGH

CABINET

Subject Heading:	Corporate Plan Q3 Performance Report: (2024/25)
Cabinet Member:	Councillor Ray Morgon
ELT Lead:	Mark Ansell, Director Public Health
Report Author and contact details:	Jodie Gutteridge | Corporate Policy and Performance Lead Jodie.gutteridge@havering.gov.uk
Policy context:	The report sets out Quarter 3 performance for each of the three strategic priorities (People, Place and Resources)
Financial summary:	There are no direct financial implications arising from this report. It is expected that the delivery of targets will be achieved within existing resources.
Is this a Key Decision?	No
When should this matter be reviewed?	The Corporate Performance Report will be brought to Cabinet at the end of each quarter.
Reviewing OSC:	

The subject matter of this report deals with the following Council Objectives

People – Supporting our residents to stay safe and well	x
Place – A great place to live work and enjoy	x
Resources – Enabling a resident –focused and resilient council	x

SUMMARY

The Council's Corporate Plan was formally adopted in April 2024.

The Corporate Plan is made up of the three Strategic Director Service plans and describes how we will deliver the vision under the following three themes:

- Supporting our residents to stay safe and well
- A great place to live work and enjoy
- Enabling a resident-focussed and resilient council

Under each theme sit a number of outcomes and key deliverables associated to the Key Performance Indicators (KPIs) that were agreed to be the most appropriate for measuring progress. These KPIs have been brought together into a Corporate Plan Performance Report, which provides an overview of the Council's performance. The report is presented in PowerBI and highlights good performance and potential areas for improvement.

The Overall KPI status page identifies where the Council is performing well (**Green**) not so well (**Amber** and **Red**). KPIs which are narrative only, or for which it is not appropriate to set a target, are shown in **Blue**. RAG ratings for 2024/25 are as follows:

- **Red** = Below target and below the **'variable tolerance'** off the target
- **Amber** = Below target but within the **'variable tolerance'** of the target
- **Green** = Above annual target

Also included in the Power-BI report are Direction of Travel (long-term and short-term), which compares:

- Short-term performance – with the previous quarter (Quarter 2 2024/25)
- Long-term performance – with the same time the previous year (Quarter 3 2023/24, where available)

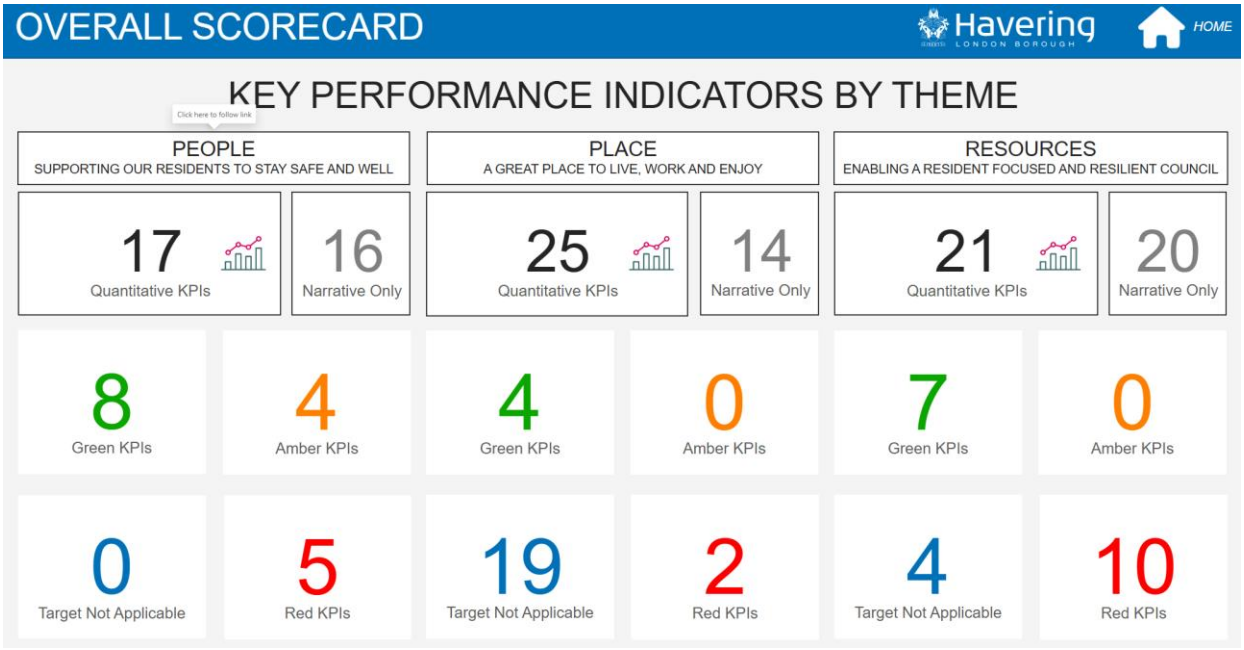
Please note the green arrow shows if (↑) higher performance is better or (↓) lower performance is better.

RECOMMENDATIONS

Members are asked to consider all indicators (especially the red indicators highlighted within the body of this report) and note the levels of performance set out in the power-bi report.

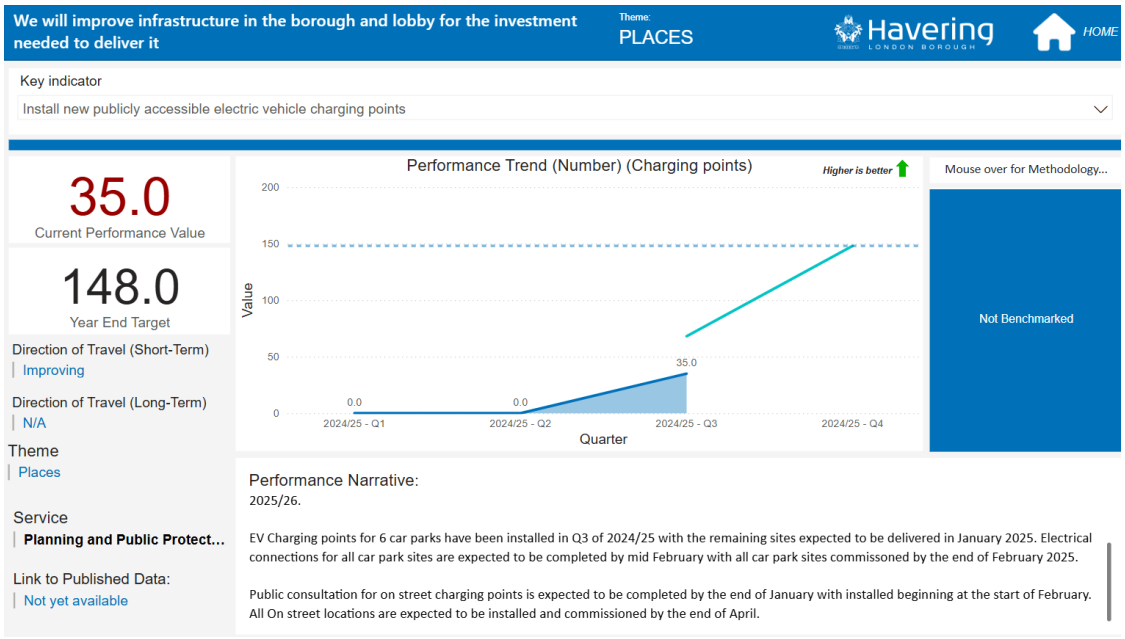
REPORT DETAIL

Quarter 3 2024/25 RAG Summary



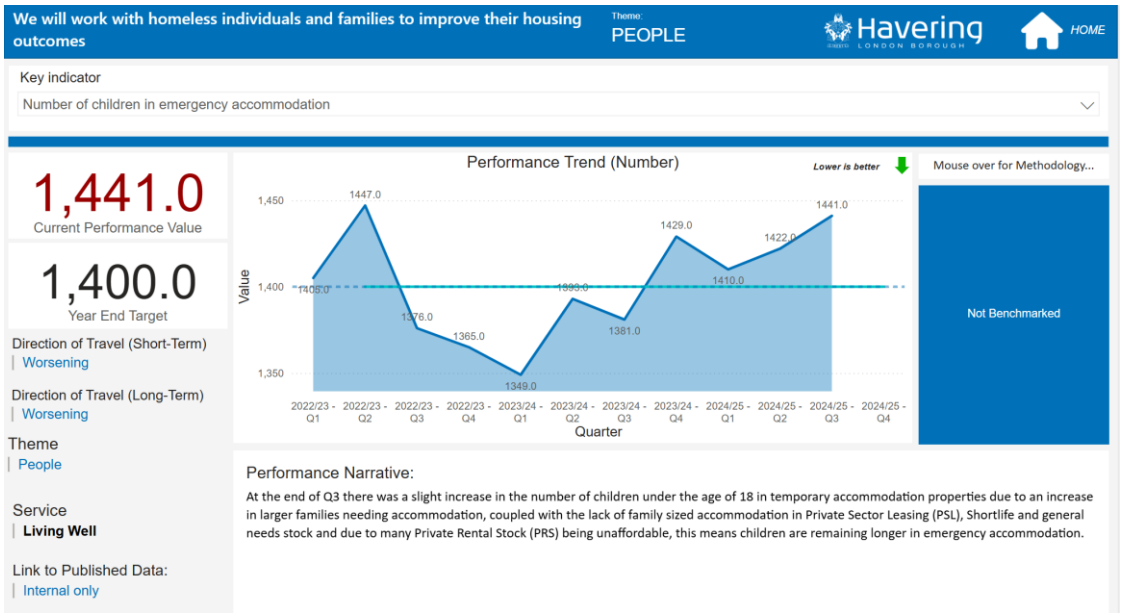
1. As at the end of Q3 2024/25, **113** Corporate Performance Indicators have been measured.
2. Of these, **73** are either narrative only (50) or are KPIS for which a target is not applicable (23). The remaining **40** have been given a RAG status outlined below:
    a. **19 (47.5%)** have a RAG status of **Green**.
    b. **4 (10%)** have a RAG status of **Amber.**
    c. **17 (42.5%)** have a RAG status of **Red**.
        - Of these, 6 are annual indicators with 5 of these due an update in Q4.
        - Taking these into account, would bring the Red RAG status down to 27.5%.
3. A full breakdown of the report is available in Power BI and can be viewed using this link.
4. As requested at Scrutiny on 22nd October 2024, we have provided the Red RAG rated indicators below for your information. Please note that annual indicators have been separated out. Also not all the commentary can be included in the screen shots provided within the report, so please do visit the Power-bi report above.
5. It has been requested that those Red RAG rated Indicators include a narrative as to how performance can be improved.

Theme	Key indicator	Current RAG	Data Type	Polarity	Current Performance	Current Target
Resources	Gender Pay Gap (MEAN)	Red	Percentage	Lower is better	7.5	0.0
Places	Install new publicly accessible electric vehicle charging points	Red	Number	Higher is better	35.0	68.0
People	Number of children in emergency accommodation	Red	Number	Lower is better	1,441.0	1400.0
People	Number of properties acquired through Property Purchasing Scheme	Red	Number	Higher is better	1.0	60.0
People	Percentage of children receiving a 2-2.5 year development check	Red	Percentage	Higher is better	76.5	95.0
People	Percentage of Education, Health and Care Needs Assessments completed within 20 weeks, including exceptions	Red	Percentage	Higher is better	0.0	75.0
People	Percentage of Havering residents receiving an offer of their first preference school (Secondary)	Red	Percentage	Higher is better	76.0	83.0
Places	Percentage of household waste recycled	Red	Percentage	Higher is better	38.1	40.0
Resources	Progress on delivering the Climate Change Action Plan	Red	Percentage	Higher is better	45.0	100.0
Resources	Reduce CO2 emissions from Council activity (Electricity - Street lighting)	Red	Number	Lower is better	578.0	520.0
Resources	Reduce CO2 emissions from Council activity (Fleet)	Red	Number	Lower is better	944.0	900.0
Resources	Reduce CO2 emissions from Council activity (Natural Gas)	Red	Number	Lower is better	1,023.0	960.0
Resources	Reducing CO2 emissions from Council activity (Electricity - Building)	Red	Number	Lower is better	642.0	620.0
Resources	The amount of Apprenticeship Levy spent (£)	Red	Money	Higher is better	521,409.0	1222801.0
Resources	The percentage of enquiries closed within target	Red	Percentage	Higher is better	65.0	100.0
Resources	The percentage of information requests closed within target - FOI / EIR	Red	Percentage	Higher is better	69.7	90.0
Resources	The percentage of information requests closed within target - SAR's	Red	Percentage	Higher is better	77.0	90.0



The target will unfortunately not be met, as whilst we have already installed 35 charging points, these are not operational yet. We are hopeful that a further 61 charging points are will be installed across council parks, electrical connections for all sites commissioned and operational by the end of April. A further 68 on street charging points will be installed by the end of September.

