Public Document Pack

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 7 May 2025	Council Chamber - Town Hall

Members: 18, Quorum: 6

BOARD MEMBERS:

Elected Members:	Cllr Gillian Ford (Chairman), Cllr Oscar Ford, Cllr Natasha Summers and Cllr Paul McGeary
Officers of the Council:	Andrew Blake-Herbert, Mark Ansell, Barbara Nicholls, Tara Geere, Patrick Odling-Smee and Neil Stubbings
NEL ICB:	Kirsty Boettcher, Narinderjit Kullar, Luke Burton and Emily Plane
Other Organisations:	Fiona Wheeler, Lynn Hollis, Vicki Kong, Anne-Marie Dean, Carol White, Paul Rose and Sarita Symon

For information about the meeting please contact:
Luke Phimister 01708 434619 01708 434619
luke.phimister@onesource.co.uk

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.

What is the Health and Wellbeing Board?

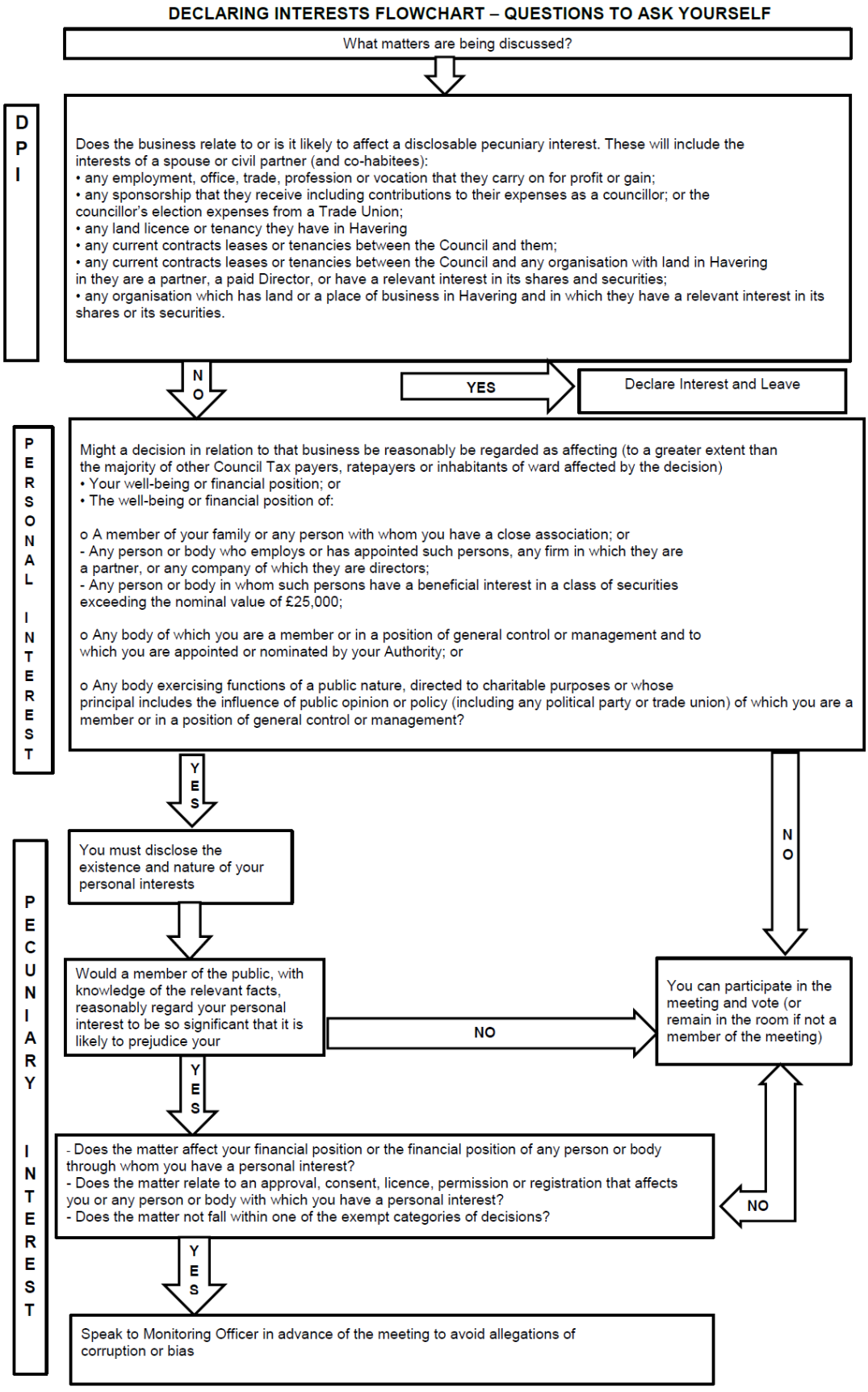
Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance

information



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 ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of 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 DISCLOSURE OF INTERESTS

Members are invited to disclose any interest in any of the items on the agenda at this point of the meeting.

Members may still disclose any interest in any item at any time prior to the consideration of the matter.

4 MINUTES

To be circulated prior to meeting.

5 MATTERS ARISING

To consider the Board's Action Log

6 BCF (Pages 7 - 14)

7 HEALTHWATCH ANNUAL REPORT (Pages 15 - 26)

8 LB HAVERING JSNA 2025 (Pages 27 - 224)

9 TOBACCO HARM REDUCTION STRATEGY CONSULTATION (Pages 225 - 278)

10 HEALTH PROTECTION FORUM ANNUAL REPORT 2024 (Pages 279 - 282)

11 JOINT LOCAL HEALTH AND WELLBEING STRATEGY UPDATE (Pages 283 - 286)

Zena Smith
Head of Committee and Election Services

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HEALTH & WELLBEING BOARD

Subject Heading:	Delivery of the Better Care Fund 2025-2026
Board Lead:	Cllr Gillian Ford, Cabinet Member for Adults and Health
Report Author and contact details:	Laura Wheatley laura.wheatley@havering.gov.uk

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

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

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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 governance 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

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**

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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.

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

- BCF 2025_26 Narrative Plan

- BCF 2025-26 Capacity and Demand Template
- BCF 2025-26 Planning Template

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HEALTH & WELLBEING BOARD

Subject Heading:	HealthWatch Annual Report
Board Lead:	Councillor Gillian Ford
Report Author and contact details:	Anne-Marie Dean anne-marie.dean@healthwatchhavering.co.uk

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

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☐	Lifestyles and behaviours • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
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☐	Local health and social care services • Development of integrated health, housing and social care services at locality level.
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SUMMARY
Statutory annual report from ‘Healthwatch Havering 2023 - 2024’, prepared as part of the annual report submitted to Government from Healthwatch England
RECOMMENDATIONS
No recommendations
REPORT DETAIL
Explains the role of Healthwatch Havering - how we have made a difference through the year, the ‘Deafness is not a barrier report’, How Havering residents voices have been heard across NEL, St Georges Health and Wellbeing hub project
IMPLICATIONS AND RISKS
There are no implications and risks
BACKGROUND PAPERS
The value of listening ppt.

Healthwatch Havering

The importance of listening and sharing

Our role is to make sure that decision makers and influencers hear the voice of the community and use the feedback to improve care.

- We provide a platform which explores and empowers residents to shape the future of their communities, setting goals, objectives and values.
- We find out what matters to people and try to include everyone in the conversation – especially those who don't always have their voice heard
- To work co-operatively with all organisations to achieve this goal.
- Recognising and encouraging the importance of adaptability = enabling solutions to be achieved even on tight budgets or unpredictable challenges
- This approach enables us to confidently deliver suggestions and possible solutions to improve services for residents

Reaching out across our communities

Reaching Out:

1,000 people

shared their experiences of health and social care services with us

139 people

came to us for advice and information about topics such as dental care and accessing GP services

Making a difference to care:

15 **reports have been published**

Setting out the improvements people would like to see in health and social care services

Our most popular report was:

Maternity Services in North-East London

Highlighted the struggles people face accessing good maternity care

How we have made a difference through the seasons this year – SPRING

- Healthy Weight Strategy
- We supported Havering Public Health team with their Health Inequalities programme and the Healthy Weight Strategy

- ICB Finance Committee
- Worked with the ICB Financial Committee to review the contract plans and funding e.g. Dental Services

Summer

1) Task and Finish Focus Group - Working with Care Home residents and staff

2)Partnership with Public Health team we helped to support further work on Long COVID

Autumn

1) Programme of formal Enter and View visits to local Care Homes

2) Working with the ICB procure new service model for the Homeless Outreach Programme

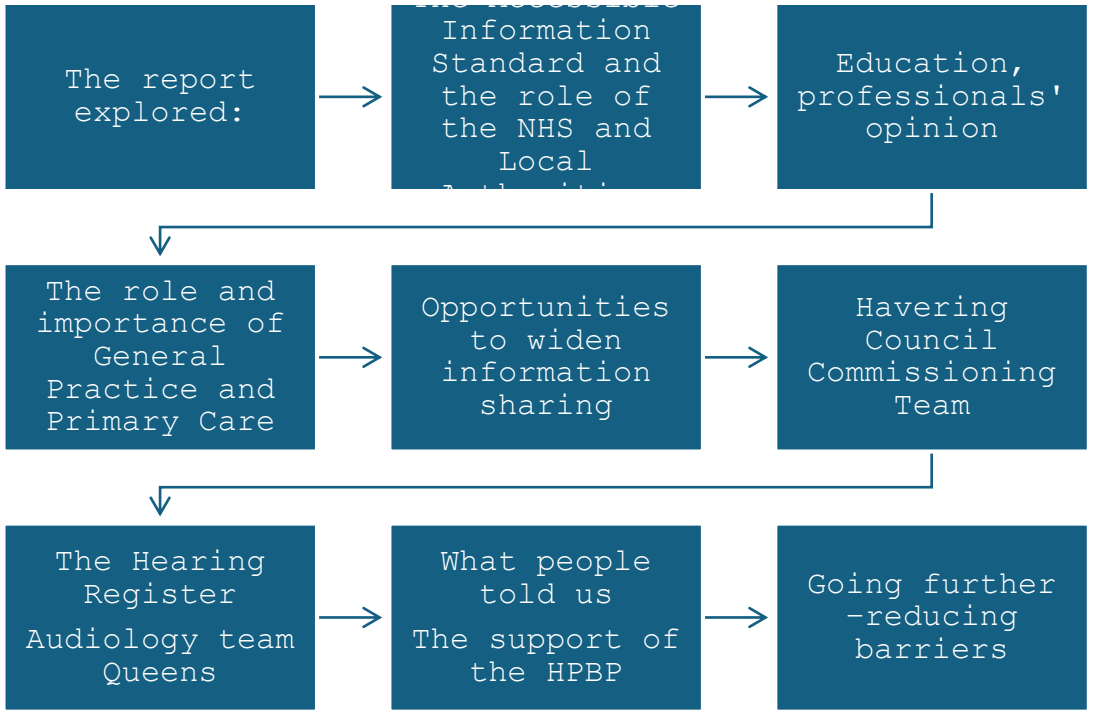
WINTER

Working with Tapestry and the Havering Volunteer Centre – stay well this winter

The launch of the NHS App London Borough of Havering, BHRUT, NELFT all help to support and increase confidence in the NHS App.