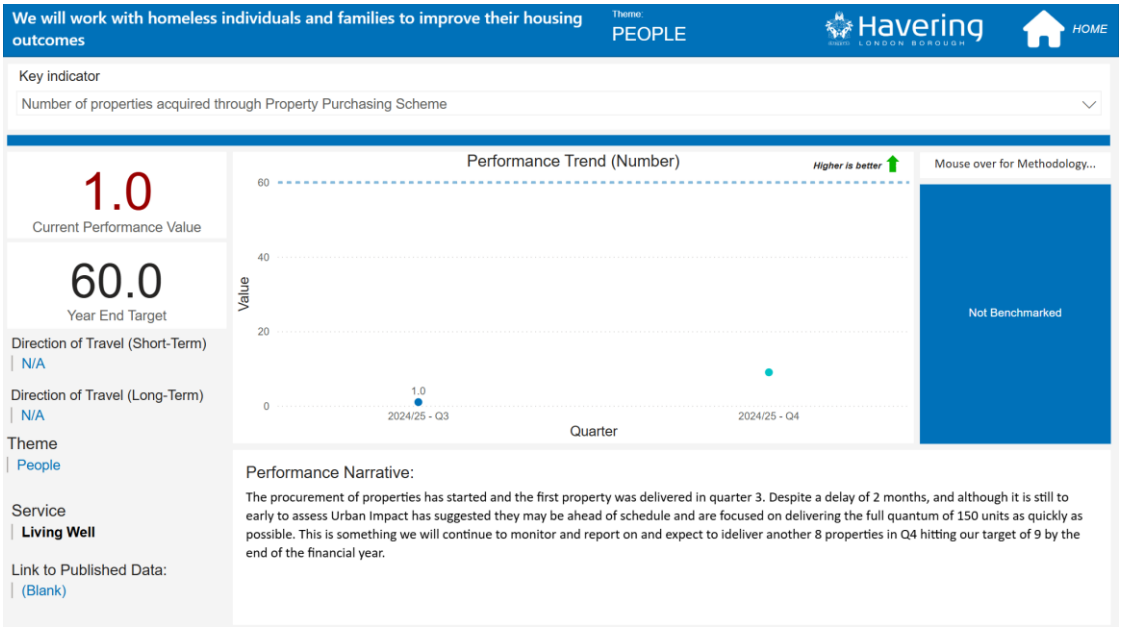
Officers have been engaging with the funding provider OZEV, and funding for the project is secure and will be carried over into the new financial year to enable completion of installation and commissioning.



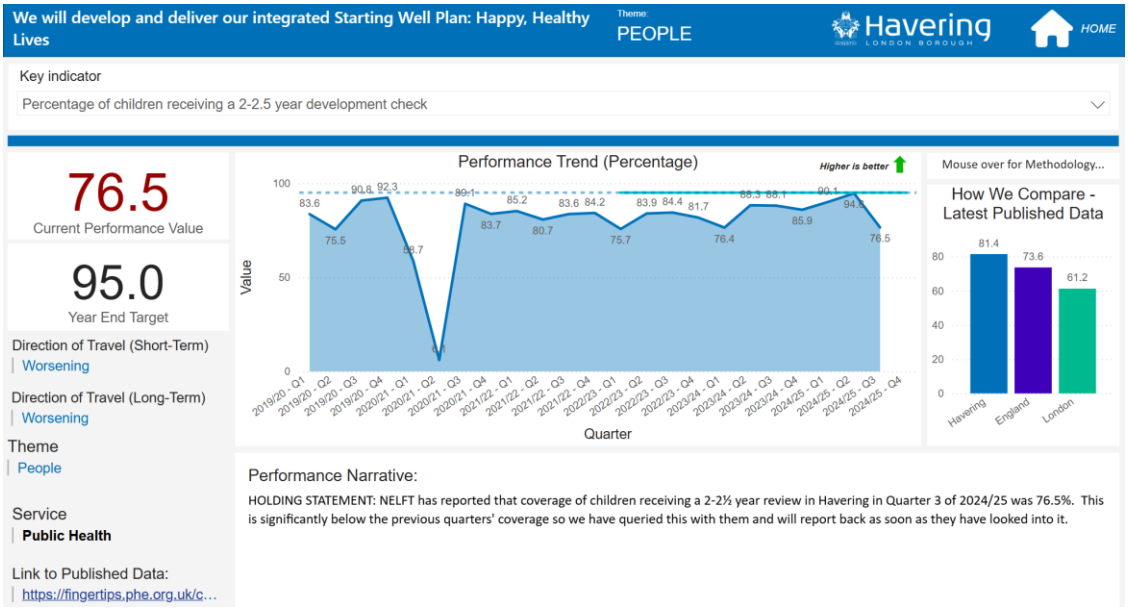
At the end of quarter 3 we are slightly below target, but we have a full Temporary Accommodation (TA) strategy and action plan, currently going through our approval governance, which acknowledges the housing crisis and details actions how we attend to respond. Furthermore, we have a hotel and nightly let action plan that details how we increase accommodation supply and TA flow to reduce the number of children in emergency TA and set out our private property acquisition programme.

Two office to residential conversions passed through cabinet in December / January respectively, and an additional 18 unit modular housing for families is to go through planning. We are exploring a further 30 modular units for families in Rainham, Mercury House as a 115 unit office to residential conversion for homeless families and a build to rent development option for 600 units.

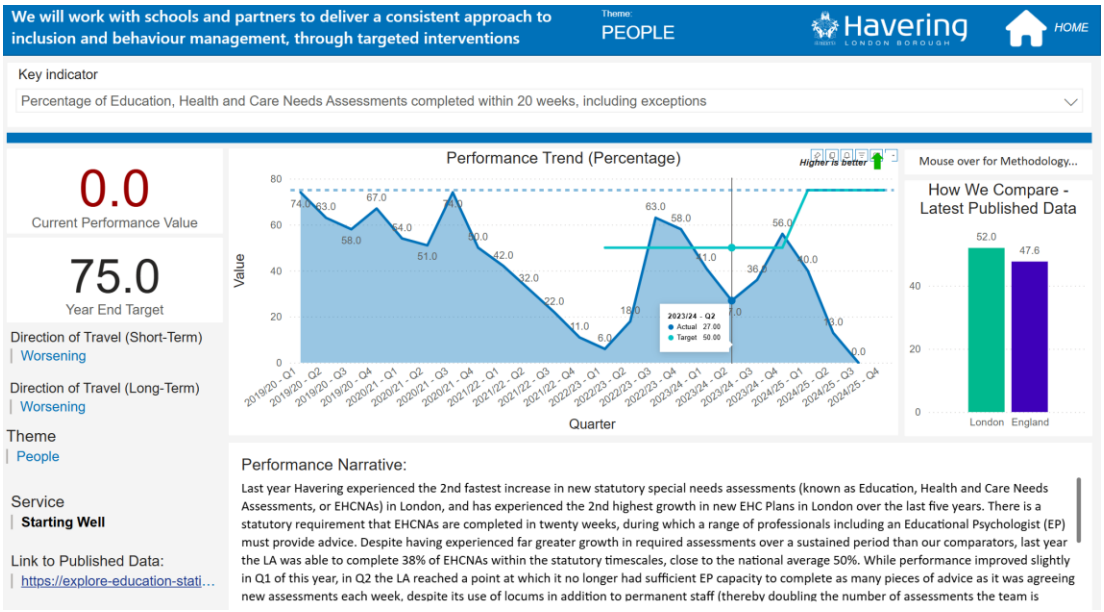
We have increased our offer of support to families whilst in emergency accommodation due to partnership working with education phycologist, Starting Well early help, safeguarding training for hotel management suppliers and health visitors.



To date Chalkhill (Urban Impact) has acquired one property and handed over to Havering with a number under offer. We are exploring pension fund related investment to bolster housing supply in Havering by 100 properties.

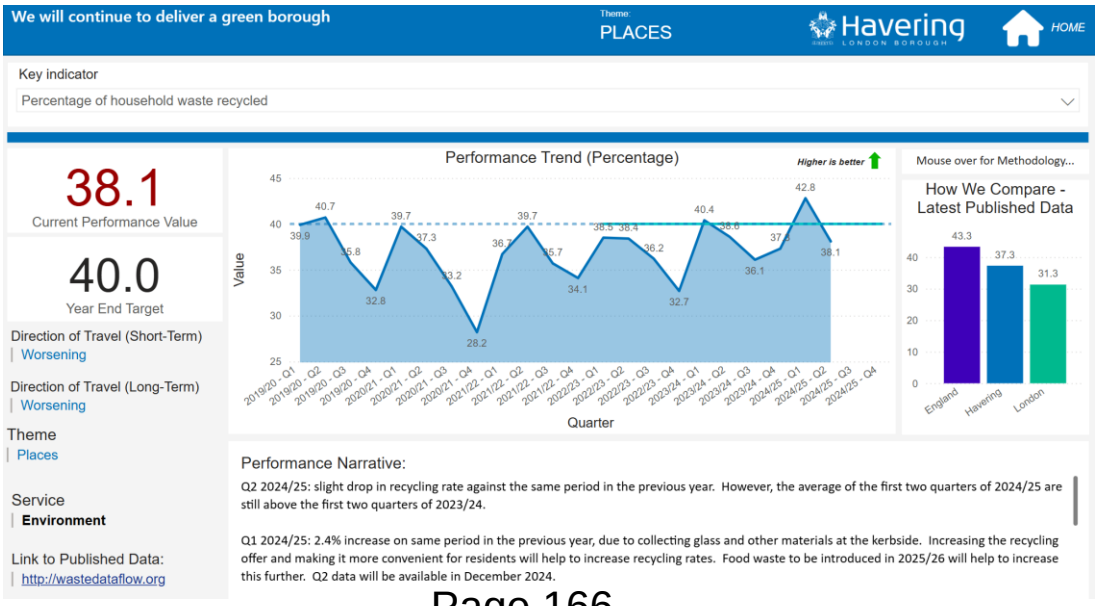


We were on track to achieving our target, however NELFT has reported an error in their previous performance reporting, which has resulted in a drop in the reported proportion of 2-2 ½ year reviews completed. LBH are working with NELFT to seek assurance around the accuracy of reporting and to identify the cause of any discrepancies. NELFT has been asked to submit an action plan to outline how they will address performance against this KPI, further updates on which will be provided when available.

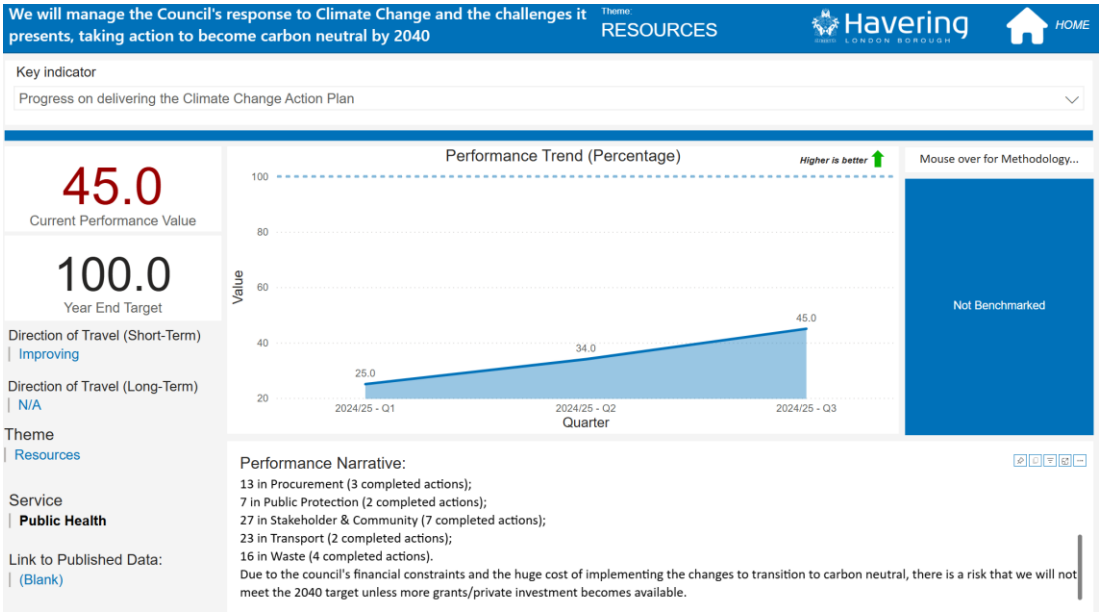


At the beginning of the year, we set a target based on the pervious years figures, however Havering has experienced some of the highest growth in Education Health Care Needs Assessment requests in London, driven primarily by population growth, with many of the children for whom assessments are being agreed have complex needs.

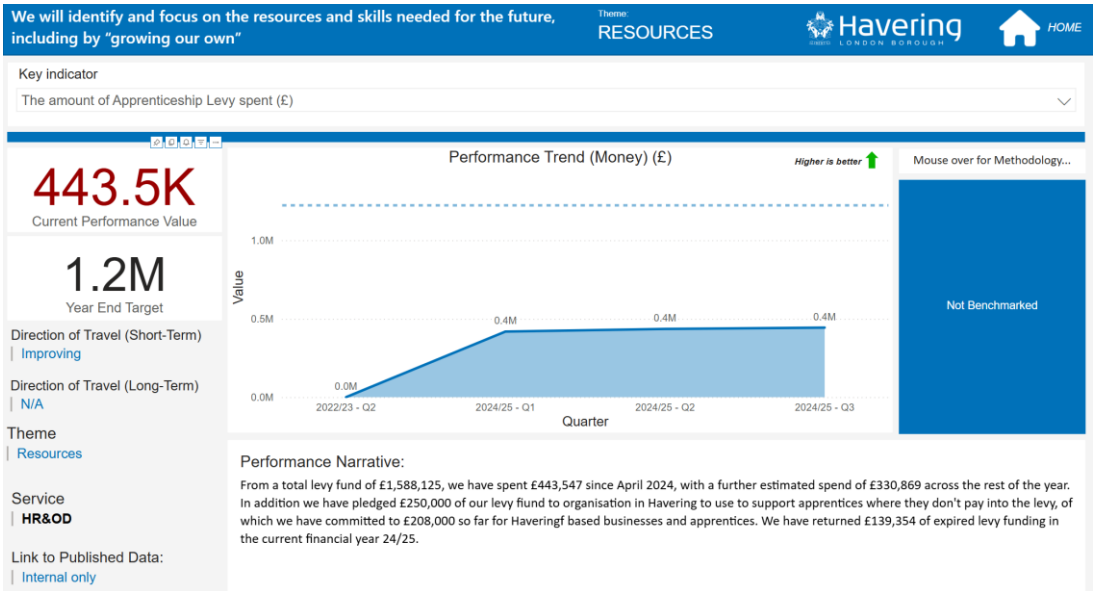
As noted in the narrative on Power-bi, this rapid growth causes two capacity challenges, firstly in terms of available educational psychologists (EPs) who must provide 'advice' as part of each of these assessments, and secondly, on Case Officers who must coordinate and write the assessments. The Education Services restructure, finalised in November 2024, supported growth in both the EP and Case Officer teams, but we are yet to be able to staff the new positions created. Further to EP capacity, there is a context of national shortage of EPs, which has seen many turning to lucrative 'locum' (i.e. agency) work. To address this, we have recently trialled a contract with a company that can deliver EP advice, as an alternative to trying to recruit permanent staff and to directly employing agency EPs. This trial was successful, and in February 2025 we were able to agree an extension to this contract via the procurement team. We had hoped this extension would allow us to purchase 200 assessments, which would be enough for us to clear our backlog by summer 2025 and therefore be unencumbered by EP capacity in terms of hitting the 20 week timescales, however procurement rules dictate that we will need to enter into a full procurement process for this bigger contract. This may cause delays, though we are hoping to move quickly so that we have cleared the backlog by August 2025. We will then establish ongoing contracts to maintain capacity and therefore performance. In the meantime, we are focusing on Case Officer performance and prioritisation to ensure that children awaiting assessments at transition points (moving between schools) are prioritised and ensuring that where TP advice is not a barrier to hitting 20 weeks Case Officers ensure timescales are met.



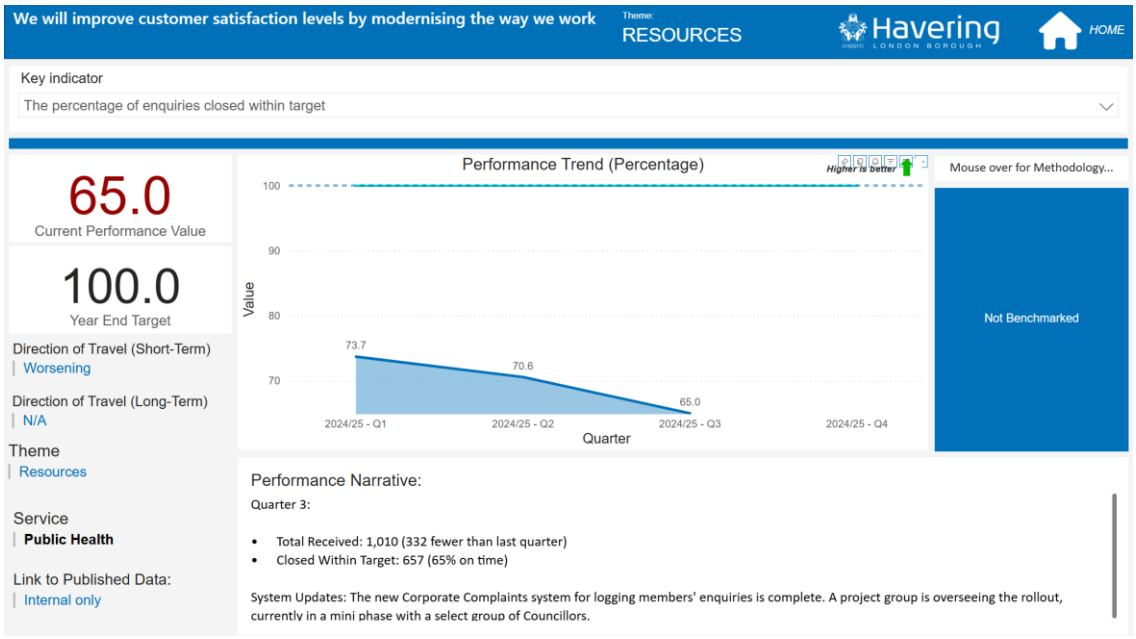
The Percentage of household waste recycled is reported a quarter behind, and as you can see from the table quarter 2 usually sees a sip in performance. Recycling rates are largely based on customer behaviours, and whilst we will continue to offer waste minimisation-based activities, and a garden waste collection that largely contributes to the recycling rate, we are also looking at bringing in food waste collections before the end of the year, which would also serve to increase recycling rates.



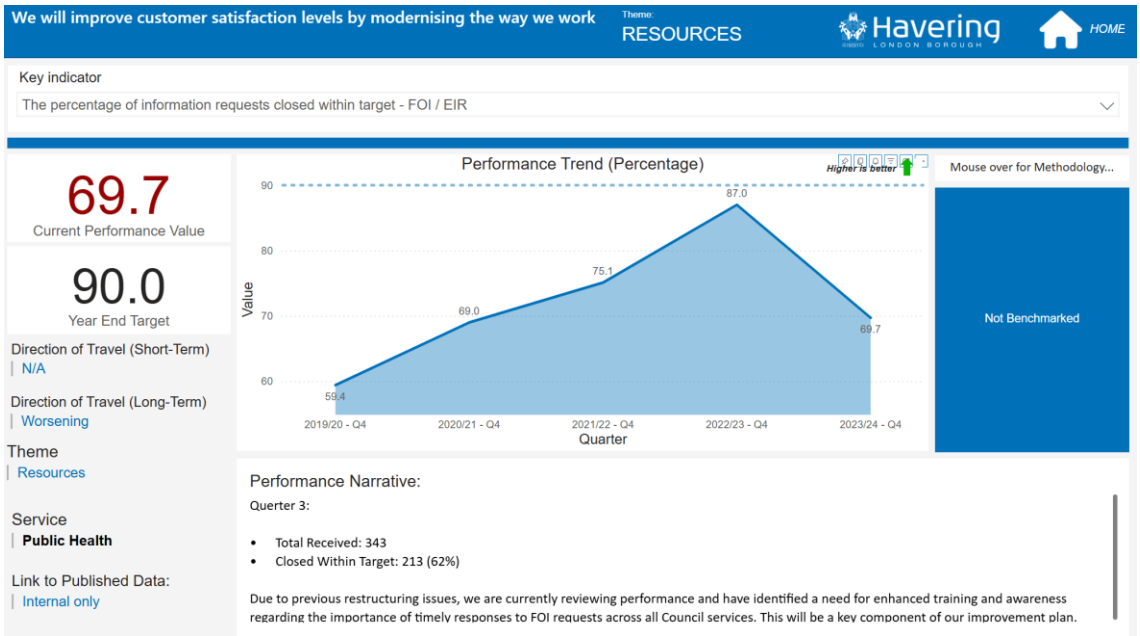
This is a 3 year action plan, with the 100% completion being the 3 year target. Actions are monitored regularly and flagged when there are any issues. Going forward the target will be amended to reflect the 3 year span of the action plan. It is anticipated that year 1 completion rate will be 50%, increasing to 75% for end of year 2 and 100% for completion at the end of year 3.

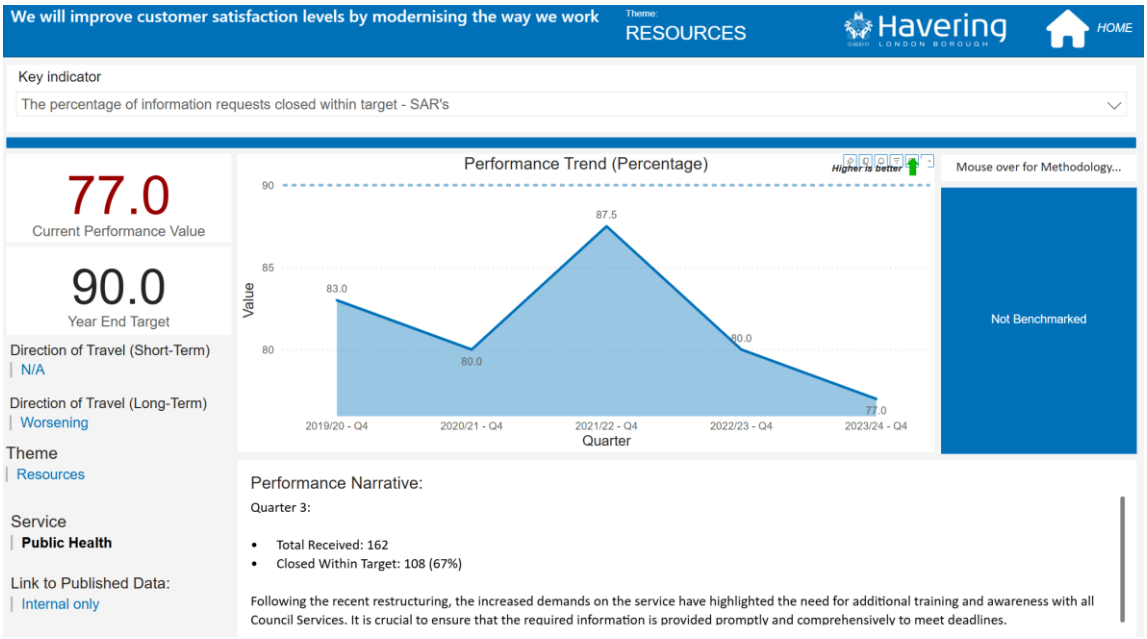


As at the 26th February our updated spend is £521,409 since April 2024. We will continue to optimise the apprenticeship levy spend, encouraging Havering to support apprenticeships and invest in employee training and development. We will continue to utilise these funds to address skill gaps, improve workforce productivity and optimise growing our own skilled and adaptable workforce for the future.



Although the number of enquiries we received last quarter were fewer than at the end of Q2 we are still seeing over 1000 enquiries. We have moved to an online tracking system to monitor them, which allows for better oversight of the enquiries and their target dates. This will also ensure timely escalation to those services where information has not been provided.

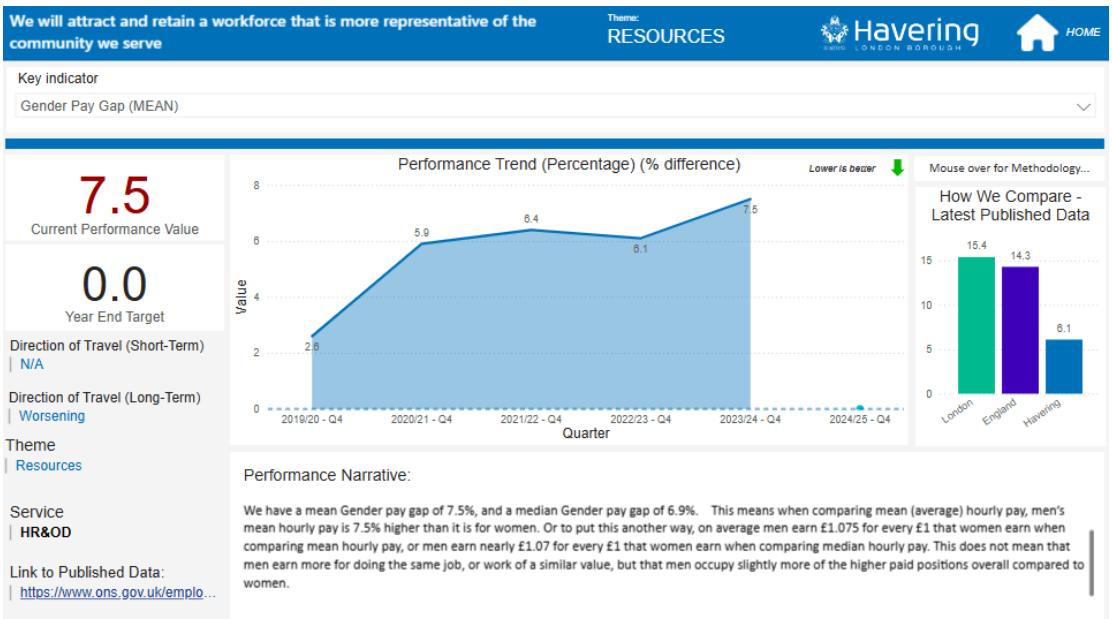




We have seen a decline in performance in both the Percentage of information requests closed within target – FOI/EIR and SAR's over the last financial year. In order to try and improve performance over the quarter 4 2024/25, we will be looking at three areas:

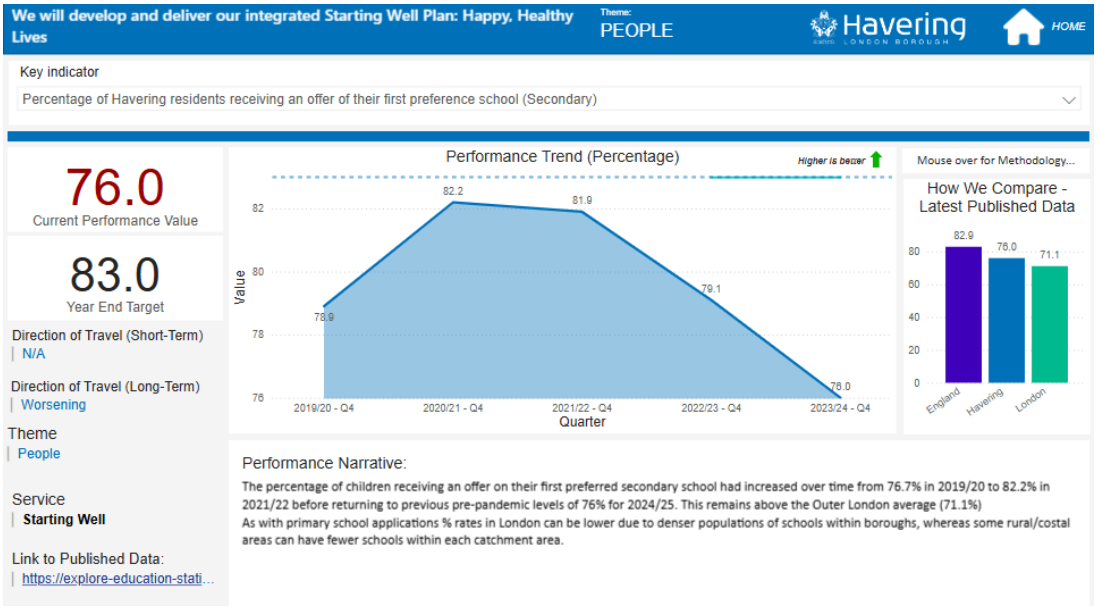
1. **Breakdown by Directorate -** We will be conducting a detailed analysis, with a deeper dive if necessary, to pinpoint exact areas where issues are impacting performance and target achievement.
2. **Escalation Process –** Any Issues will now be escalated to the Assistant Director and if required, to the Director for a swift resolution and alignment with performance goals.
3. **Case Tracker Implementation -** We will utilise Case Tracker to provide better visibility of outstanding requests, including key details such as deadlines and expected resolution timelines, ensuring targets are met efficiently.