Deafness is not a barrier –

It only becomes a barrier if there is a l accessibility



The Deaf community is international. What binds Deaf people, despite their different national sign languages, is their shared visual communication, history, cultural activities, and the need for a Deaf "space" where people come together.(*above is the International Sign Union Flag*)

HPBP received the report in December 2024 and quickly launched a Summit meeting for members of the deaf community, community staff, LBH staff, Audiology and the patient experience team from BHRUT

Identified social networks and deaf clubs e.g. Remark which provides a range of clubs, events and a wide range of on-line advice and support

LBH offer free Deafness awareness sessions, organised for individuals and teams across the borough

The working group has a Project Driver plan and is now planning "Going further to reducing barriers for those with different

Havering Residents voices are heard at the wider level of commissioning in North-East London

We collaborate with other local Healthwatch to ensure the experiences of people in Havering can influence decisions made about services at North-East London ICB

- The Big Conversation

The eight Healthwatches were commissioned by the ICB to ask over a 1,000 residents what good care looked like to them

Residents told us the ICB should focus on:

✓**Outcomes**

✓**Competency**

✓**Accessible**

✓**Person-Centre**

- Maternity

A detailed and comprehensive engagement with pregnant women was undertaken by the either Healthwatch

Improvements Needed

✓**Cultural competency**

✓**Trauma informed care**

✓**Multi-lingual advocates on site**

✓**Accessible Information**

The St Georges Health and Wellbeing Hub

The St Georges Health and Wellbeing Hub become operational in late September.

Healthwatch has been a member of the Project Board for 10 years and is very aware of how hard the local health care teams and council services have lobbied to ensure that the residents of Havering have this amazing new service model

The new clinical service models provided by BHRUT are making an enormous contribution to the health and wellbeing of patients. The GP and Primary Care services are developing very well.

The Voluntary sector team are providing an amazing 'meet and greet' service model as well as providing the opportunity to support patients who may be anxious and/or alone and would welcome support

Always good to share good news!

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HEALTH & WELLBEING BOARD

Subject Heading:	LB Havering JSNA 2025: Living Well, Ageing Well & Dying Well
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Tha Han tha.han@havering.gov.uk and Adult Delivery Board partners

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

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SUMMARY

This publication of the Joint Strategic Needs Assessment (JSNA) covers the life courses of living well, ageing well, and dying well. The recommendations in this profile are evidence-based and highlight any existing inequalities. They are intended for commissioners and local providers to address the causes and consequences of poor health and wellbeing through prevention, early intervention, and collective activity. The report has been approved after the presentation at the Adults Delivery Board on the 24th March 2025, and has been shared at Havering Place based Partnership on the 9th April 2025.

The co-authors of this JSNA urge the Council as a local planning authority to explore and quantify any opportunities arising from the proposed amendments to the National Planning Policy Framework that will enable additional housing schemes that meet local needs to be brought forward, including those arising through proposed changes to utilisation and definition of brownfield and grey belt land.

In health and care, we can see the evidence that prevention has worked. The hospital admission rate from stroke in Havering in 2022/23 was 121 per 100,000, which was lower than the England average (168 per 100,000). Hospital admissions from uncontrolled long-term conditions overall in Havering were better than the London average but similar to the England average. The percentages of people dying at hospitals across all age groups were significantly lower than the London average.

However, health inequality exists between the deprived and the less deprived regarding health outcomes. Circulatory diseases and cancer are the two top causes behind the differences in life expectancy. In 2022/23, Havering's under 75 mortality rate from cancers (116 per 100,000) was higher than the London average (110 per 100,000).

Havering services have been trying to meet the demand related to its ageing population. In 2023/24, 4,483 residents aged 65 years and over received support from Havering's Adult Social Care. Altogether, they received 6,655 care packages. It is also crucial that dementia is diagnosed early so that support for the affected resident and family can be planned early including management of symptoms.

The Havering JSNA steering group recommends that HWB members support the implementation of the following published strategies that will have a positive impact on Havering's population health:

- Poverty Reduction Strategy
- Serious Violence Strategy
- Healthy Weight Strategy
- Tobacco Harm Reduction Strategy
- Combating Substance Misuse Strategy
- North East London Sexual and Reproductive Health Strategy
- Suicide Prevention Strategy

The following recommendations are also made to the Health and Wellbeing Board by the JSNA steering group:

- To improve early diagnosis of cancers through further improving screening coverage, raising awareness of cancers with highest numbers of late diagnosis among the

residents (lung, colorectal, upper GI, prostate), working with GPs to review opportunities for early detection and appropriate referrals, and strengthening diagnostic capacity including the use of the RDC (rapid diagnostic clinic) and targeted lung health check.

- To strengthen the community infrastructure and awareness to improve the detection of hypertension, obesity, atrial fibrillation and prediabetes and to use transformation and innovation (which includes digital health/medical technologies) to speed up diagnosis and management of LTCs.
- To review and improve where necessary the current approach to the delivery and monitoring of long-term conditions (e.g., diabetes, long-covid) to ensure access to effective care, self-management and peer support.
- To support individuals with mental health conditions to live, fulfilling, meaningful and healthy lives, and ensure equitable access to mental health services, and doing so in a timely manner to prevent deterioration of mental health to crisis presentations
- To support implementation of plans developed by the BHR Planned Care Transformation Board to reduce waiting times for planned care.
- To enable same day access to urgent care in the community whenever possible, and, if a visit to the Emergency Department is needed, to provide a positive experience
- To use Population Health Management (PHM) approach to identify the avoidable risk factors for learning disability and other care packages; and to recommend most effective mental health and physical support interventions, including the use of technology for better and efficient care.
- To empower older people to live independently in their own homes with appropriate care and support and to facilitate social connectivity.
- To support residents by ensuring that the last stages of their life happens in the best possible circumstances, receiving the right help at the right time from the right people, and place.

RECOMMENDATIONS

- To agree/ approve the London Borough of Havering JSNA 2025: Living Well, Ageing Well & Dying Well (attached).

REPORT DETAIL

Please see the attached JSNA 2025 Living Well, Ageing Well and Dying Well report.

IMPLICATIONS AND RISKS

Financial implications and risks:
There will be no direct resource implications/revenue or capitals costs arising from this report. Nonetheless, there will be associated costs from the interventions that use the information in this report to improve population health outcomes.

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 are no direct workforce implications with the implementation of the Strategy. It is therefore cleared from a HR perspective.

Equalities implications and risks:
The report highlights health inequalities that were identified through the JSNA process. There is no equalities risks due to the approval of the report.

Health and Wellbeing implications and risks:
The information in the report are to be used as evidence in informing decision to improve the wider determinants of health and to improve health inequalities and outcomes of Havering residents.

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

JSNA 2025 Living Well, Ageing Well and Dying Well report.

LB Havering JSNA 2025

Living Well, Ageing Well & Dying Well

Draft 5 v1

FOR HWB APPROVAL

Havering
LONDON BOROUGH

Havering Joint Strategic Needs Assessment (JSNA) 2025

Living Well, Ageing Well & Dying Well Profiles

publichealth@havering.gov.uk

Version Control

Version	Action	Date	By
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Draft 5 v1	Final draft for HWB approval	07/04/2025	A Wakhisi

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Infographic Summary

Population & Health Outcomes

POPULATION & HEALTH OUTCOMES

According to the ONS 2023 mid-year population estimates, the Havering resident population is currently estimated to be **268,145**, an increase by **3.4**% in the last 5 years.

The Havering over 65 population (**16.7%**) remains higher than the London average (**12.2%**) but slightly lower than the England average (**18.7%**).

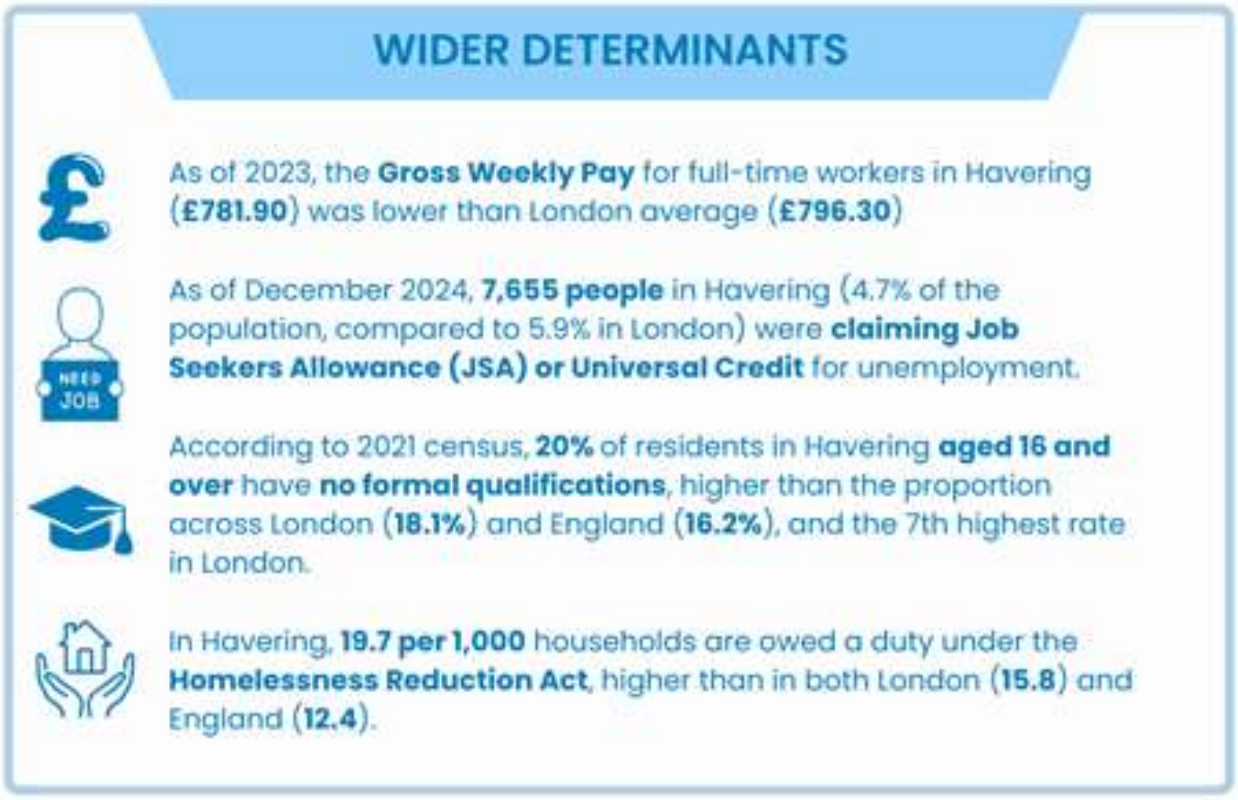
In 2024 there were an estimated **34** people aged 65 and over for **every 100** Havering residents of "working age" (20-64 years).

Non-communicable diseases make up approximately **79%** of the burden of disease experienced by Havering residents; the largest contributors of non-communicable disease being neoplasms (**17%** of the burden of DALYs), cardiovascular disease (**12%** of the burden of DALYs) and musculoskeletal disorders (**9%** of the burden of DALYs)

Havering is ranked near to the National average regarding an Active and Engaged Community (**14,510/33,755**), however has a higher score than the National average in the Loneliness Index (**Havering, 1.22; England 0.07**)

Living well

Wider Determinants of Health



PLACES AND COMMUNITIES

Domestic abuse in Havering has seen a steady increase over the past 3 years (668 per quarter in 2021 to 746 per quarter in 2022) and now constitutes **14% of reported crime**. This is the only crime type in Havering reported to reach a rate (34.5/1,000) similar to London average (34.5/1,000).

In 2024, Havering earned a combined score of **1.97** out of **10** in the overall **Healthy Street Score Card Assessment**- the **fifth lowest** in London.

In 2022, it was estimated that the equivalent of **6.4% of all-cause deaths** amongst adults aged 30 and over in Havering could have been attributable to exposure to **PM2.5 air pollution**.

In 2021/22, the number of premises licensed to sell **alcohol per square km in Havering** (**5.2**) was higher than England average (**1.3 per square km**), but significantly below the London average (**13.7 per square km**)

Havering's resident **digital exclusion risk index (2.8)** is slightly higher than the London average (**2.7**).

In 2021, Havering had the highest age standardised proportion (ASP) of residents providing **unpaid care** (**8.7%, 20,637 residents**) among all local authorities in London (**London average, 7.8%**).

In Havering, 2% of the population identify with one of the **LGBTQ+** orientations.

3,645 residents in Havering previously served in UK regular **armed forces** and **1,243** in UK reserve armed forces.

LIFESTYLE & BEHAVIOURS

In 2022/23, based on the latest Sport England Survey data from OHID, **65.8% of adults in Havering (18+)** were classified as **overweight or obese** using self-reported height and weight. This is in line with the **England average** (**64%**)

Havering had one of the highest proportions of respondents reporting being **physically inactive, at 27.9%**, higher than both London (**22.9%**) and England (**22.3%**) averages

Havering's adult **smoking prevalence** over the latest 3-year period (2021 to 2023) was **12.4%**, similar to London (**11.6%**) and England (**12.4%**) averages.

In 2023/24, the percentage of **pregnant women smoking** at time of delivery in Havering was **3.7%**, similar to London average (**3.9%**), but lower than the England average (**7.4%**)

The latest data (2023) shows that for every 100,000 deaths in Havering, **36 are related to alcohol**. This death rate is similar to the London (**34/100,000**) and England (**41/100,000**) averages

Number of Havering residents in treatment for **substance misuse** has increased from **528 in 2020/2021** to **1,093 in Q2 2024**. This was facilitated by offering additional capacity using a supplementary grant which will end in April 2025

INTEGRATED HEALTH & SOCIAL CARE

During the 2021-23 period, the under 75 mortality rate from **all cancers** in **Havering** (**116/100,000**) was higher than London average (**110/100,000**) but lower than England average (122). Under 75 mortality rate for **colorectal cancer** in Havering over the same period (12.1/100,000) was higher than both London (10.5/100,000) and England (11.9/100,000) averages

It is estimated that **5,265 residents** in Havering could be having **diabetes** without knowing it. Around **14,000 residents** currently do not know they have hypertension and therefore cannot seek help to stop the consequences

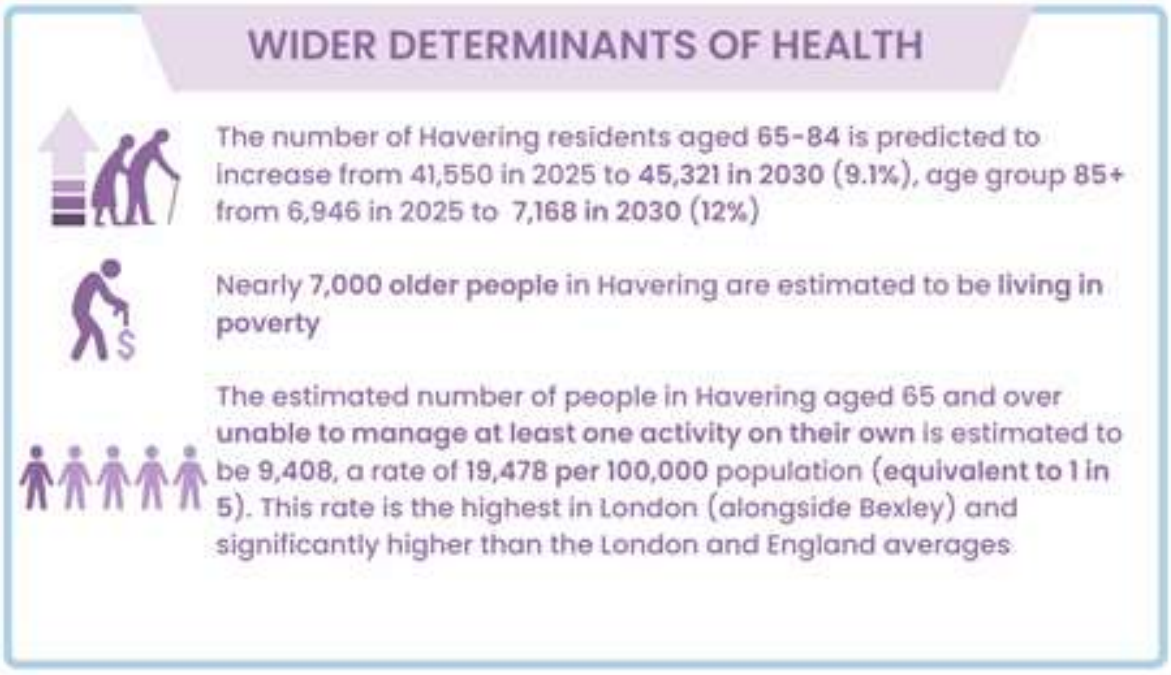
In 2023/24, the number of adults who were registered to a GP practice in Havering and had **depression or anxiety disorder** was **17%** (**49,665**)

According to GP records, **0.8%** of the Havering adult population (**2,073**) have a **Severe Mental Illness (SMI).**

In 2023/24, **1,368 Havering** residents aged 18-64 received a total of **2,043 care packages** support from Havering Adult Social Care

Ageing well

Wider Determinants of Health



Places & Communities

Lifestyle & Behaviours / Healthy Ageing

LIFESTYLE & BEHAVIOURS

In 2023/24, all Havering PCNs achieved the **bowel screening coverage** target of 60%. Nonetheless, latest available data on cancer staging (2019-21, NDRS) found that nearly **70% of rectal cancers** and over **50% of colon cancers** in Havering were diagnosed in later stages

Havering has around **8,061 residents** who are recorded to be **frail.** Havering South PCN (3,758), Liberty PCN (1,587) and Havering North PCN (1,530) have the highest number of patients of age 65+ who have a frailty diagnosis

In 2023/24, the Havering coverage of both **pneumococcal and shingles vaccines** was above the London and England averages. Flu vaccine coverage of those aged 65 and over was **72.7%** (**below England average 77.8%**)

Integrated Health & Social Care

INTEGRATED HEALTH AND SOCIAL CARE

The percentage of Havering residents **aged 75 years** and over having **emergency admissions** within 30 days of discharge (**20.8%**) in 2023/24 was slightly higher than London (19.1%) and England (17.2%) averages. However, **87.3%** of those **age 65 and over remained at home 91 days** after discharge from hospital.

In 2023/24, the percentage of patients with **delayed discharge** from BHRUT hospitals (**53%**) was similar to the London average

There are an estimated **3,121** people with **Dementia** in Havering. In 2024, the number of people diagnosed was **1,757**. A further **335** people need to be diagnosed to meet the national diagnosis target of **67%**

In 2023/24, **4,483** Havering residents aged 65 years and over received support in form of 6,655 **care packages** from Havering Adult Social Care

In 2021/22, **282** Havering residents aged 65 years and over were admitted permanently to **residential or nursing care homes**. This was the third highest number in London

60% of the **Havering adult social care service users** aged 65 years and over are overall extremely or very satisfied compared to **54.9%** for service users in London and **61.8%** for service users in England

Dying well

DYING WELL

In 2023, **11.3%** of people of pension age in Havering were **living in poverty** in their last year of life

The percentages of people **dying at hospitals** across all age groups in Havering were significantly lower than London averages. In addition, the percentages of people **dying at home** across all ages were marginally lower than London averages in 2022. Nonetheless, the percentages of the residents **dying at care homes** across all ages in Havering were significantly higher than London average

In 2024, **61%** of the service users at **Saint Francis Hospice** in Havering, were **cancer patients**, and **39%** had **dementia, frailty, COPD, heart failure, Parkinson's disease** and other **neurological conditions**

The **ethnicity** composition of those receiving **palliative care** at Saint Francis hospice (**White 85.7%, Asian 5.1%, Black 3.8% and others 5.5%**) reflects underlying population distribution of Havering residents

Havering's achievement of the **preferred place of death** in 2024 was just above **80%** in care homes and hospice sector.

Executive Summary

This publication of the Joint Strategic Needs Assessment (JSNA) covers the life courses of living well, ageing well, and dying well. There are no clear boundaries for these life courses, but this approach helps us to focus on key issues that prevail at each life course.

The recommendations in this profile are evidence-based and highlight any existing inequalities. They are intended for commissioners and local providers to address the causes and consequences of poor health and wellbeing through prevention, early intervention, and collective activity.

All things being equal, the size and age structure of the population are the most direct drivers of the need for health and care services. The type and quantity of health and care services vary with age, and they are generally higher in the early years and much higher in old age. Not all older people are frail, but Havering has around 8,061 residents recorded as frail.