Annual Indicators



Gender Pay gap for 2024/25 will be released around June 2025, it will refer to the difference in average earning between women and men in the workplace. We will review any significant issues that reflect boarded inequalities which can be influenced by varying factors including, but not exhaustive employment types, structure levels and remuneration. We will produce a plan towards Gender equity to move Havering forward to be a more inclusive

workplace. A target of zero on a gender pay gap, is not achievable so will be reviewed each year with the target next year being the same as our current performance this year in the hope to hit or better than this year.



This is an annual indicator and data for 2024/25 should be available once applications have been allocated. Achieving a higher percentage of first-preference offers are significantly influenced by the realism of parental applications. This year, we observed a notable concentration of first-preference applications from Havering residents for a few highly sought-after schools:

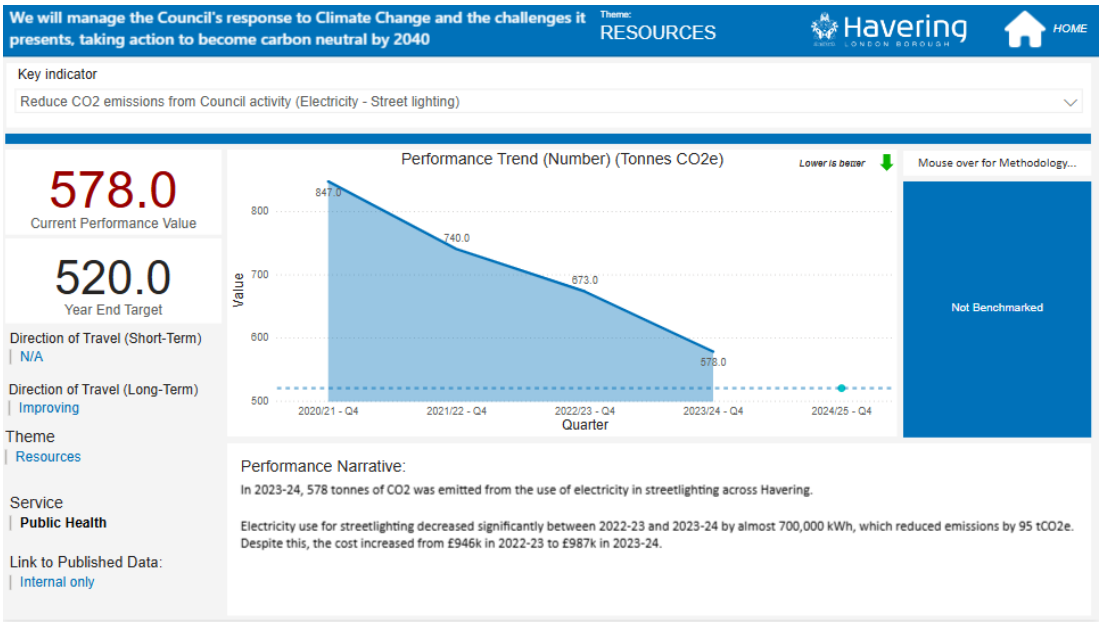
- Redden Court School - 404 applications (12.18%);
- The Coopers' Company and Coborn School - 282 applications (8.50%); and
- Hall Mead School - 233 applications (7.02%).

These three schools alone accounted for 27.7% of all applications from Havering residents.

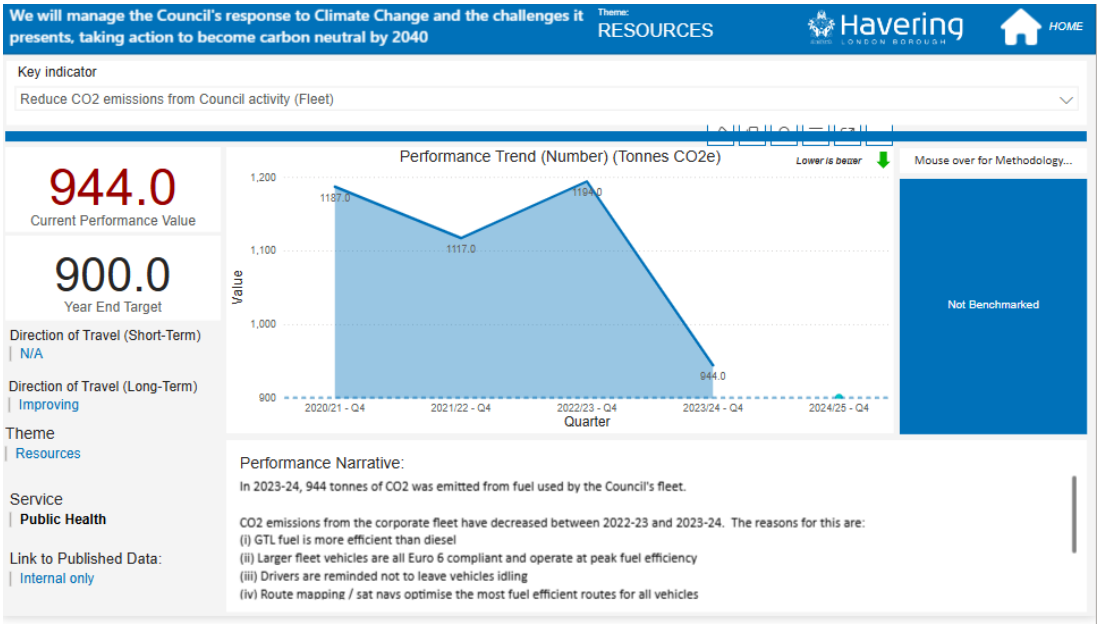
To directly address this and empower parents to make informed choices, we are reintroducing our pre-pandemic Primary to Secondary Presentation Evenings. These borough-wide meetings will provide a clear and comprehensive overview of the admissions process. We will place an emphasis on realistic applications, actively guiding parents on how to assess school suitability and make informed choices based on historical admissions data. Additionally, we will present historical admissions data in a clear, visual format to help parents understand the likelihood of securing places at specific schools.

We believe these initiatives will contribute to a more informed application process, leading to a higher percentage of first-preference offers in future years.

We are actively working to improve this indicator and will continue to monitor the impact of these strategies.



This is an annual indicator, and based on customer consumption. When the Q4 data is available, given the trajectory from previous years, it is possible we will meet our year-end target.



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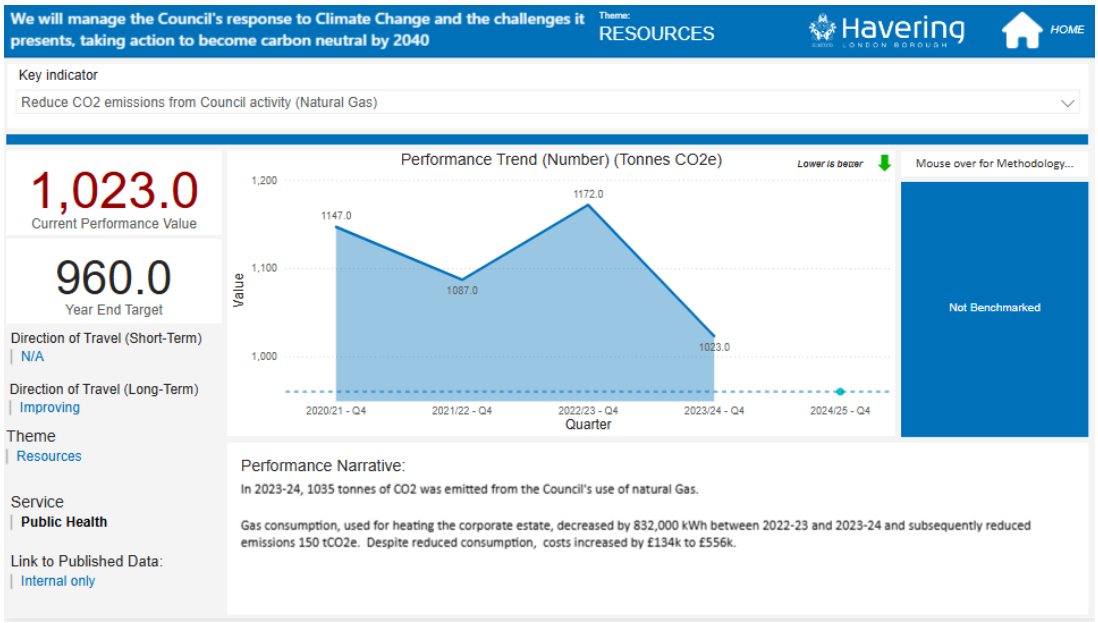

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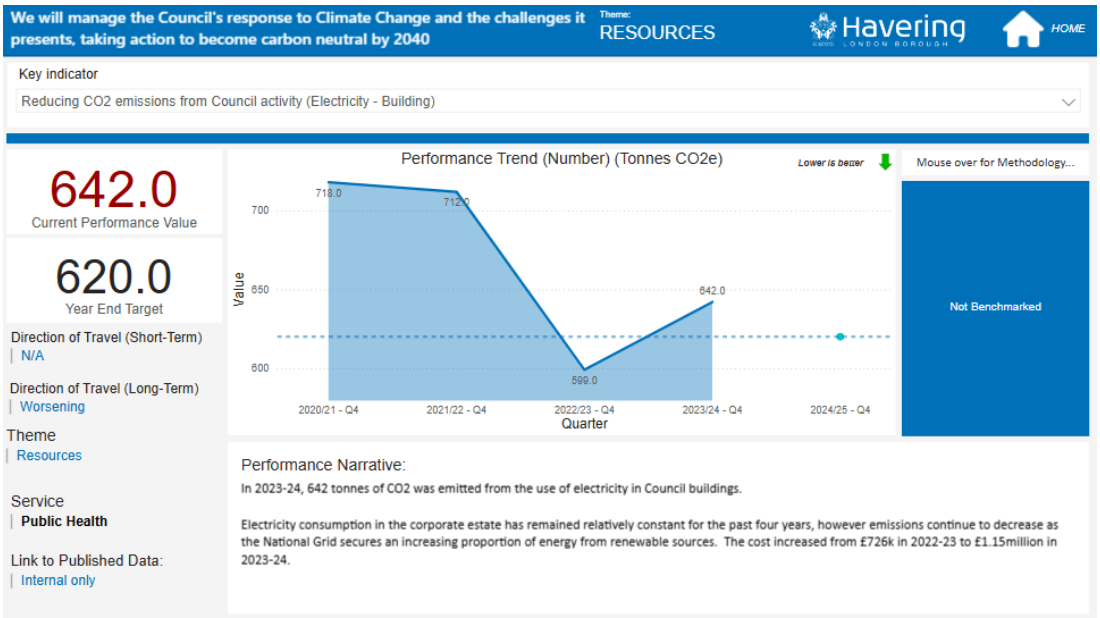

This is an annual indicator, and based on customer consumption. When the Q4 data is available, given the trajectory from previous years, it is possible we will meet our year-end target

REASONS AND OPTIONS

Reasons for the decision: To provide Cabinet Members with an update on the Council's performance against each of the strategic goals (People, Place and Resources).

Other options considered: The option of not reporting was quickly dismissed as robust performance management underpins the Council's commitment to make informed, evidence-based decisions, and to be open and transparent with our residents, staff and partners.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no direct financial implications directly arising from the recommendations in this report.
Adverse performance against some Corporate Performance Indicators may have financial implications for the Council, particularly where targets are explicitly linked with particular funding streams. Conversely, correcting poor performance can require reallocation of resources. The funding available to deliver targets is reviewed regularly as part of the Council's ongoing MTFS and budget monitoring processes.

Legal implications and risks:

There are no direct legal implications arising from the recommendations in this report. Whilst reporting on performance is not a statutory requirement, it is considered best practice to review the Council's progress against the Corporate Plan Objectives and is an indicator of good governance and efficiency.

Human Resources implications and risks:

There are no major direct HR implications or risks from this report. Any HR issues which occur will be managed in accordance with the Council's HR policies and procedures and any change processes that are required will be managed in accordance with both statutory requirements and the Council's Organisational Change Policy and Procedure and associated guidance.

Equalities implications and risks:

The Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010 requires the Council, when exercising its functions, to have due regard to:

(i) the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
(ii) the need to advance equality of opportunity between persons who share protected characteristics and those who do not, and;
(iii) foster good relations between those who have protected characteristics and those who do not.

Note: 'Protected characteristics' are: age, sex, race, disability, sexual orientation, marriage and civil partnerships, religion or belief, pregnancy and maternity and gender reassignment.

The Council is committed to all of the above in the provision, procurement and commissioning of its services, and the employment of its workforce. In addition, the Council is also committed to improving the quality of life and wellbeing for all Havering residents in respect of socio-economics and health determinants.

Equality impact assessments are systematically carried out for any services, projects or other schemes that have the potential to impact on communities and / or staff on the grounds of particular protected characteristics or socio-economic disadvantage.

Equalities assessment is normally required for significant impacts upon ANY of the "protected characteristics". As this is a report pulls together the work that is already being completed or due to start, an assessment is not required.

Health and Wellbeing implications and Risks

Under the Health and Social Care Act 2012 the Council is responsible for improving and protecting the health and wellbeing of local residents. Havering Council is committed to improving the health and wellbeing of all residents.

There are no health and wellbeing implications arising from the proposed decision to approve and publish this report.

ENVIRONMENTAL AND CLIMATE CHANGE IMPLICATIONS AND RISKS

The Council has committed to taking action towards the organisation and the borough becoming carbon neutral by 2040.