In addition to the demographic characteristics, a person's physical and mental health and wellbeing are influenced throughout life by the wider determinants of health. These are a diverse range of social, economic and environmental factors, alongside behavioural risk factors which often cluster in the population. All these factors can be categorised as protective factors or risk factors. Health outcomes could become unequal due to the interaction with these factors within or outside individuals.

There are some situations where the Havering population is in a fair position. The long-term unemployment rate (1.8 per 1,000 working-age population, 294 people) was similar to London's average (1.9) in 2021/22. Havering has a relatively low number of rough sleepers compared with many other London authorities. After a number of years of increases, the most recent figures show this has declined from 58 (2022/23) to 39 (2023/24). 1,007 families and 2,127 single people were relieved from homelessness in 2023/24.

Crime, particularly violent crime, negatively impacts the health of victims and the wider community. Fear of crime and antisocial behaviour have wider effects, deterring residents from using community assets and reducing social interaction. Havering Council has a strategy to reduce the incidence of violence and knife crime. The latest data (2023/24) shows Havering was ranked 26th out of 32 London boroughs for the total number of notifiable crimes (TNO) and 24th for the total number of recorded violent crimes.

By influencing opportunities, skills, employment, and earning potential, increasing educational attainment is associated with improved health behaviours and outcome measures such as life expectancy. We should not be content that 20% of residents in Havering aged 16+ reported having no formal qualifications in 2021, the 7th worst rate in London.

The term' toxic trio' is used by some professionals to refer to the co-occurrence of parental domestic abuse, parental substance misuse and parental mental illness in a child's life[1]. Unfortunately, domestic abuse (DA) in Havering has seen a steady increase over the past 3 years and now constitutes 14% of reported crime. However, in 2023/24, the rate of admissions due to alcohol-related conditions for persons aged 65 and over in Havering (564/100,000) was lower than the London (783/ 100,000) and England (864/100,000) averages. 2,073 adults are

[1]https://learning.nspcc.org.uk/news/why-language-matters/how-toxic-trio-is-unhelpful-and-inaccurate#:~:text=The%20term%20%27toxic%20trio%27%20is,be%20experiencing%20abuse%20or%20neglect.)

recorded to have serious mental illness, and nearly 50,000 adults have depression or anxiety disorder.

People with poor health and/or disability are at particular risk of disadvantage in all its forms, e.g. people living with a long-term condition, mental illness or mental and physical disability are more likely to be living on a low income, be unemployed or in unsuitable housing putting them at additional risk of further decline. The DWP, the Council and the providers such as NELFT and CGL are working on a programme called Individual Placement Scheme to improve employment of those with mental health conditions, substance misuse, disability and other risk factors. For those who are severely disabled to care for themselves, adult social care supports them. In 2024, 1,368 residents aged 18-64 received the support of Havering Adult Social Care, receiving 2,043 care packages.

The built and natural environments are part of the wider determinants of health and wellbeing, significantly influencing physical and mental health and health inequalities.[2] Some of our most pressing health challenges, including obesity, poor mental health issues and physical inactivity (please refer to the infographics summary of findings) are influenced by our environment. This underlines the importance of leveraging every opportunity within the work of the Council, NHS and other partners to support the delivery of health promoting and protecting environments and ensuring that health is effectively considered within planning and delivery of regeneration and infrastructure project[3].

The co-authors of this JSNA urge the Council as a local planning authority to explore and quantify any opportunities arising from the proposed amendments to the National Planning Policy Framework that will enable additional housing schemes that meet local needs to be brought forward, including those arising through proposed changes to utilisation and definition of brownfield and grey belt land. As part of supporting a diverse local retail offer, the Council should consider any opportunities for further policies (including the new Local Plan) that may prevent the further proliferation of fast food takeaways, alcohol-licensed premises, and other retail premises with negative health and wellbeing impacts, particularly in areas of highest deprivation.

In health and care, we can see the evidence that prevention has worked. The hospital admission rate from stroke in Havering in 2022/23 was 121 per 100,000, which was lower than the England average (168 per 100,000). Hospital admissions from uncontrolled long-term conditions overall in Havering were better than the London average but similar to the England average. The percentages of people dying at hospitals across all age groups were significantly lower than the London average.

However, health inequality exists between the deprived and the less deprived regarding health outcomes. Circulatory diseases and cancer are the two top causes behind the differences in life expectancy. In 2022/23, Havering's under 75 mortality rate from cancers (116 per 100,000) was higher than the London average (110 per 100,000). A very high percentage and number of the cancers of the lung, colon and rectum were diagnosed at late stages (3 and 4) in 2019-21. A high percentage of the cancers of the oesophagus, pancreas, stomach and oral cavity were also diagnosed at late stages.

As discussed at the beginning, Havering services have been trying to meet the demand related to its ageing population. In 2023/24, 4,483 residents aged 65 years and over received support from Havering's Adult Social Care. Altogether, they received 6,655 care packages. It is also

[2] https://www.gov.uk/government/publications/phe-healthy-places/phe-healthy-places
[3]Putting Health Into Place (2019) https://www.england.nhs.uk/wp-content/uploads/2019/09/phip-executive-summary.pdf

crucial that dementia is diagnosed early so that support for the affected resident and family can be planned early including management of symptoms. Havering's diagnosis rate is 56.3%, below both London and England averages.

The Havering JSNA steering group recommends that HWB members support the implementation of the following published strategies that will have a positive impact on Havering's population health:

- Poverty Reduction Strategy
- Serious Violence Strategy
- Healthy Weight Strategy
- Tobacco Harm Reduction Strategy
- Combating Substance Misuse Strategy
- North East London Sexual and Reproductive Health Strategy
- Suicide Prevention Strategy

The following recommendations are also made to the Health and Wellbeing Board by the JSNA steering group:

- To improve early diagnosis of cancers through further improving screening coverage, raising awareness of cancers with highest numbers of late diagnosis among the residents (lung, colorectal, upper GI, prostate), working with GPs to review opportunities for early detection and appropriate referrals, and strengthening diagnostic capacity including the use of the RDC (rapid diagnostic clinic) and targeted lung health check.
- To strengthen the community infrastructure and awareness to improve the detection of hypertension, obesity, atrial fibrillation and prediabetes and to use transformation and innovation (which includes digital health/medical technologies) to speed up diagnosis and management of LTCs.
- To review and improve where necessary the current approach to the delivery and monitoring of long-term conditions (e.g., diabetes, long-covid) to ensure access to effective care, self-management and peer support.
- To support individuals with mental health conditions to live, fulfilling, meaningful and healthy lives, and ensure equitable access to mental health services, and doing so in a timely manner to prevent deterioration of mental health to crisis presentations
- To support implementation of plans developed by the BHR Planned Care Transformation Board to reduce waiting times for planned care.
- To enable same day access to urgent care in the community whenever possible, and, if a visit to the Emergency Department is needed, to provide a positive experience
- To use Population Health Management (PHM) approach to identify the avoidable risk factors for learning disability and other care packages; and to recommend most effective mental health and physical support interventions, including the use of technology for better and efficient care.
- To empower older people to live independently in their own homes with appropriate care and support and to facilitate social connectivity.
- To support residents by ensuring that the last stages of their life happens in the best possible circumstances, receiving the right help at the right time from the right people, and place.

List of abbreviations

Abbreviation	Full Form
AAA	Abdominal aortic aneurysm
ADDER	Addiction, Diversion, Disruption, Enforcement and Recovery Project
ADHD	Attention deficit hyperactivity disorder
AHAH	Access to Healthy Assets and Hazards
AI	Artificial Intelligence
ASB	Anti-Social Behaviour
ASC	Adult Social Care
ASH	Action against Smoking and Health
ATR	Alcohol Treatment Requirement
BAME	Black, Asian and Minority Ethnic
BHR	Barking, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
BMI	Body Mass Index
CDP	Combating Drugs Partnership
CGL	Change Grow Live (Substance Misuse Provider)
CI	Confidence Interval
CIL	Community Infrastructure Levy
CMD	Common Mental Health Disorders
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus SARS-COV-2
CQC	Care Quality Commission
CSP	Community Safety Partnership
CVD	Cardiovascular disease
DA	Domestic Abuse
DALY	Disability adjusted life year
DATRIG	Drugs and Alcohol Treatment and Recovery Improvement Grant
DDR	Drug Diversion and Referral
DES	Diabetic eye screening
DPP	Diabetes Prevention Programme
DV	Domestic Violence
DWP	Department for Work and Pensions
ED	Emergency Department
EHCH	Enhanced Health in Care Homes
EoL	End of Life
EoLC	End of Life Care
EV	Electric Vehicle
FIT	Faecal immunochemical test
GBMSM	Gay, Bisexual and Men Who Have Sex With Men
GCSE	General Certificate of Secondary Education
GI	Not found in predefined list
GLA	Greater London Authority
GP	General Practitioner

Abbreviation	Full Form
GPPS	GP Patient Survey
HCSP	Havering Community Safety Partnership
HIV	Human Immunodeficiency Virus
HMO	Home of Multiple Occupation
HPV	Human papillomavirus
HRA	Housing Revenue Account
HSG	Housing Support Grant
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IDAOPI	Income Deprivation affecting older people index
IDVA	Independent Domestic Violence Advisor
IMD	Index of Multiple Deprivation
INT	Integrated Neighbourhood Teams
IOM	Integrated Offender Management
IPD	Inpatient Detoxification
IPS	Individual Placement and Support
JSA	Job Seekers Allowance
JSNA	Joint Strategic Needs Assessment
KSI	Killed or Seriously Injured
LAS	London Ambulance Service
LBH	London Borough of Havering
LD	Learning Disability
LES	Locally Enhanced Services
LFS	Labour Force Survey
LGBTQ	Lesbian, gay, bisexual, transgender, and questioning (or queer)
LIP	Local Implementation Plan
LTC	Long-term conditions
MARAC	Multi Agency Risk Agency
MDT	Multi-disciplinary team
MECC	Making every contact count
MH	Mental Health
MPS	Metropolitan Police Service
MSK	Musculoskeletal
NDRS	National drug referral service
NDTMS	National drug treatment management service
NEET	Not in Education, Employment, or Training
NEL	North East London
NELCA	North East London Cancer Alliance
NELFT	North East London Foundation Trust
NHL	Non-Hodgkin lymphoma
NHS	National Health Service
NHSE	NHS England

Abbreviation	Full Form
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
NVQ	National Vocational Qualification
OCU	Opiate and Crack Use
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PCN	Primary Care Network
PHE	Public Health England
PHI	Public Health Intelligence
PHM	Population Health Management
PID	Pelvic Inflammatory Disease
PM	Particulate matter
PMLD	Profound and multiple learning disability
POPPI	Projection Older People Population Information system
PTALS	Passenger Transport Access Level
QALY	Quality adjusted life year
RSDATG	Rough Sleeping Drug and Alcohol Treatment Grant
RTT	Referral to Treatment
SARS	Severe acute respiratory syndrome
SEND	Special Educational Needs and Disabilities
SMI	Serious Mental Illness
SOIR	Synthetic opioids incident response
SSMTR	Substance Misuse Treatment and Recovery
STI	Sexually Transmitted Infection
TNO	Total Notifiable Offences
UCL	University College London
UEC	Urgent and Emergency Care
UK	United Kingdom
UT	University Trust
VAT	Value Added Tax
VCS	Voluntary Control Sector
WHO	World Health Organisation

1. Introduction

What is JSNA?