The table below gives the carbon footprint of activities associated with the publication of the corporate performance indicators:

Activity	**Carbon footprint**
Production of 1kg paper	1kg CO_2
Production of 1 A4 sheet paper	5g CO_2
Laser printing	10 pages per minute = 10.27g CO_2
One internet search	0.2g CO_2
Average website page view	1.8g CO_2

Printing a single report to include all 113 corporate performance indicators would have a carbon footprint of approximately 681g CO_2. For all nine cabinet members this would equate to just over 6kg CO_2 per quarter, or 24kg CO_2 per year. Printing this 14 page report will equate to 84.391g CO_2 per member (approximately 759.52g CO^2 for all nine cabinet members)

Publishing the corporate performance indicators on the Council website would have a lower carbon footprint of approximately 2g CO_2. For all nine cabinet members this would equate to 18g CO_2 per quarter, or 72g CO_2 per year.

No significant detrimental climate change implications or risks are expected as a direct outcome of this report, however it is recommended that printing is kept to a minimum to reduce organisational CO_2 emissions.

BACKGROUND PAPERS

The Corporate Plan 2024-2027 is available to view on the Council website:
https://issuu.com/haveringcouncil/docs/6609_vision_for_havering_v9

CABINET

Subject Heading:	**Revenue and Capital Budget Monitoring Report - Period 9**
Cabinet Member:	**Councillor Chris Wilkins (Cabinet Member for Finance)**
ELT Lead:	**Kathy Freeman** Strategic Director of Resources
Report Author and contact details:	Richard Tyler Katherine Heffernan/Philippa Farrell Head of Financial Strategy and Business Intelligence 01708 433 340 Heads of Finance Business Partnering Richard.Tyler@Havering.gov.uk Katherine.Heffernan@havering.gov.uk Philippa.Farrell@havering.gov.uk
Policy context:	The report provides an update on the financial monitoring position of the Council at the end of Period 9 2024-2025.
Financial summary:	This report includes: Projected 2024/25 Revenue Outturn position at Period 9 Projected Capital spend for 2024/25 as at Period 9 Update on progress towards delivering the 2024/25 savings Update on the position on Earmarked Reserves

Is this a Key Decision? No

1. EXECUTIVE SUMMARY

1.1. This Report sets out the monitoring position for the Council for 2024/25 based on figures to period nine (31st December). The report also updates on the latest position on the Capital programme detailing spend and outputs so far and planned spend for the remainder of the year

1.2. The Council is projecting a £20.14m overspend on its General Fund revenue budget at period 9, this excludes the funding directive of £14m that was required to balance the budget. Overall, the Council has a General Fund pressure of £34.14m. The Council continues to enforce strict spending controls and focus on driving down spend. The current projected outturn position would result in the Council needing to utilise the full extent of the £32.5m Capitalisation Direction provisionally agreed with the Government at budget setting.

1.3. The report also sets out progress to date on delivery of the 2024/25 savings agreed in setting the budget in February 2024. Most savings are forecast to be delivered, however at present C£8.9m have been delivered to date. This creates considerable risk that the position could worsen because of savings not being delivered. There are several savings which are either delayed or will not be delivered and the resultant pressure is fully included in the projected variances presented in this report. The overspend reported within the services are predominantly driven by delivery of core services, which have either increased in cost for delivery, demand or both. The pressures are not being driven by one off events. Savings are therefore becoming more difficult to identify. Departments are, however, reviewing all areas to identify underspends and efficiencies to mitigate written out savings and reduce the cost base.

2. RECOMMENDATIONS

2.1. Cabinet is asked to note the revenue financial position at Period 9 as set out in section 4 and Appendix A of this report

2.2. Cabinet is asked to note the progress towards delivery of the 2024/25 savings and the updated position on earmarked reserves

2.3. Cabinet is asked to note the Quarter 3 Capital Programme update as set out in Appendix B to this report.

3. BACKGROUND

3.1. Havering like many authorities has seen demand increase against a backdrop of reduced funding, but this has been more acute for Havering due an inequitable funding formula

which does not reflect the demographic pressures the Council faces. It is an efficient well-run authority which has managed its budgets carefully over many years.

3.2. Over the last decade the Government has reduced the amount of grant funding the authority has received in comparison to the increase in pressures it is facing. The overall level of funding for Social Care in particular is a national problem but Havering is also disadvantaged by the continued use of a formula which does not reflect current relative need.

3.2 This position has resulted in Havering having no alternative to requesting exceptional financial support to balance its budget for 2024/25. The Council received provisional agreement from central Government to balance its 2024/25 budget using a £32.5m capitalisation direction which represented a worst-case scenario.

3.3 Central Government agreed exceptional financial support of £32.5m based on Havering's assumptions of the worst-case scenario for the funding gap for 2024/25. Growth was allocated to service budgets at the start of the year based on the most likely scenario which identified a £14m funding gap, the remainder of the £32.5m was an upper limit based on the worst-case scenario. This report shows the Council's position has now in effect exceeded the worst-case scenario with demographic and inflationary demand on people services in particular exceeding the budgets allocated to departments.

3.4 The new national Government have committed to funding reform and multi-year spending reviews from 2025 onwards. This is welcomed and Havering will work closely with the LGA, London Councils and other Councils to make sure all our concerns are presented to Government to inform decision making. It is hoped that these reforms ultimately will lead to a sustainable financial basis for the Council to deliver its services in the medium term. These reforms will take time to introduce and so in the short term it is inevitable that the Council will require further exceptional financial support to deliver its services. What has been demonstrated in allocation of funding today is that the government is focusing on deprivation and council tax base in the formula. Neither of these factors favour Havering, and therefore one-off additional funding for 2024/25 and 2025/26 has not benefited Havering.

4. PERIOD 9 REVENUE MONITORING POSITION

4.1. This section sets out the reported monitoring position at the end of Period 9 2024. The current forecasted position is a £34.14m overspend which if not mitigated would exceed the capitalisation direction permitted by the Government and result in a reduction in general balances. This position has worsened from Period 6 by £0.93m. This increase has been driven predominantly by the People Pillar, with the removal of unachievable savings and an increase in pressure from Placements. The table below sets out the summary position.

Table 1: Period 9 Budget Monitoring Position

TOTAL NET	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	Variance as % of Budget	Forecast Variance P6	Change in Forecast Variance
TOTAL NET	£m	£m	£m	£m	£m	£m	£m
PEOPLE	159.61	136.19	181.95	22.34	0.14	18.59	3.75
PLACE	14.86	13.90	17.33	2.48	0.17	2.74	(0.26)
RESOURCES	25.59	14.37	25.59	0.02	0.00	(0.06)	0.08
TOTAL SERVICE DIRECTORATES	**200.06**	**164.46**	**224.87**	**24.84**	**0.12**	**21.27**	**3.57**
Corporate Budgets	(2.54)	(6.09)	(5.31)	(4.70)	7.70	(2.06)	(2.64)
TOTAL COUNCIL REVENUE	**197.52**	**158.37**	**219.56**	**20.14**	**0.10**	**19.21**	**0.93**
Budget Financing	(197.52)	(8.96)	(197.52)	0.00	0.00	0.00	0.00
TOTAL NET	**0.00**	**149.41**	**22.04**	**20.14**	**0.10**	**19.21**	**0.93**

4.2 Further details of Departmental variances can be found at **Appendix A** later in this report. The main variances however continue to be across people services through additional demographic demand across, market pressures and increased complexity of need across all areas of social care, the rising cost of temporary accommodation and the financial impact of delivering the recommendations from the recent OFSTED resulting in not only in year pressure but an inability to meet saving targets.

4.3 The Council has been operating under strict spending controls for over a year since it was apparent that external financial support would be needed to balance the budget. These spending controls have recently been enhanced by the creation of recovery boards for each Department to report and action mitigations to the budget position. These Boards are continuing to work on delivering the items outlined at Period 6.

4.3.1 Ageing Well and Living Well Recovery Board

The Ageing Well and Living Well Recovery Board has agreed a series of actions which have already been put into action with the aim of containing and reducing spend. These include:

- **Cost Control** Meetings – Weekly cost approval meetings have been scheduled. These meeting focus on challenging proposed spend to ensure value for money on essential spend.

- **Contract review –** top ten contracts in terms of spend being reviewed with a view to reduce spend by 10%

- Director of Ageing Well to sign off all one to one, out of panel requests and review of all under £650 panel requests.

- **Review of structures across Living and Ageing Well with aim of:**

- Ensuring that appropriate resources are in place to manage the demand and complexity.
- Ensuring that targets on reviews are in place across the service to control expenditure.
- Ensure that we are meeting our Care Act duties to mitigate a negative outcome of a CQC inspection.

4.3.2 **The Starting Well Recovery Board**

The Starting Well Recovery Board has set up the following actions to help control and mitigate spend.

- **Cost Control Meetings** – Daily cost approval meetings have been scheduled. These meeting focus on challenging proposed spend to ensure value for money on essential spend.

- **Panels –** Starting Well has implemented a number of specialist panels to approve and regularly review expenditure on care and other support for children and families.

- Section 17 Homelessness and NRPF panel
- HARP – internal panel for high cost care placements
- MARP – Multi Agency panel to approve placements and agree split funding arrangements. This panel has been successful in securing commitment from the ICB to part fund a number of expensive placements for children who have needs arising from health conditions.
- Section 23/24 (Care Leavers) panel

- **Improving Foster Carer Recruitment and Retention and Usage** – **Local Community Fostering** (a six-borough partnership) was launched in Spring 24 to improve recruitment and assessment of foster carers.

- **Agency Reduction –** as part of the Starting Well Restructure and Improvement Plan there was initially an increase in agency spend in order to meet the recommendations of the 2024 OFSTED report. The Council is working hard to convert agency staff to permanent or to recruit to those posts.

- **Improved Commissioning –** There have been three provider forums recently with care agencies, and this has led to improved placement pathways with fostering agencies and local children's homes and supported accommodation providers.

4.3.3 Resources Recovery Board

Resources has already put in place several measures to reduce costs including:

- Agreement with One Source partners on a revised allocation of Microsoft licences based on current usage – saving of £275k in year
- Resources senior management restructure completed which will deliver £560k of senior management savings across Resources
- Holding senior vacancies for example the Director of Finance post and now holding the shared onesource IT director post with alternative cover arrangements in place.
- Significant reduction of agency spend across resources through permanent recruitment to posts.
- The cost control boards have rejected costs of £33k and keep tight control of all spend to ensure it is necessary, grant funding is optimised and value for money is demonstrated in all spend decisions.

4.3.4 Place Recovery Board

Place have commenced a series of reviews of services to both identify efficiencies and to ensure effective income collection. Actions include:

- Six Month Parking Review – All the current parking regimes and arrangements will be reviewed including usage, impact of any fee changes and potential impact if the current charges were amended.
- Joint work with London Councils to review PCN Banding
- Review of parking transactional charges to ensure best value for the Council
- Review of permits issued by the Council
- Review of Highways maintenance costs. Areas include structures, drainage, flood risk management, signs, street lighting and gully cleaning work
- Review of the Highways improvement programme to identify schemes that safely can be slipped to a later date
- Review of expenditure across all other Place Services to identify if any works can be stopped or delayed to save costs in the short term
- Review of all agency posts across the service to recruit to permanent roles where possible

4.3.5 Creation of a Debt Board

The Debt Board will oversee all income collection, debt, debt recovery and bad debt provisions of the Council. The role of the board is to ensure collection is maximised for all debt whilst having full regard for residents and other debtors' welfare and ability to pay.

The board will oversee updates for the collection of income and outstanding debt across the Council and periodically review write off procedures and the Council's bad debt provisions

The board met for the first time in January and reviewed all areas of debt. It was recognised in some areas that investment was needed to improve collection rates and actions included

- Investment in additional Council Tax collection officers to improve debt collection
- Pilot a visiting Officer in Social Care to streamline the assessment process in order to get payment plans set up at the inception of placements
- Officers to review the enforcement process within parking to ensure maximum debt recovery is secured
- Detailed review of sundry debt to ensure effective collection across the Council.

5. SAVINGS AND EFFICIENCIES DELIVERY

5.1. In setting the 2024/25 budget the Council identified £15.35m of savings, efficiencies and fee changes which would need to be delivered in order to balance the budget. These proposals were partially offset by a £3.0m budget provision recognising that some proposals might not be fully realised. Departments worked collectively to achieve the proposals wherever possible. The tables below show progress towards delivery of those savings split into Departments and rag- rated. Green indicates the savings is believed to be deliverable in year. Amber indicates there is a good chance the saving will be delivered in year. The table also identifies those savings that have slipped into next year or have been classified as unachievable. Unachievable may indicate the savings itself was not achievable or that the saving action was executed but did not deliver the value assigned to it, therefore any unrealised amount would be classified as unachievable.

Table 1: Savings Progress RAG rating

	Green £'m	Amber £'m	Red £'M	Slipped into ~~Next Year~~2025/26	Unachievable
PEOPLE	£2.00	£1.71	£1.20		£1.30
PLACE	£1.14	£0.95	£0.30	£0.24	£0.33
RESOURCES	£0.94				
CORPORATE	£4.94			£0.30	
TOTAL	**£9.02**	**£2.66**	**£1.50**	**£0.54**	**£1.63**

5.2. The table below shows the savings delivered to date and those forecasted to be delivered. As at Period 9 having only £~~4.99~~9.8m of savings delivered to date does highlight a risk of underachievement. However, the forecasted position remains at £10.72m for the full year ~~and £9.02m is rag rated as Green at Period 9~~. The focus on delivering these savings is crucial to ensuring the outturn position does not worsen.