The Joint Strategic Needs Assessment (JSNA) is a systematic method for reviewing the issues facing a population, leading to agreed priorities and resource allocation that will improve health and wellbeing and reduce inequalities within the population. The Health and Social Care Act 2012 supports the principle of local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs. JSNAs which are utilised in developing Joint Health & Wellbeing Strategies (JHWSs) are important, locally owned processes through which to achieve this.[4]

Purpose of the JSNA

The purpose of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning. The core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, are used to help to determine what actions local authorities, the local NHS and other statutory and voluntary sector partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing[5]

The living well, ageing well and dying well profiles

The living well, aging well and dying well profiles form the third, fourth and fifth chapters respectively of the Havering JSNA, an addition to the demography and starting well profiles published in 2024.[6] It is part of a series of needs assessments which align with the life-course approach taken in the NHS Long Term Plan for Starting Well, Living Well, Ageing Well and Dying Well.[7] It also reflects how the Local Authority and Place Based Partnership organises their work to support local residents, focusing on getting the best outcomes for people over their lifetimes by addressing identified needs and inequalities.
This profile, describes both the assets that we have locally to promote and support the health and wellbeing of families, and the needs of communities, areas or groups of people where we need to target with our limited resources.

The data and insight presented here follows a life-course approach (living well, ageing well and dying well) and includes an in-depth analysis of how key indicators associated with the four pillars of population health namely; The Wider Determinants of Health, Health Behaviours and Lifestyles, The Places and Communities We Live In and an Integrated Health and Care System and how they impact on the wellbeing of our residents.[8] Key data used in these profiles can also be accessed via Havering's interactive JSNA mapping tool and dashboard available at Local Insight (haveirng.communityinsight.org). Some specific indicators where data is

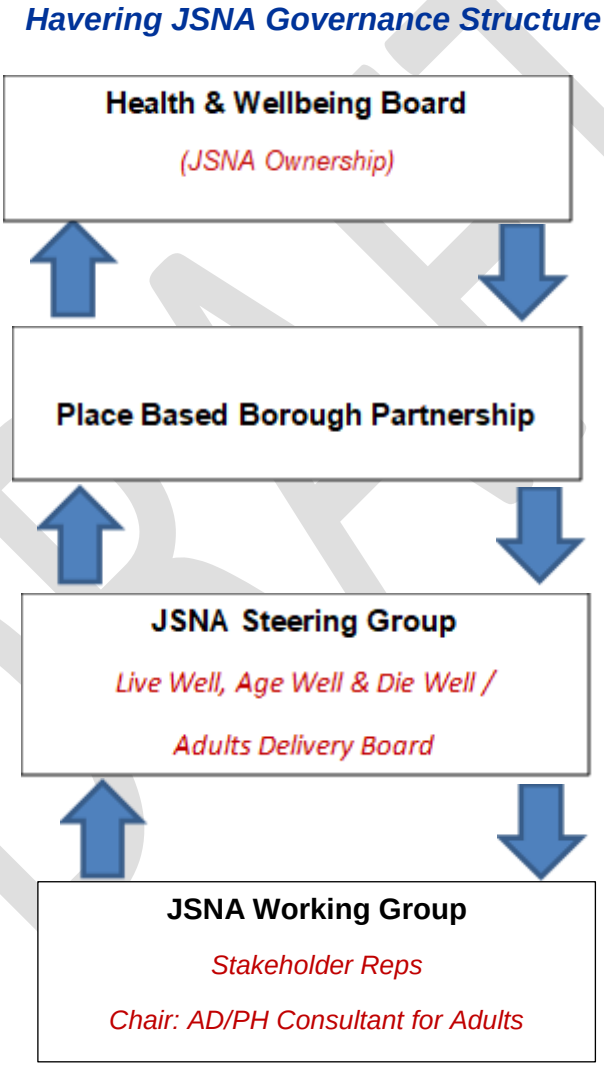
[4] https://assets.publishing.service.gov.uk/media/6304e6fdd3bf7f3664b65b35/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf
[5] https://assets.publishing.service.gov.uk/media/5a7b88cced915d131105fdff/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf
[6] https://havering.localinsight.org/#/view-custom-pages?page-id=98
[7] https://www.england.nhs.uk/wp-content/uploads/2022/07/nhs-long-term-plan-version-1.2.pdf
[8] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/population-health-approach?gad_source=1&gclid=EAIaIQobChMI7vWn3-6GiwMV75VQBh2xOhaREAAYASAAEgJ-ufD_BwE

available on local insight have also been directly linked and can be accessed by clicking on the hyperlink (underlined teal text).

Governance

As a strategic needs assessment, the indicators chosen represent the local intelligence drawn from a range of partners, both statutory and voluntary sector. Their valuable contribution has offered a unique perspective on what the data means in practice for service providers, allowing us to highlight the assets we have as a borough, but also identifying where the gaps are. This work is overseen by the Adult Delivery Board sub-group of the Havering Borough Place Based Partnership, who in turn report to the Havering Health and Wellbeing Board (Figure 1).

Figure 1: Live Well Age Well and Die Well JSNA Governance Arrangements



Recommendations

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

Acknowledgments

We wish to thank everyone who has contributed to the assessment and drafting of the Havering 2025 JSNA. This includes members of the core working group, adults delivery board and associated colleagues whose feedback and valuable insight was critical in the development of these profiles.

Core Working Group

Name	Position & Organisation	JSNA Role
Tha Han	Assistant Director of Public Health, LBH	Chair and Lead author
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Anthony Wakhisi	Public Health Principal, LBH	Project manager, co-author, lead analyst, final report editing, formatting and publication

2. The Havering Population Estimates & Growth

The Havering resident population is currently estimated to be 268,145[9]. This represents a significant rise in the last 5 years of 8,916 people (3.4%) from 259, 229 in mid-2018. The largest proportion of the change (58%) has been attributed to international net migration (5, 201 people). The population age structure has not significantly changed. The mid-23 ONS estimates show children aged 0-15 are 20.4% (54,500), people aged 16 -64 are 62% (166,241) and persons aged 65 and over are 17.6% (47,104) of the total population.

The over 65 population remains higher than the London average (12.2%) but slightly lower than the England average (18.7%). All things being equal, the size and age structure of the population are the most direct drivers of need for health and care services. The type and quantity of health and care services varies with age and is generally higher in the early years and very much higher in old age.

According to the Greater London Authority (GLA), housing led model Havering's population is projected to increase from 272,853 in 2025 to:

- 277,852 in 2030 (1.8%)
- 277,284 in 2035 (1.6%)
- 279,425 in 2040 (2.4%)

It is projected the very elderly cohort (65 and over), with the most complex health and social care needs will see the greatest growth (Table 1).

Table 1: Projected percentage population change by age group from 2025 to 2040

	Population	Percentage change from 2025 to 2040		
Age band	**2025**	**2030**	**2035**	**2040**
0-4	15,987	-2.3	-6.0	-5.6
5-10	21,102	-9.0	-13.2	-14.9
11-17	24,023	2.0	-6.2	-11.4
18-24	20,185	7.1	6.8	1.6
25-64	143,060	1.0	0.6	2.0
65-84	41,550	9.1	14.1	19.5
85+	6,946	3.2	23.1	30.5

Data source: GLA 2022-based Demographic Projections Housing-led Model

A detailed Havering demographic profile is available at:

https://havering.localinsight.org/#/view-custom-pages?page-id=98

[9] Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland - Office for National Statistics

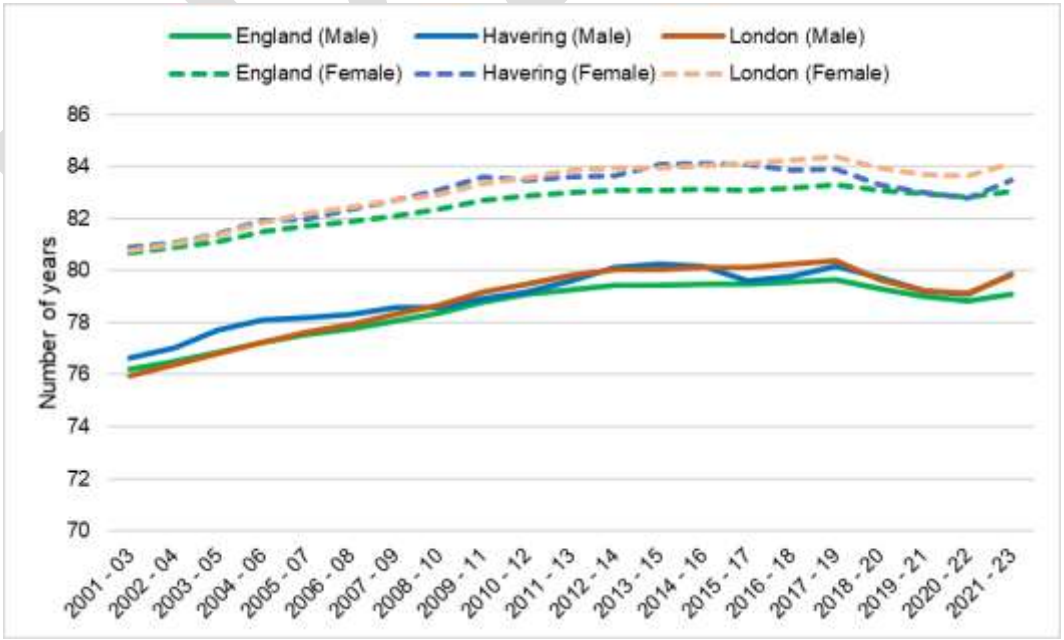
3. Health Outcomes

3.1 Life Expectancy

Over the past 100 years substantial increases in life expectancy at birth in the UK have resulted from improvements to sanitation, nutrition and hygiene, mass immunisation against infectious disease and other advances in medical science. In more recent years the rate of increase in life expectancy has been slowing down (even dipping slightly since 2017). Nationally, female life expectancy at birth has increased by almost 6 years over the last four decades (from 76.8 years in 1980-81 to 82.6 years in 2020-2022), and male life expectancy at birth by almost 8 years (from 70.8 years in 1980-81 to 78.6 years in 2020-2022)[10]. A similar picture has been seen in Havering and London as a whole (Figure 2).

Whilst there is likely scope to increase life expectancy further, it is generally accepted that there is a biological limit to the length of the human lifespan. Given the radical improvements over the last century and the plateauing of life expectancy at birth seen in recent years, now is the time to refocus and critically examine the quality of life, and how to improve it, not just the quantity of time a person lives. Increasing healthy life expectancy represents an area where improvements can be made – for example females live on average almost 20 years of life in poor health.

Figure 2: Female and male life expectancy at birth, Havering, London & England, 2001-03 to 2021-23.



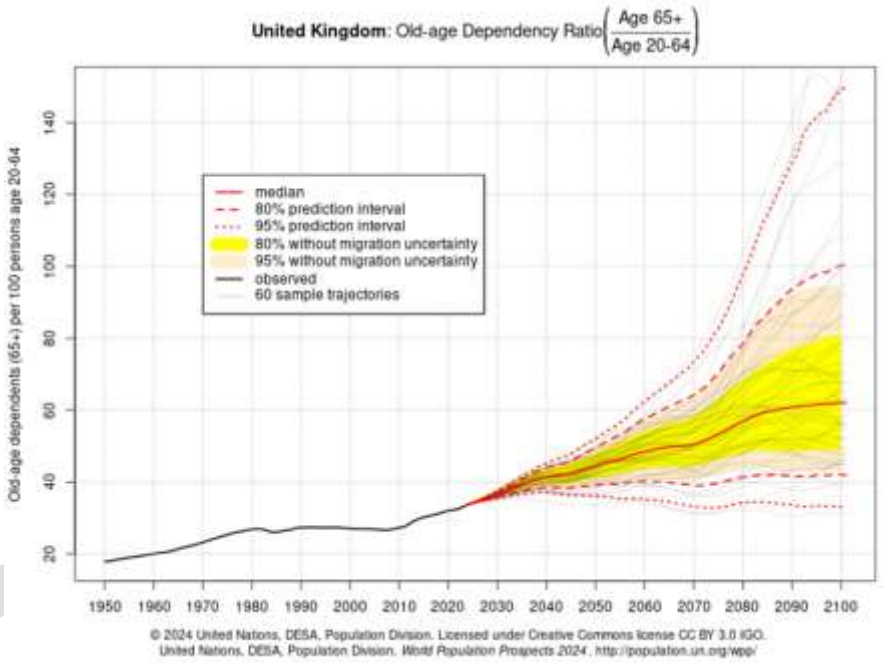
Data Source: Office for National Statistics11 , Produced by LBH Public Health Intelligence

[10] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2020to2022

[11] www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/lifeexpectancyforlocalareasoftheuk/between2001to2003and2021to2023

Not only would increasing the proportion of life lived in good health be beneficial to each individual, but it would also benefit society as a whole. In the future the average age of the UK population is predicted to continue to increase, along with the ratio of older people compared to those of working age[12]. In 2024 there were an estimated 34 people aged 65 and over for every 100 people of "working age" (20-64 years), a proportion that has been steadily increasing over time and is predicted to continue to increase in the future (Figure 3). The spend on healthcare in the UK is increasing enormously, almost entirely driven by the ageing population. Reducing the number of years lived in ill-health (by increasing healthy life expectancy) would help to slow the increase in the health and social care needs of the ageing population.

Figure 3: Old-age dependency ratio over time for the United Kingdom.



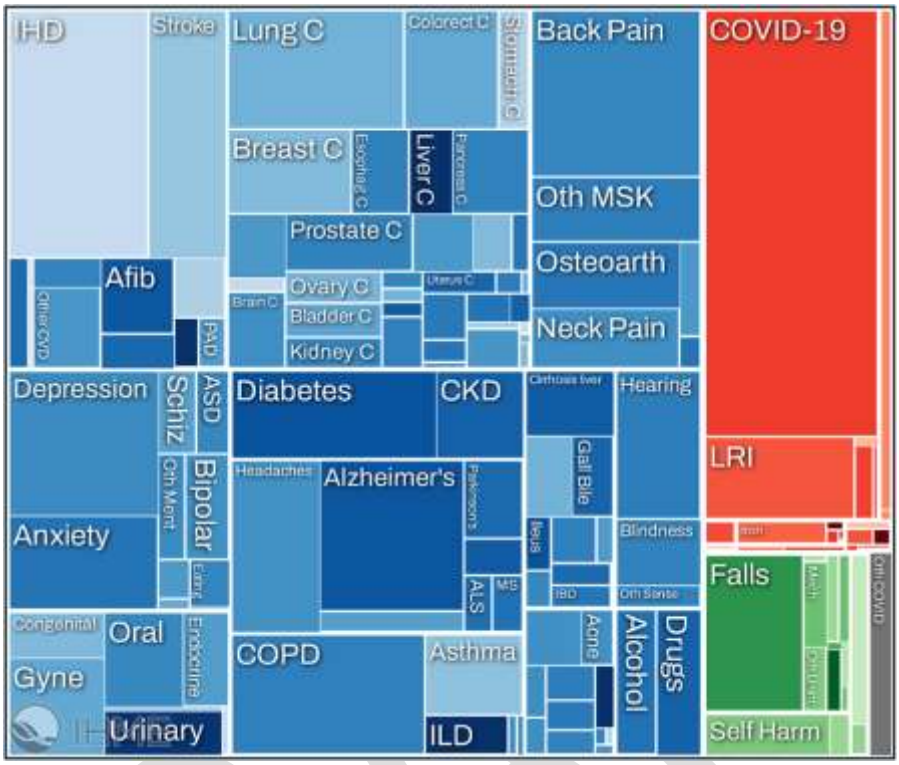
Source: United Nations https://population.un.org/wpp/graphs

3.2 Healthy Life Expectancy

Healthy life expectancy is defined by the years of life lived in good health and without disability. The two main units of measurement that enable us to take into account quality of life are the quality adjusted life year (QALY) and the disability adjusted life year (DALY). Non-communicable diseases make up approximately 79% of the burden of disease experienced by Havering residents (Figure 4); the largest contributors of non-communicable disease being neoplasms (17% of the burden of DALYs), cardiovascular disease (12% of the burden of DALYs) and musculoskeletal disorders (9% of the burden of DALYs)[13]. This is similar to the pattern of disease seen nationally, and all three of these disease areas are amenable to improvement through prevention efforts.

[12] https://population.un.org/wpp/graphs
[13] https://vizhub.healthdata.org/gbd-compare/

Figure 4: Representation of the proportion of different diseases (burden of disease) in Disability Adjusted Life Years (DALY) for Havering (both sexes, all ages; 2021).



Source: Institute for Health Metrics and Evaluation www.healthdata.org

In Havering 6.3% of the residents meet the Equality Act definition of Disabled where their day to day activities are "limited a lot". This is in comparison to 5.8% London average and 7.3% of people nationally. In 2021, there were 570 per 100,000 people aged 65 and over in Havering who were permanent residents in nursing/care homes; higher than both London (377) and England (506). Both support for those living with a disability and prevention of disability where possible are therefore important areas of consideration locally.

3.3 Inequalities in life expectancy and healthy life expectancy

Gender

As can be seen by the differences in females and males shown in figure 2, life expectancy at birth is not equally distributed, nor is healthy life expectancy. Whilst females have a longer life expectancy, national data shows that disability-free life expectancy is similar for both sexes (women, 61.9 years; men, 61.5 years) indicating that women live for more years in a state of ill-health than their male counterparts. In Havering, as is seen nationally, healthy life expectancy at birth has been declining over the past 10 years (women, 61.1 years, men, 61.8 years).[14]

[14] www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/between2011to2013and2021to2023

Ethnicity

Experimental analysis performed by the Office for National Statistics in 2021 on pre-COVID19 pandemic data (2011 – 2014) details differences in life expectancy by self-reported ethnic group[15]. The largest differences in life expectancy between females and males were seen in those of Bangladeshi ethnicity (women live 6.2 years longer) and black African ethnicity (women live 5.1 years longer).

This difference in life expectancy by ethnicity is accompanied by differences in the proportions of different causes of death, and is likely a result of the interplay of a number of complex contributing factors including historical migration patterns, socioeconomic composition of the groups, health-related behaviours, and clinical and biological factors. As the demographics of the local population changes, it will likely become increasingly important in the future to explore differences in health outcomes by ethnicity.

Geography

As is shown in Figure 3, it is predicted that the ratio of older people to those of working age will continue to increase nationally. There is geographical variation within each country by geographical area; areas outside/on the periphery of big cities see an even larger proportion of older adults. This can be seen in Havering, an outer London Borough. Whilst the London region has the highest healthy life expectancy in the country (females, 64.0 years; males, 63.9 years), the healthy life expectancy for a female born in Havering is nearly three years shorter than the London regional average, and for men just over 2 years less than the London average[16].

Additionally, life expectancy is correlated closely with deprivation, where the most disadvantaged areas have a higher rate of deaths amongst those aged under 75 compared to more advantaged areas. There is a concentration of ill-health in places where geographical differences and poverty in older age overlap, for example in disadvantaged coastal areas such as Blackpool, where there is both the lowest overall life expectancy (73.1 years) and the lowest healthy life expectancy at birth (51.7 years) in the country for men[17]. It is therefore likely that areas of our borough with a higher proportion of older people and more socioeconomic disadvantage are home to those with the shortest healthy life expectancy.

3.4 Prevention

The overall aim of Public Health is to protect and improve the health of the population. It is unrealistic that the need for health and social care services can be prevented entirely, however success in Public Health efforts would see ill-health reduced or delayed as long as possible (compressed morbidity). Prevention is the cornerstone of Public Health and extends far

[15] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/articles/ethnicdifferencesinlifeexpectancyandmortalityfromselectedcausesinenglandandwales/2011to2014

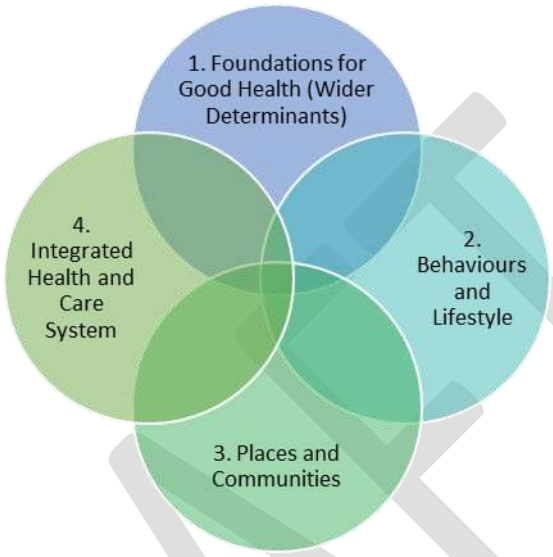
[16] www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/healthstatelifeexpectancyallagesuk

[17] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/between2011to2013and2021to2023

upstream of health and care services including; the foundations for good health ("wider determinants of health"), behaviours and lifestyle, places and communities as well as an integrated health and care system (Figure 5).