Table 2: Savings Delivery

Pillar	Savings Budget	Savings Achieved to Date	Savings Forecast for the Full Year	Variance
PEOPLE	£6.21	£2.60	£3.27	£2.94
PLACE	£2.96	£1.37	£1.57	£1.39
RESOURCES	£0.94	£0.94	£0.94	£0.00
CORPORATE	£5.24	£4.94	£4.94	£0.30
TOTAL	**£15.35**	**£9.84**	**£10.72**	**£4.63**

5.3. The Council will continue with the aim of delivering all savings and efficiencies set out in the budget.

6. CORPORATE BUDGETS AND CONTINGENCY

6.1. The Council holds a number of budgets centrally including Treasury Management, levies and provisions for items that are agreed in the year such as the pay award. The table below sets out the current position on these items which is a £4.7m forecast underspend to year end

Table 3: Corporate Budgets

Corporate Items	Revised Budget £m	Period 9 Forecast £m	Variance £m
Corporate Contingency	1.000	0.000	(1.000)
Treasury Management	11.900	7.700	(4.200)
Concessionary Fares and Taxi Cards	6.500	6.200	(0.300)
Provision for 2024/25 pay award	3,000	4,000	1,000
Business Rate Pool saving	(1,000)	(1,200)	(0.200)
Other Corporate Budgets	(5.500)	(5.500)	0.000
Total	**15.900**	**11.200**	**(4.700)**

6.2 The main underspend relates to Treasury management through a combination of higher interest receivable on the Council's short term cash balances and an underspend on borrowing and repayment costs, principally due to slippage in the Capital programme. The

Council has not borrowed externally for the general fund and therefore any interest costs on new borrowing is likely to be minimal.

6.3 The Council holds a £1m contingency for unforeseen events during the year. This has been released to support the overall budget position as it has not been needed to date in year.

6.4 There are also underspends Corporately due to one off rebates on the cost of the freedom pass for 24/25 and a forecasted overachievement on the business rate saving through the joint pool with Thurrock and Barking and Dagenham. The 2024/25 pay award has now been agreed and the final cost will exceed the most likely scenario set out in the Council's budget by £1m

7. EARMARKED AND GENERAL RESERVES

7.1 The Council holds both general reserves and earmarked reserves. General reserves are held to mitigate against any unforeseen risks that materialise. Earmarked reserves are held for a specific length of time to be spent on specific projects and outcomes.

7.2 General Reserves: The Council has an internal target of £20m general reserves. At the end of 2023/24, the Council held £10.2m in general reserves. The Council budgets to add £5m to this balance annually but due to the continued financial pressure in year this will not be fully achieved in 2024/25 at the current forecast the £5m will be reduced by £1.6m. Based on the current revenue position the Council expects to increase general balances by £3.4m in 2024/25, although this will be reviewed at year end.

7.3 Earmarked Reserves: Are held for the delivery of specific projects. These reserves are regularly reviewed and if the Council chooses to not proceed with a project the reserve would be released. In addition, any underspend against these reserves would also be released.

7.4 There are also contractual obligations that the Council must meet for which we have reserve balances and identified risks for which we must set aside budget in reserves. These reserves are also regularly reviewed to ensure that any amounts not required are released to the general fund at year end.

Table 4: Earmarked Reserves and General Balances

RESERVE	24/25 Opening Balance £m	24/25 Forecast Balance £m	25/26 Forecast Balance £m	26/27 Forecast Balance £m
General Balances	(10.20)	(13.56)	(18.60)	(20.00)
Risk Mitigation Reserves	(13.51)	(9.93)	(8.01)	(8.01)
Contractual Reserves	(12.18)	(10.59)	(9.36)	(9.36)
Internally Earmarked Projects	(9.44)	(6.06)	(4.90)	(4.36)
TOTAL	**(45.33)**	**(40.18)**	**(40.88)**	**(41.73)**

8. HOUSING REVENUE ACCOUNT (HRA)

8.1 The HRA is forecasting an £0.08m improvement between Period 6 and Period 9, with a forecasted outturn of £2.12m underspent.

Delays in recruitment in staff have driven underspends within Resources Public health and Place – Housing and Property, with Resources Public Health seeing an increased in hall hire income and Housing Property also seeing utility cost forecasts contributing to an improving position.

Resource Customer Services Transformation & IT HRA has seen a delay in ICT hardware budget being spent resulting in the underspend.

The table below outlines the position:

Table 5: Housing Revenue Account

HRA	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	Variance as % of Budget	Forecast Variance P6	Change in Forecast Variance
HRA	£m	£m	£m	£m	£m	£m	£m
Resources - Public Health	0.91	0.57	0.67	(0.23)	(0.25)	(0.26)	0.03
Resources - Customer Services Transformation & IT	1.22	0.59	1.18	(0.04)	(0.03)	0.02	(0.06)
Place - Housing & Property	(4.28)	(27.14)	(4.46)	(0.18)	0.04	(0.16)	(0.02)
People - Living Well	0.50	0.50	0.49	(0.01)	(0.02)	0.02	(0.03)
TOTAL HRA	**(1.65)**	**(25.48)**	**(2.12)**	**(0.46)**	**0.28**	**(0.38)**	**(0.08)**

9. CAPITAL PROGRAMME 3RD QUARTER MONITORING UPDATE

9.1 The Capital monitoring 3rd quarter update is presented in **Appendix B** of this report. The appendix shows that the Council is currently projecting to spend £~~166.89~~140.4m on Capital in 2024/25.

9.2 Capital expenditure as at the 31th December is £74.144m to date. Notable achievements so far for 2024/25 are as follows:

- £5.529m on the 12 Estates project to improve housing across borough.
- £16.618m spent on enhancing and increasing our existing housing stock.
- £4.046m on improving the quality of our roads and infrastructure.
- £3.179m on enhancing our schools and educational facilities.
- £0.555m in addition to last year's spend of £8.1m on the purchase of refuse vehicles.
- £1.411m on enabling residents to continue to live at home rather than care homes or hospital via the disabled facilities grant.
- An additional £1.937m on two buildings to provide semi-independent living for young people leaving care and adults with learning disabilities.
- £3.792m spent on Bridge Close Acquisitions.

- £11.068m spent on the Rainham & Beam Park regeneration project.
- £0.967m spent on improving parks and open spaces across the borough.

10. IMPLICATIONS AND RISKS

10.1 Financial Implications and Risks
The financial implications of the Council's monitoring position are the subject of this report and are therefore set out in the body of this report.

10.2 Legal Implications and Risks

10.2.1 The Council is required under S151 of the Local Government Act 1972 to make arrangements for the proper administration of its financial affairs.

10.2.2 Under S28 of the Local Government Act 2003 a local authority has to review its budget calculations from time to time during the financial year and take appropriate action if there is any deterioration in its budget.

10.2.3 In accordance with section 3(1) of the Local Government Act 1999, the Council has a duty to "make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness" (This is "the best value duty".) The monitoring of the financial position assists the Council in meeting that duty.

10.3 Human Resource Implications and Risks

10.3.1 There are no immediate Human Resource implications or risks arising from the report at this stage and any specific workforce impact is difficult to assess at the present time. However, any current or future savings proposals or changes to the funding regime that impact on staff numbers or job roles, will be managed in accordance with both statutory requirements and the Council's Organisational Change policy and associated procedures.

10.4 Equalities and Social Inclusion Implications and Risks
There are no immediate Equalities and Social Inclusion implications arising from the report

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Havering
LONDON BOROUGH

Service Revenue Budget Monitoring

Period 9 – December 2024

High Level Summary - Services

Havering LONDON BOROUGH

Service Forecast: £224.90m 12% overspend against Budget

As at the end of December Service Budgets are predicting an **overspend of £24.84m** against budget. This is a worsening position from Period 6 for the Service position of **£3.57m** This is in addition to the budget assumption that the Council will need to use £14m of the Capitalisation Directive to finance the budgets approved.

This is reduced by an underspend in the Corporate Budget driving a variance of (£4.7m). The overall position is therefore a variance of **£20.14m** which would require borrowing of **£34.14m** (£14m + £20.14m).

TOTAL NET	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	Variance as % of Budget	Forecast Variance P6	Change in Forecast Variance
TOTAL NET	£m	£m	£m	£m	£m	£m	£m
PEOPLE	159.61	136.19	181.95	22.34	14%	18.59	3.75
PLACE	14.86	13.90	17.34	2.48	17%	2.74	(0.26)
RESOURCES	25.59	14.37	25.61	0.02	0%	(0.06)	0.08
TOTAL SERVICE DIRECTORATES	**200.06**	**164.46**	**224.90**	**24.84**	**12%**	**21.27**	**3.57**
Corporate Budgets	(2.54)	(6.09)	(7.24)	(4.70)	770%	(2.06)	(2.64)
TOTAL COUNCIL REVENUE	**197.52**	**158.37**	**217.66**	**20.14**	**10%**	**19.21**	**0.97**
Budget Financing	(197.52)	(8.96)	(197.52)	0.00	0%	0.00	0.00
TOTAL NET	**0.00**	**149.41**	**20.14**	**20.14**	**10%**	**19.21**	**0.97**

High Level Summary – Movement Drivers Explained

The Service variance has increased by 2% against budget from Period 6 to Period 9. The key movements have been within the People Pillar which aligns to the key Pillar driver of the Council's overall service overspend of **£24.84m,** reduced by the Corporate underspends to £20.14m.

Ageing Well and Living Well have each seen a movement of **£1.6m** from Period 6 to Period 9. In Ageing Well this movement is driven by the removal of unachievable savings. Savings progress is evaluated as we progress through the financial year and at the last assessment several savings were identified as unachievable.

Living Well has continued to see increases in people presenting as Homeless and requiring placement. This is combined with the delay in programmes such as Urban Impact coming online, this accounts for £0.13m, the remaining £1.5m is driven by increased placement costs because of market pressures coupled with increased complexity in cases driving up placement costs. This is a trend that has continued throughout the year and is anticipated to continue into the next financial year. There has also been the removal of unachievable savings.

Starting Well has moved by **£0.5m,** this movement is the result of increased placement and SEND transport costs but have been offset by increased Health funding contributions have also been agreed and are now included giving only a small net increased pressure.

The **Place Directorate** has reduced spend by **£0.26m** between Period 6 and Period 9. This is the result of several in year mitigations to reduce spend. Resources has held relatively steady with a small increase of **£0.08m.**

Coporate Budgets are overachieving with additional Treasury Income and the release of £1m contingency meaning an additional **£4.7m** has offset the Service overspends.

PEOPLE Summary

The forecast across People is a pressure of £22.34m which is 14% of the budget.

PEOPLE	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	Variance as % of Budget	Forecast Variance P6	Change in Forecast Variance
PEOPLE	£m	£m	£m	£m	£m	£m	£m
People - Starting Well	67.63	55.59	75.11	7.48	11%	6.95	0.53
People - Ageing Well	47.26	40.57	54.99	7.73	16%	6.13	1.60
People - Living Well	44.72	40.03	51.85	7.13	16%	5.51	1.62
TOTAL PEOPLE	**159.61**	**136.19**	**181.95**	**22.34**	**14%**	**18.59**	**3.75**

This is a worsening of the position by £3.75m from period 6.

Starting Well's overspend has increased by £0.53m between Period 6 and Period 9. The main drivers are spending on placements for Looked After Children and Home to School transport, as well as increased pressure in improvement plan costs.

Ageing Well is reporting an increase pressure of £1.6m, this pressure is being driven by the removal of unachievable savings from the forecast, targeted reviews and Better Living savings have continued to perform well.

Living Well is reporting a pressure increase of c£1.62m from Period 6 to Period 9 because of living well social care, this increase has been caused by an increase to existing client packages due to complexity and new clients requiring services and removing unachievable savings out from the forecast which has worsened the position.

PEOPLE: Ageing Well

Ageing Well is forecasting a pressure of £7.73m overspend which is 16% of the budget.

People - Ageing Well	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	As % of Budget	Forecast Variance P6	Change in Forecast Variance
PEOPLE - AGEING WELL	£m	£m	£m	£m	£m	£m	£m
Adult Social Care	44.97	40.19	52.84	7.88	0.18	6.29	1.59
Ageing Well Principal Social Workers	0.66	(0.62)	0.66	0.00	0.00	0.03	(0.03)
Adult Safeguarding	1.63	1.01	1.48	(0.15)	(0.09)	(0.19)	0.04
TOTAL PEOPLE - AGEING WELL	**47.26**	**40.57**	**54.99**	**7.73**	**0.16**	**6.13**	**1.60**

The position has increased by £1.6m from period 6.

Period 9 sees a continuation of the pressures that Ageing Well have experienced throughout the financial year, with providers accepting the Council rates decreasing, and new placements attracting a cost of c£400 per week higher than exiting placements. In addition, as at Period 9 further savings were removed from the forecast to £1.5m. Although, a large amount of the savings is now considered unachievable the service have successfully delivered a large proportion of the Better Living and Targeted review savings. It should be noted that there is still the potential Health funding will materialise but the certainty around this is low, so it is not within the forecast at present.

PEOPLE: Living Well

Living Well is forecasting an overspend of £7.130m which is 16% of the Budget.

People - Living Well	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	As % of Budget	Forecast Variance P6	Change in Forecast Variance
PEOPLE - LIVING WELL	£m	£m	£m	£m	£m	£m	£m
Housing Demand	8.45	5.69	10.76	2.31	0.27	2.18	0.13
Culture & Leisure	(0.22)	2.18	(0.20)	0.02	(0.09)	0.04	(0.02)
Living Well Social Care	36.49	32.16	41.29	4.80	0.13	3.30	1.50
TOTAL PEOPLE - LIVING WELL	**44.72**	**40.03**	**51.85**	**7.13**	**0.16**	**5.51**	**1.62**

This is an increase of £1.62m from period 6.

Temporary accommodation is forecasting an overspend of £2.310m, this has increased by £0.130m from period 6 to 9 mainly due to an upward trend in people presenting as homeless and placements in hotels and nightly lets as cheaper forms of accommodation are being withdrawn from the market, at an extra cost of £14 - 30k per unit per year although the service has successfully negotiated some reductions in price for nightly lets in the last few periods, however the reductions are outweighed by additional demand and placements into hotels. There has also been slippage in the Chalkhill scheme meaning that more families are staying in more expensive temporary accommodation than initially projected and this is contributing to the overspend.