Each of the four pillars of public health are expanded on below, and are detailed further throughout the Joint Strategic Needs Assessment.

Figure 5: The four pillars of public health; each contributing to the health outcomes of the population as part of an interconnected system.



Source: Adapted from The Kings Fund, www.kingsfund.org.uk/insight-and-analysis/reports/vision-population-health#what-needs-to-change?

3.4.1 Foundations of Good Health – The "Wider Determinants of Health"

The wider determinants of health are non-medical elements that affect the conditions in which people live (Figure 6), and are the most important contributor to health outcomes; including life expectancy and healthy life-expectancy. The unequal distribution of these assets for good health is interlinked with socioeconomic determinants including gender, ethnicity and economic disadvantage, and is directly influenced by the local, national and international distribution of power.

The local data and impact of the wider determinants on health outcomes is further discussed in all chapters.

Figure 6: The non-medical foundations for good health (wider determinants of health) that influence how people live their lives and the health outcomes experienced by individuals. The distribution of the building blocks for good health are determined by the local, national and international distribution of power.

Source: Background image generated using AI.

3.4.2 Health Behaviours and Lifestyle

The second most influential element for health outcomes is the behaviours and lifestyle of the population (Figure 7). Improvement to health outcomes (length and quality of life) and reduction of health inequalities can be achieved through the promotion and maintenance of healthier behaviours and lifestyle.

Figure 7: Behaviours and lifestyle that impact health outcomes along with the areas of measurement for assessing the impact of behaviours on the population.

Reduction in the rate of smoking over the past 70 years has significantly contributed to the increase in life expectancy observed. However, there is still progress to be made; helping those who already use tobacco products to stop, and preventing a new generation from ever initiating the behaviour. Chapter 4.4.2 details the needs of the population of Havering regarding tobacco-related harm, along with recommendations to further reduce tobacco use and tobacco-related harm.

Misuse of substances including drugs and alcohol is associated with several diseases and poorer health outcomes. As with other health behaviours drug and alcohol misuse is unequally distributed amongst the population; with a higher burden occurring in more deprived areas. The local needs and recommendations are detailed in Chapter 4.4.3.

The prevalence of excess weight in the population globally, nationally and locally is currently a substantial cause of harm to health outcomes; details of the impact of diet and exercise on our local population and recommendations for improvement can be found in Chapter 4.4.1.

3.4.3 The Places and Communities We Live In

The role of the place and communities in which we live on the health and wellbeing of the population is becoming increasingly recognised. A community is a group of people joined together by a common interest, characteristics or experience. There is strong evidence of the impact of social relationships and community networks on health outcomes including mental health and wellbeing, as well as the role of social "norms" and the local environment relating to lifestyle and health behaviours (Figure 8).

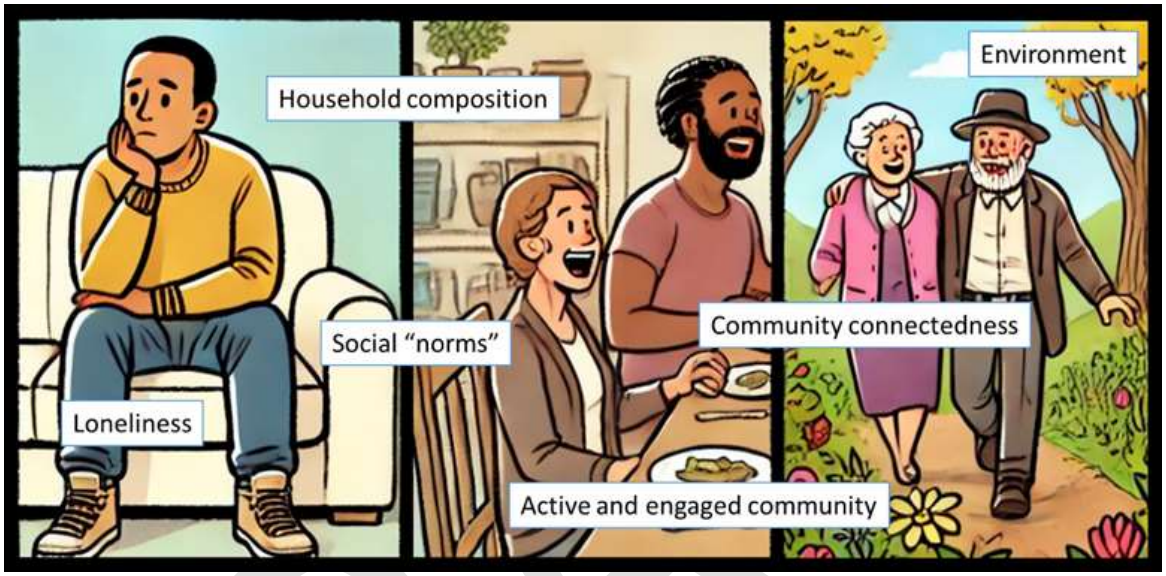
Havering is ranked near to the National average regarding an Active and Engaged Community (14,510/33,755)[18], however has a higher score than the National average in the Loneliness

[18] Oxford Consultants for Social Inclusion (OCSI) and Local Trust, 2023

Index (Havering, 1.22; England 0.07)[19]. This varies across Havering, where those in Romford South are predicted to have the highest levels of loneliness in the Borough (4.09) compared to those in Collier Row and Park Farm where there is the lowest level in Havering (-0.84).

Further local data and recommendations are detailed in Chapters 4.3.2 Healthy Places; 4.3.4 Social Connectivity and 4.3.5 “Specific” Communities.

Figure 8: The role of Place and Community in health outcomes.



Source: Background image generated using AI.

3.4.4 An Integrated Health and Care System

The benefit of a better integrated health and care system has long been recognised, and more recently been explicitly focused upon. By 2035 it is predicted that two thirds of adults over 65 will be living with multiple health conditions[20]. This growing number of people living with multiple long-term conditions (resulting from accumulation of conditions throughout a longer life time) further highlights the need to ensure that care pathways are joined up and optimised in order to meet the rising needs of the ageing population and prevent frequent use of secondary care/readmission for conditions or needs that could be prevented or better met in the community setting.

Locally, Havering are amongst the worst quartile of local authorities nationally for emergency admissions within 30 days of discharge from hospital (18.7%; compared to a London average of 14.8% and a National average of 14.8%; 9)[21].

Another indication that there are improvements to be made regarding better integration of the health and care system is Emergency admissions for acute conditions that should not usually require hospitalisation. These are thought to be admissions that could have been avoided if the patient had been better managed outside of hospital[22]. The rate of such admissions was

[19] Loneliness Index, Office for National Statistics' (2019)

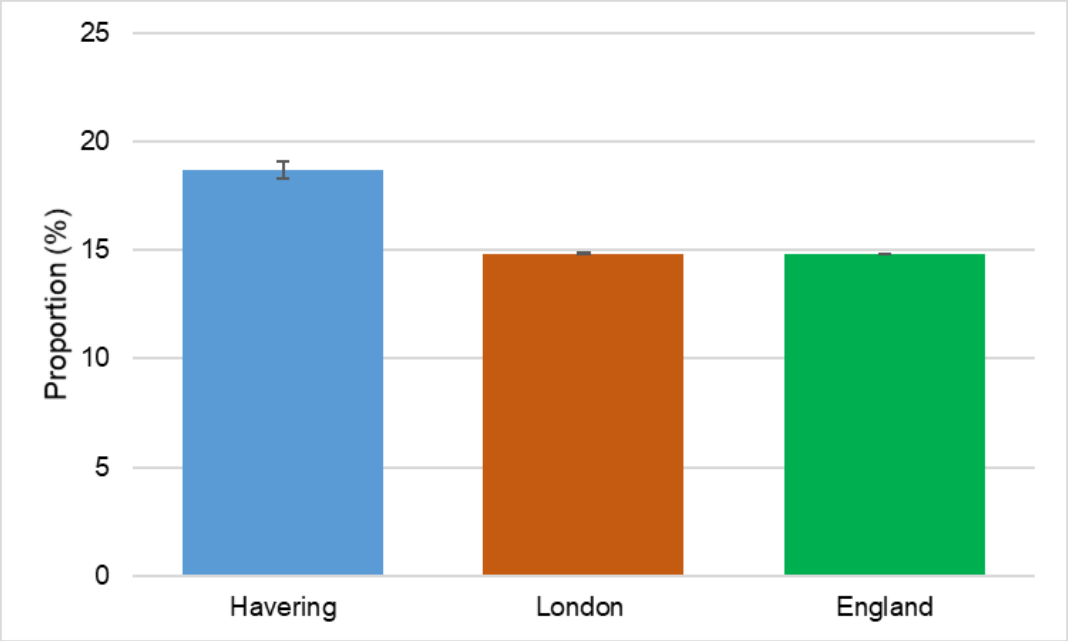
[20] https://evidence.nihr.ac.uk/alert/multi-morbidity-predicted-to-increase-in-the-uk-over-the-next-20-years/

[21] https://fingertips.phe.org.uk/search/within%2030%20days%20of%20discharge

[22] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework

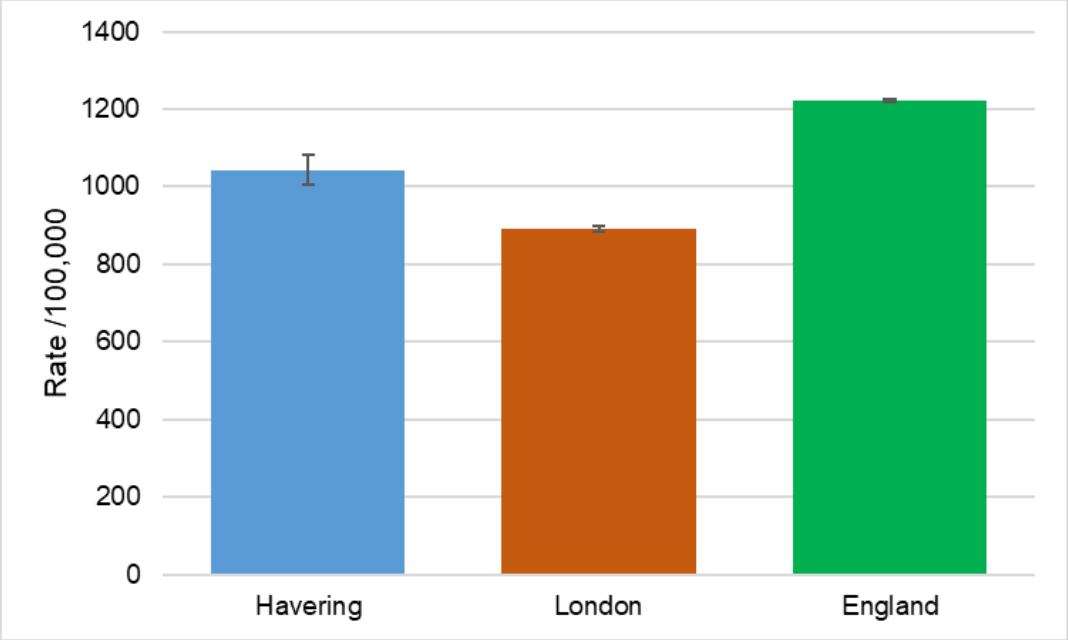
higher for Havering (1,043/100,000) than the London average (891/100,000) but lower than the England average (1,223/100,000) (10).