Culture and Leisure is forecasting a small overspend of £0.020m, this is a reduction of £0.040m from period 6. This overspend is being driven from various small pressures within the service.

PEOPLE: Living Well continued

Living Well social care is reporting a pressure of £4.800m, this has increased by £1.500m from period 6 to 9. This overspend is mainly being driven from the increased complexity of clients and from the continuing trend of market pressures. There have been providers who have given notice on client's placements and providers exiting the market, this has meant that placement costs have had to be renegotiated, or alternative placements sourced. New placements being sourced are costing significantly more with some placements being up to double the price of current placements. The increase from period 6 is mainly due to a combination of these factors and that £0.720m of savings were removed from the forecast as they were unachievable.

There has also been some delays regarding CHC funding being agreed and these high-cost placements remain in the forecast until an agreement is reached.

There is a **RED** risk of £0.3m in Living Well Social Care due to modelling based on the likely number of new joiners starting packaged in year at a rate of c.£400 above leavers rates.

PEOPLE: Starting Well

Forecast an overspend of £7.48m, 11% overspend against budget. This is an increase of £0.40m since last month and £0.53m since Pd6.

People - Starting Well	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	As % of Budget	Forecast Variance P6	Change in Forecast Variance
PEOPLE - STARTING WELL	£m	£m	£m	£m	£m	£m	£m
Education	12.14	8.90	13.73	1.59	13%	1.72	(0.13)
Children's Social Care	54.35	45.22	59.48	5.14	9%	4.36	0.78
Principal Social Worker	1.14	1.47	1.89	0.75	66%	0.86	(0.11)
TOTAL PEOPLE - STARTING WELL	**67.63**	**55.59**	**75.11**	**7.48**	**11%**	**6.95**	**0.53**

Staffing and Improvement Plan: £1.50m in Social Care and an underspend of £-0.04m in Education. The total full year cost of the improvement plan is estimated at £5m, though not all of this is expected to be incurred in 24/25. £2.1m additional funding has been applied to the budget from the Social Care grant leaving around £1m gap. This is a small decrease from Pd6.

Special Home to School Transport forecast overspend has decreased by £0.05m since Pd6, mainly due to revised routes in the new school year and reduced forecasts for other expenditure.

Care for Children with Disabilities has increased by £0.26m since Pd6. . There have been increases in all levels of support driven by numbers and more complex needs, particularly in residential home placements and direct payments.

Children in Care Placements – there has been a significant increase in high-cost residential care placements. Since Pd6 the overspend has increased by £0.35m despite contributions from the Health Authority and Education.

PLACE Summary

Forecast £2.48m overspend, 17% of Budget. An overall improvement of (£0.26) on Period 6.

PLACE	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	Variance as % of Budget	Forecast Variance P6	Change in Forecast Variance
PLACE	£m	£m	£m	£m	£m	£m	£m
Place - Planning & Public Protection	3.29	3.47	3.07	(0.22)	7%	(0.14)	(0.08)
Place - Environment	10.42	6.62	12.58	2.17	21 %	2.22	(0.05)
Place - Housing & Property	1.15	3.81	1.68	0.53	46 %	0.66	(0.13)
TOTAL PLACE	**14.86**	**13.90**	**17.33**	**2.48**	**17 %**	**2.74**	**(0.26)**

Planning & Public Protection (£0.22m) is largely down to one-off events like the cessation of the Littering Enforcement Contract. The improvement (£0.08m) this quarter (and from Period 8) is down to salaries revisions and improved income in Enforcement.

Environment overspend **£2.17m** is driven by Parking and Highways as was the case in Period 6. Parking accounts for just over two thirds of this with the majority down to parking income forecasts being substantially lower than budgeted which has been addressed in the 2025/26 draft budget. Highways is a mixture of one-off consultancy costs relating to the delayed maintenance contract and shortfall on income due to the wider economic outlook. Aside from the latter matter, these issues should be resolved for 2025/26. The improvement from prior quarter (£0.05m) was largely due to penalties on the waste contract following performance monitoring. However, the position worsened from prior month by £0.07m, driven by further deterioration in the Parking income forecasts.

Housing & Property overspend **£0.53m** is due to the retention of Mercury House for longer than assumed and the regeneration of Hildene Shopping Centre creating a pressure on rental income offset by an underspend in Inclusive Growth and Regeneration. From Period 6, the position has improved (£0.13m) due to business rate revaluation, delays in recruitment and utilities following new price information.

RESOURCES Summary

Forecasted overspend of **£0.02m** (excluding HRA element of Resources) 0% variance

RESOURCES	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	Variance as % of Budget	Forecast Variance P6	Change in Forecast Variance
RESOURCES	£m	£m	£m	£m	£m	£m	£m
Resources - Public Health	(0.67)	(0.80)	(0.67)	0.00	0%	0.00	0.00
Resources Non-Shared LBH	1.00	(3.55)	0.96	(0.04)	-4%	(0.09)	0.05
Resources - HR & OD	2.21	2.22	2.43	0.22	10%	0.18	0.04
Resources - Customer Services Transformation & IT	1.04	1.89	0.69	(0.35)	-34%	(0.43)	0.08
Resources - Finance	5.69	4.61	5.59	(0.10)	-2%	0.00	(0.10)
Resources - Communication	0.92	0.92	0.87	(0.04)	-4%	(0.04)	0.00
Resources - Partnerships	0.48	1.96	0.68	0.21	44%	0.28	(0.07)
oneSource Cost Share LBH Adjustment	12.06	5.57	12.38	0.32	3%	0.17	0.15
Resources - Public Health - Non-Grant	2.86	1.55	2.66	(0.20)	-7%	(0.13)	(0.07)
TOTAL RESOURCES	**25.59**	**14.37**	**25.59**	**0.02**	**0%**	**(0.06)**	**0.08**

Resources overall is forecasting to come out close to budget. There is a worsening of the position from Period 6 to Period 9. This is driven by crematorium income dropping as the death rate and cost of living crisis have impacted. In addition to worsened recovery in legal costs and enforcement services running costs. Partnership savings delivery have slipped, and HR are seeing pressures because of the Children's improvement plan and Union costs.

Corporate Summary

	Budget 2024-25	Outturn Forecast at end of December	Forecast Outturn Variance	Period 6 Forecast
Corporate	**£m**	**£m**	**£m**	**£m**
Provision for Pay award	3.000	4.000	1.000	1.000
Treasury Management	11.880	7.680	-4.200	-2.600
Contingency	1.000	0.000	-1.000	0.000
Other Corporate Budgets	-14.560	-14.060	-0.500	-0.460
TOTAL CORPORATE	**1.320**	**-3.380**	**-4.700**	**-2.060**

The Corporate forecast position has improved significantly since Period 6 and is now forecasting a 4.7m underspend.

The treasury management outturn position continues to improve. The Council has not taken out any General Fund External borrowing to date in 2024/25 and continues to benefit from short term investments as interest rates remain at around 5% (estimated underspend to date £3.1m). As previously reported there is also an underspend on the amount of minimum revenue provision the Council has to set aside resulting in a £1.1m underspend. This has resulted in a significant underspend on the general fund budget.

The Council has also not utilised the £1m contingency it holds in the general fund budget. This can now be released to support the overall general fund position. There are other one off Corporate underspends on concessionary travel (£0.3m) and an overachievement on the business pool saving (£0.2m).

HRA Summary Revenue

Forecast (£0.46m) underspend, 28% improvement against budget

HRA	Revised Budget 2024-25	Actuals YTD as Period 9	Outturn Forecast at end of December	Forecast Outturn Variance	Variance as % of Budget	Forecast Variance P6	Change in Forecast Variance
HRA	£m	£m	£m	£m	£m	£m	£m
Resources - Public Health - HRA	0.91	0.57	0.67	(0.23)	(25%)	(0.26)	0.03
Resources - Customer Services Transformation & IT HRA	1.22	0.59	1.18	(0.04)	(3%)	0.02	(0.06)
Place - Housing & Property HRA	(4.28)	(27.14)	(4.46)	(0.18)	4%	(0.16)	(0.02)
People - Living Well - HRA	0.50	0.50	0.49	(0.01)	(2%)	0.02	(0.03)
TOTAL HRA	**(1.65)**	**(25.48)**	**(2.12)**	**(0.46)**	**28%**	**(0.38)**	**(0.08)**

The HRA is forecasting an £0.08m improvement between Period 6 and Period 9.

Delays in recruitment in staff have driven underspends within Resources Public health and Place – Housing and Property, with Resources Public Health seeing an increased in hall hire income and Housing Property also seeing utility cost forecasts contributing to an improving position.

Resource Customer Services Transformation & IT HRA has seen a delay in ICT hardware budget being spent resulting in the underspend.

Dedicated Schools Grant (DSG) Summary

Forecast £22.2m Overspend 12.48% of overall in-year budget.

Forecast cumulative overall DSG deficit position to increase from £15.3m to £36.3m overspend by the end of financial year 24-25.

Period 9 forecasts an increasing overspend against original budget.

	Post-recoupment budget - LA responsible for	Forecasted Expenditure	Forecast Outturn Variance	% of budget	Notes
Schools Block	92,674	91,486	1,188	1.28%	Transfer from Schools Block to High Needs Block
Central Schools Services Block	1,747	1,747	0	0.00%	expected to be nil or small underspend
High Needs Block	39,914	62,114	-22,200	-55.62%	projected expenditure based on current demand
Early Years Block	34,082	34,082	0	0.00%	expected to be nil or small underspend
DSG - overall	**168,417**	**189,429**	**-21,012**	**-12.48%**	

The material variance within the DSG is in the DSG High Needs Block and is updated to reflect the additional funding to support mainstream schools with SEND children.

The DSG High Needs Block is a part of the funding provided by the central government to local authorities to support education for children and young people with special educational needs and disabilities (SEND). This grant funding is ring-fenced and specifically allocated to meet the needs of pupils who require additional support due to their learning difficulties or disabilities.

The forecasted overspend is reflective of the increasing demand for support, that the current central government formula of distribution does not cover for Havering and other LAs across England.

The Department for Levelling Up, Housing and Communities (DLUHC) regulations has extended the **Statutory Override for DSG until the end of financial year 2025-26**. This regulation reduces the overall financial risks posed by the deficit falling on the council unearmarked general fund reserves.

High Level Summary – Risks and Ops

Overall, there is still an upper risk of **c.£5.69m** that could be realised and opportunities and mitigations of **£4.11m** (at the upper limit).

As we approach the end of the financial year, we would anticipate the reduction in risks and opportunities as they materialise or disappear.

However, within the People Directorate there are still risks of a material value that could significantly add to the pressure at outturn. Most notably within **Starting Well there is a £2.05m risk** relating to health income in the forecast that may not be realised and £1m of improvement programme risk. There is a combined risk of **£0.7m risk for placements in Ageing Well and Living Well** as these forecasts do not reflect movements in and out of placements and are based on existing placements to date.

If both upper limits of risks, and opportunities and mitigation, were realised the outturn would be outside the funding directive provided as exceptional financial support by central government. All possible action should be taken to avoid it.

*£14m is the Capitalisation Direction

Overall High Level Risks

Pillar	Pillar/Directorate	Summary of Main Risks	TOTAL Value
People	Ageing Well	Forecasts are only for known clients and panel decisions.	£0.40m
People	Living Well	Forecasts are only for known clients and panel decisions.	£0.30m
People	Starting Well	Forecasts include Health funding that may not materialise £2.05m, Improvement Plan £1m and £0.5m for uplifts to placements. Salary uplift risk is recognised but not quantified.	£3.55m
Place	Place	Mercury House	
Place	Environment	Winter Pressures could result in demand in services and loss in parking income, current assumptions relate only to mild winter conditions	£0.60m - £0.80m
Place	PPP	Income materialisation risk in Building Control, Planning and Local Land Charges – all demand led and subject to changes in behaviour	£0 - £0.49m
Resources	One Source	ICT cost inflation, cloud migration	£0.05m
Resources	Housing Benefit	Housing Benefit Subsidy – Area subject to movement in either direction. Risk range identified.	£0.10m
Total Services			**£5.0m -£5.69m**

Overall High Level Opportunities and Mitigations

Pillar	Pillar/Directorate	Summary of Opportunities	TOTAL Value
People	Ageing Well	Additional Health funding	£0.50m
People	Starting Well	There is a contingency of £0.26m for CiC within the forecasts. The CiC is based on the trend on placement growth. There is no longer a contingency with CWD.	£0.26m
Place	Place	Increased parking income	£0.05 -£0.10m
Resources	Resources	Housing Benefit Subsidy additional income and reduction in agency costs	£0.10m
Total Services			**£0.91m - £0.96m**

Pillar	Pillar/Directorate	Summary of Mitigations	TOTAL Value
People	Starting Well	Panel reviews of new placements scrutinising high cost placements and identifying possible step-down options.	£2.00m - £3.00m
People	Starting Well	Temp to Perm	£0.15m
Total Services			**£2.15m -£3.15m**

APPENDIX B – CAPITAL MONITORING UPDATE Quarter 3

1. CAPITAL MONITORING

1.1. The Capital programme for 2024/25 through to 2027/28 was agreed at Council in February 2024. Since then slippage from 2023/24 has been added as per the capital outturn report and there have been some additions to the programme resulting in a summary programme as set out in the table below.

Summary of Existing Approved Capital Programme	Previous Years Budget £m	2024- 25 Budget £m	2025-26 Budget £m	2026-27 + Budget £m	Total Budget £m
Ageing Well	0.778	5.827	2.330	0.000	8.935
Living Well	26.920	1.804	0.742	3.353	32.819
Starting Well	2.223	32.997	17.834	19.000	72.054
People	**29.921**	**40.628**	**20.906**	**22.353**	**113.808**
Environment	25.247	17.588	9.950	14.000	66.785
Housing & Property (GF)	44.228	54.617	123.166	232.702	454.713
Housing & Property (HRA)	358.764	114.805	229.100	611.214	1,313.883
Planning & Public Protection	0.201	0.411	1.088	0.000	1.700
Place	**428.440**	**187.421**	**363.304**	**857.916**	**1,837.081**
Customer Services	7.077	0.343	0.000	0.000	7.420
Finance	0.104	1.184	1.404	0.000	2.692
Partnership Impact and Delivery	6.761	7.332	10.716	0.300	25.109
Public Health	0.012	0.325	0.000	0.000	0.337
Resources	**13.954**	**9.184**	**12.120**	**0.300**	**35.558**
Grand Total	**472.315**	**237.233**	**396.330**	**880.569**	**1,986.447**

GF / HRA Split	Previous Years Budget £m	2024- 25 Budget £m	2025-26 Budget £m	2026-27 + Budget £m	Total Budget £m
General Fund	113.551	122.428	167.230	269.355	672.564
Housing Revenue Account	358.764	114.805	229.100	611.214	1,313.883
Grand Total	**472.315**	**237.233**	**396.330**	**880.569**	**1,986.447**

1.2. Financing - The Council finances its capital expenditure through a combination of resources both internal and externally generated. Each funding stream is considered in terms of risk and affordability in the short and long term. The current and future climates have a significant influence on capital funding decisions. As a result, the planned disposals and borrowing costs are kept under regular review to ensure timing maximises any potential receipts or reduces borrowing costs.

1.3. Excluding previous years spend of £472.315 (shown for information in the table above), the total capital programme for 2024/25 and beyond is £1,514.132m split between the GF (£559.013m) and HRA (£955.119m). Funding for the planned capital expenditure for both the GF and HRA is set out in the 2 tables below.

General Fund Financing	2024/25 Financing Budget £m	2025/26 Financing Budget £m	2026/27+ Financing Budget £m	Total Financing Budget £m
Capital Receipts	30.070	53.299	87.741	**171.110**
Revenue & Reserves	2.004	0.102	0.000	**2.106**
Grants & Other Contributions	48.936	21.992	31.185	**102.113**
Borrowing	41.418	91.836	150.430	**283.684**
Total GF Financing	**122.428**	**167.229**	**269.356**	**559.013**

HRA Financing	2024/25 Financing Budget £m	2025/26 Financing Budget £m	2026/27+ Financing Budget £m	Total Financing Budget £m
Capital Receipts	27.509	78.568	152.218	**258.295**
Revenue & Reserves	11.339	10.577	32.651	**54.567**
Grants & Other Contributions	11.169	17.239	0.000	**28.408**
Borrowing	64.788	122.716	426.345	**613.849**
Total HRA Financing	**114.805**	**229.100**	**611.213**	**955.119**

2. Capital Achievements as at 31th December 2024

2.1. Capital expenditure as at the 31th December is £74.144m to date. Notable achievements so far for 2024/25 are as follows.

- £5.529m on the 12 Estates project to improve housing across borough.
- £16.618m spent on enhancing and increasing our existing housing stock.
- £4.046m on improving the quality of our roads and infrastructure.
- £3.179m on enhancing our schools and educational facilities.
- £0.555m in addition to last year's spend of £8.1m on the purchase of refuse vehicles.
- £1.411m on enabling residents to continue to live at home rather than care homes or hospital via the disabled facilities grant.
- An additional £1.937m on two buildings to provide semi-independent living for young people leaving care and adults with learning disabilities.
- £3.792m spent on Bridge Close Acquisitions.
- £11.068m spent on the Rainham & Beam Park regeneration project.

- £0.967m spent on improving parks and open spaces across the borough.

3. 2024/25 Capital Programme

3.1. The report below sets out the Period 9 position for the Council's capital programme for the 2024/25 financial year.

	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Starting Well	32.997	5.484	(27.513)
Living Well	1.804	0.876	(0.928)
Ageing Well	5.827	5.007	(0.820)
People	**40.628**	**11.367**	**(29.261)**
Housing & Property (GF)	54.617	25.687	(28.930)
Housing & Property (HRA)	114.805	83.281	(31.524)
Planning & Public Protection	0.411	0.611	0.200
Environment	17.588	14.761	(2.827)
Place	**187.421**	**124.340**	**(63.081)**
Partnership Impact and Delivery	7.332	4.234	(3.098)
Customer Services	0.343	0.309	(0.034)
Finance	1.184	0.000	(1.184)
Public Health	0.325	0.123	(0.202)
Resources	**9.184**	**4.666**	**(4.518)**
Total	**237.233**	**140.373**	**(96.860)**

	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
General Fund	122.428	57.092	(65.336)
Housing Revenue Account	114.805	83.281	(31.524)
Total	**237.233**	**140.373**	**(96.860)**

3.2. The forecast expenditure for 2024/25 is £140.373m with actual expenditure at the end of Period 9 standing at £74.144m. Whilst most project budgets are on track to be spent over the full MTFS period there are a number of projects where expenditure has slipped back into future years, the explanations for the main programmes that contribute towards the slippage provided below:

3.3. **PEOPLE**

3.3.1. Starting Well

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Childrens Social Care Programme	3.211	2.996	(0.215)
Education - Other	0.011	0.000	(0.011)
Schools	29.775	2.488	(27.287)
Education	**32.997**	**5.484**	**(27.513)**
Starting Well	**32.997**	**5.484**	**(27.513)**

Schools – Slippage of £27.287m

The Schools programme comprises of a number of grants that are awaiting allocation and have slipped into future years. Delays in the allocation of Basic Needs grant including to Gidea Park School has led to slippage £12.713m in the Capital Programme. A further £9.153m of slippage is as a result of delays in the allocation of High Needs grant.

3.3.2 Living Well

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Leisure Other	0.105	0.045	(0.060)
Leisure SLM	1.699	0.831	(0.868)
Housing Demand (GF)	**1.804**	**0.876**	**(0.928)**
Living Well	**1.804**	**0.876**	**(0.928)**

Leisure SLM – Slippage of £0.868m

The slippage relates to the Sapphire Ice and Leisure - Fit Out scheme which has slipped into future years.

3.3.3 Ageing Well

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Adults Social Care - DFG	2.729	2.756	0.027
Adults Social Care - Other	3.098	2.251	(0.847)
Adults Social Care	**5.827**	**5.007**	**(0.820)**
Ageing Well	**5.827**	**5.007**	**(0.820)**

Adults Social Care – Other – Slippage of £0.847m

The slippage relates to the Adults Learning Disabilities Provision Build at Mowbrays (P3). The construction work is in progress; however, the scheme has experienced some delays, reflected in the revised forecasts.

3.4. PLACE

3.4.1. Housing and Property – General Fund

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Mercury Land Holdings	4.441	3.697	(0.744)
Rainham & Beam Park	15.638	12.180	(3.458)
Regeneration - Other	22.122	0.284	(21.838)
Regeneration - TFL	0.050	0.000	(0.050)
Regeneration & Place Shaping	**42.251**	**16.162**	**(26.089)**
Corporate Buildings	3.812	2.127	(1.685)
Health & Safety	0.065	0.052	(0.013)
Pre Sale Expenses	0.376	0.153	(0.223)
Schools Building Maintenance	3.024	3.024	0.000
Schools Expansions	2.996	2.114	(0.882)
Vehicle Replacement	1.978	1.940	(0.038)
Housing, Property and Assets	**12.251**	**9.410**	**(2.841)**
Inclusive Growth Programme	0.115	0.115	0.000
Inclusive Growth	**0.115**	**0.115**	**0.000**
Housing & Property (GF)	**54.617**	**25.687**	**(28.930)**

Rainham & Beam Park – Slippage of £3.458m

The slippage relates to re-profile of any potential CPO's that would be required as a result of the project. There are currently no known CPO's that need progressing.

Regeneration - Other – Slippage of £21.838m

The slippage relates to the Provision for Future Regen Opportunities budget, this budget has now been removed from the Capital Programme.

Corporate Buildings – Slippage of £1.685m

£1.390m of the slippage relates to the Corporate Buildings & Other Initiatives. The Town Hall reroofing project did not fully commence until September last year. The project needs listed building consent and quite a bit of design co-ordination which has the caused the delay.

Schools Expansions – Slippage of £0.882m

The slippage relates to Suttons Primary School SEND Unit. The project is on site, with completion in Spring 2025.

3.4.2. Housing & Property (HRA)

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Bridge Close Acquisitions	19.538	5.311	(14.227)
Bridge Close Regeneration	0.687	0.642	(0.045)
HRA Regeneration	22.158	19.460	(2.698)
Regeneration & Place Shaping	**42.383**	**25.413**	**(16.970)**
Capital HRA	40.693	37.126	(3.567)
HRA Stock Adustments	5.353	5.853	0.500
Housing HRA	26.376	14.889	(11.487)
Housing, Property and Assets	**72.422**	**57.868**	**(14.554)**
Housing & Property (HRA)	**114.805**	**83.281**	**(31.524)**

Bridge Close Acquisitions – Slippage of £14.227m

Negotiations are progressing on a number of acquisitions and forecasts will be updated monthly to assess timescales against cash flow assumptions. The 2024/25 forecast is based on completion of a number of acquisitions plus professional fees paid via the LLP. Acquisitions are of significant value, and forecasts are prepared against current acquisition schedule, which may be subject to change. Revised forecast at Period 9 reflecting current predictions for conclusion of commercial negotiations for property acquisitions plus revision of drawdowns expected for creditors payments for scheme design and planning.

HRA Regeneration – Slippage of £2.698m

The slippage relates to HRA Regeneration – Acquisitions programme. The latest forecasts are based on current acquisition schedule. Remaining properties to be bought back at Oldchurch Gardens, Chippenham, Farnham & Maygreen.

Capital HRA – Slippage of £3.567m

£2.202m of the slippage relates to the Decent Homes Works – External. £0.715m of the slippage relates to Decent Home Works – Internal. The slippage is due to uncertainty in getting building safety approval to high-rise lift works, budget to be carried forward.

Housing HRA – Slippage of £11.487m

The slippage relate to the GLA Council Housing Acquisitions Programme. The £9.2m expenditure to date is based on 34 properties.

3.4.3. Planning & Public Protection

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Enforcement	0.384	0.584	0.200
Planning Other	0.000	0.000	0.000
Planning TFL	0.027	0.027	0.000
Planning & Public Protection	**0.411**	**0.611**	**0.200**
Planning & Public Protection	**0.411**	**0.611**	**0.200**

There is no significant slippage forecast at this stage within Planning & Public Protection.

3.4.4. Environment

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Environment - TFL	2.315	2.315	0.000
Highways & Street Lighting	7.554	7.333	(0.221)
Public Realm - Parks	2.252	2.048	(0.204)
Public Realm - Waste	5.275	2.872	(2.403)
Environment - Parking	0.145	0.145	0.000
Public Realm - Grounds Maintenance	0.047	0.048	0.001
Environment	**17.588**	**14.761**	**(2.827)**
Environment	**17.588**	**14.761**	**(2.827)**

Public Realm - Waste – Slippage of £2.403m

The slippage relates to the Food Waste - Collection scheme. The current year spend on the scheme is expected to reach £2m, on the purchase of caddies and vehicles. The remaining budget will be carried forward into new financial year for purchase of flats bins and bin housings.

3.5. **RESOURCES**

3.5.1. IT, Digital and Customer

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
ICT Cloud Migration	2.080	0.800	(1.280)
ICT Modern Device Management	1.986	1.205	(0.781)
Transformation	3.266	2.229	(1.037)
IT, Digital and Customer	**7.332**	**4.234**	**(3.098)**
Resources - IT, Digital and Customer	**7.332**	**4.234**	**(3.098)**

ICT Cloud Migration programme – Slippage of £1.280m

An engagement with Microsoft to carry out planning work has been undertaken. This has highlighted the scale and complexity of the task and informed programme planning and spend profiling. Spend to date with Agilisys has been made via matrix MM milestones and needs to be recharged to capital. This accounts for the disparity between the capital programme's current actuals and forecasted spend.

ICT Modern Device Management programme – Slippage of £0.781m

Following an initial pilot, current assumptions are that a 'network as a service' model may be the best option for the Council, rather than investing in on premise networking. A business case is being produced for review. The current forecast reflects an assumed move to a revenue model, hence the reduction in the capital forecast.

Transformation – Slippage of £1.037m

The majority of the slippage in this area is due to Sovereignty Management IT and Digital Platforms schemes. A conversion of agency posts to council contract has had a favourable impact on the forecast.

3.5.2 Customer Services

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Libraries	0.152	0.106	(0.046)
Customer Services	**0.152**	**0.106**	**(0.046)**
Cemeteries and Crematorium	0.191	0.203	0.012
Bereavement & Registration Services	**0.191**	**0.203**	**0.012**
Resources - Customer Services	**0.343**	**0.309**	**(0.034)**

There is no significant slippage forecast within Customer Services.

3.5.3 Finance

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Exchequer & Transactional Programme	0.135	0.000	(0.135)
Finance People & Place Programme	0.049	0.000	(0.049)
Contingency	1.000	0.000	(1.000)
Corporate Finance	**1.184**	**0.000**	**(1.184)**
Resources - Finance	**1.184**	**0.000**	**(1.184)**

The contingency budget is delegated to the S151 officer for approval to either new or existing capital schemes. As such the forecast for contingency is zero as their will be no spend allocated directly to the project.

3.5.4 Public Health

Programme Area /Service/ Directorate	Budget 2024/25 £m	2024/25 Forecast Period 9 £m	2024/25 Variance £m
Insight, Policy & Strategy	0.325	0.123	(0.202)
Insight, Policy & Strategy	**0.325**	**0.123**	**(0.202)**
Resources - Public Health	**0.325**	**0.123**	**(0.202)**

There is no significant capital slippage forecast at this stage in Public Health.

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