Figure 9: Emergency readmissions to hospital within 30 days of discharge, Havering, London and England, 2023/24.



Data Source: NHS Outcomes Framework, NHS England, 2023/24. Produced by LBH Public Health Intelligence

Figure 10: Emergency hospital admissions that could have been avoided if the patient had been better managed outside of hospital, Havering, London and England, 2022/23.



Data Source: NHS Outcomes Framework, NHS England, 2022/23. Produced by LBH Public Health Intelligence

Further details of the wider health and care system and the impact on the health outcomes of the Havering population is detailed in chapter 5.6.

When focussing on any one of the specific health needs of the local population, especially through prevention activities, it is crucial to consider the four pillars detailed above, and importantly how they interconnect, in order to implement both successful and sustainable long-term change.

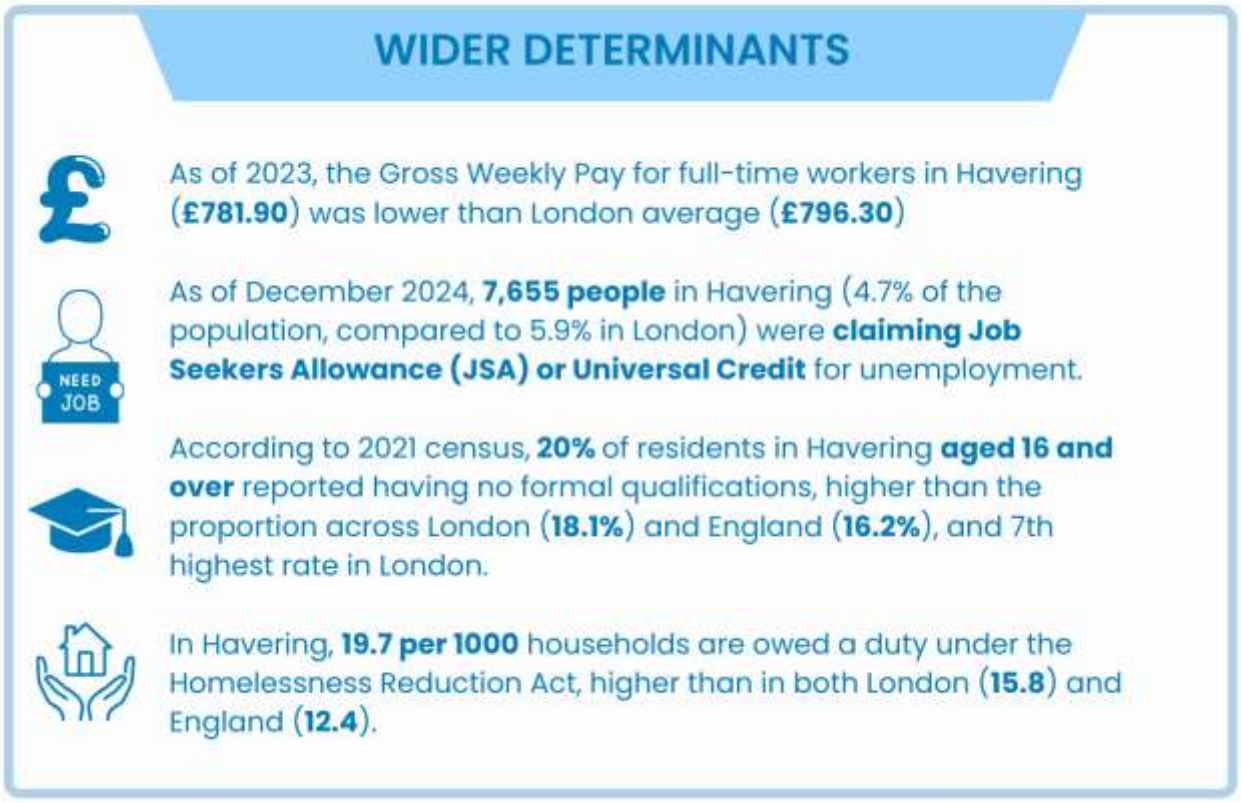



Living Well

4. Living Well

4.1 Infographic Summary

Wider Determinants of Health



PLACES AND COMMUNITIES

Domestic abuse in Havering has seen a steady increase over the past 3 years (668 per quarter in 2021 to 746 per quarter in 2022) and now constitutes **14% of reported crime**. This is the only crime type in Havering reported to reach a rate (34.5/1,000) similar to London average (34.5/1,000).

In 2024, Havering earned a combined score of **1.97** out of **10** in the overall **Healthy Street Score Card Assessment**- the **fifth lowest** in London.

In 2022, it was estimated that the equivalent of **6.4% of all-cause deaths** amongst adults aged 30 and over in Havering could have been attributable to exposure to **PM2.5 air pollution**.

In 2021/22, the number of premises licensed to sell **alcohol per square km in Havering** (**5.2**) was higher than England average (**1.3 per square km**), but significantly below the London average (**13.7 per square km**)

Havering's resident **digital exclusion risk index (2.8)** is slightly higher than the London average (**2.7**).

In 2021, Havering had the highest age standardised proportion (ASP) of residents providing **unpaid care** (**8.7%, 20,637 residents**) among all local authorities in London (**London average, 7.8%**).

In Havering, 2% of the population identify with one of the **LGBTQ+** orientations.

3,645 residents in Havering previously served in UK regular **armed forces** and **1,243** in UK reserve armed forces.

LIFESTYLE & BEHAVIOURS

In 2022/23, based on the latest Sport England Survey data from OHID, **65.8% of adults in Havering (18+)** were classified as **overweight or obese** using self-reported height and weight. This is in line with the **England average** (**64%**)

Havering had one of the highest proportions of respondents reporting being **physically inactive, at 27.9%**, higher than both London (**22.9%**) and England (**22.3%**) averages

Havering's adult **smoking prevalence** over the latest 3-year period (2021 to 2023) was **12.4%**, similar to London (**11.6%**) and England (**12.4%**) averages.

In 2023/24, the percentage of **pregnant women smoking** at time of delivery in Havering was **3.7%**, similar to London average (**3.9%**), but lower than the England average (**7.4%**)

The latest data (2023) shows that for every 100,000 deaths in Havering, **36 are related to alcohol**. This death rate is similar to the London (**34/100,000**) and England (**41/100,000**) averages

Number of Havering residents in treatment for **substance misuse** has increased from **528 in 2020/2021** to **1,093 in 2024**. This was facilitated by offering additional capacity using a supplementary grant which will end in April 2025

INTEGRATED HEALTH & SOCIAL CARE

During the 2021-23 period, the under 75 mortality rate from **all cancers** in **Havering** (**116/100,000**) was higher than London average (**110/100,000**) but lower than England average (122). Under 75 mortality rate for **colorectal cancer** in Havering over the same period (12.1/100,000) was higher than both London (10.5/100,000) and England (11.9/100,000) averages

It is estimated that **5,265 residents** in Havering could be having **diabetes** without knowing it. Around **14,000 residents** currently do not know they have hypertension and therefore cannot seek help to stop the consequences

In 2023/24, the number of adults who were registered to a GP practice in Havering and had **depression or anxiety disorder** was **17%** (**49,665**)

According to GP records, **0.8%** of the Havering adult population (**2,073**) have a **Severe Mental Illness (SMI).**

In 2023/24, **1,368 Havering** residents aged 18-64 received a total of **2,043 care packages** support from Havering Adult Social Care

4.2 Key Findings and Recommendations

Key findings

Wider Determinants of Health

- In 2023, the **Gross Weekly Pay** for full-time workers in Havering (£781.90) was lower than London average (£796.30).
- As of December 2024, 7,655 people in Havering (4.7% of the population, compared to 5.9% in London) were claiming **Job Seekers Allowance** (JSA) or Universal Credit for unemployment.
- In 2021/22, Havering's **long-term unemployment** rate (1.8 per 1,000 working age population, 294 people) was similar to the London average (1.9 per 1,000).
- According to 2021 census, 20% of Havering residents aged 16 years and over reported having **no formal qualifications**, higher than the proportion across London and England, and 7th highest rate in London.
- The proportion of Havering's population with **level 4 qualifications or above** (29.5%) is below the London (46.7%) and England (33.9%) averages.
- In Havering, 19.7 per 1,000 households are **owed a duty under the Homelessness Reduction Act,** higher than both the London (15.8 per 1,000) and England (12.4 per 1,000) averages.

Places & Communities

- **Domestic abuse** (DA) in Havering has seen a steady increase over the past 3 years (668 per quarter in 2021 to 746 per quarter in 2022) and now constitutes 14% of reported crime. This is the only crime type in Havering reported to have reached a rate of 34.5/1,000, similar to London average (34.5/1,000).
- In 2021/22, Havering's **re-offending** rate among adults was 19.2%, lower than London (23.3%) and England (25.0%) averages.
- In 2024, Havering earned a combined score of 1.97 out of 10 in the overall **Healthy Street Scorecard** assessment- the fifth lowest in London.
- In 2022, it was estimated that the equivalent of 6.4% of all-cause deaths amongst adults aged 30 and over in Havering were attributable to exposure to PM2.5 **air pollution**.
- In 2021/22, the number of **premises licensed to sell alcohol** per square km in Havering (5.2) was higher than England average (1.26 per km^2), but significantly below the London average (13.7 per km^2)
- The **digital exclusion risk** index for Havering residents (2.8) is slightly higher than the London average (2.7).
- Havering had the highest age standardised proportion (ASP) of residents providing **unpaid care** (8.7%, 20,637 residents) among all local authorities in London (London average - 7.8%) in 2021.
- The percentage of adult **carers** (65 years and over) who have as much **social contact** as they would like (22.7%) is lower than both London (27.7%) and England (28.8%) averages.
- In Havering, 2% of the population identify with one of the **LGBTQ+** orientations.
- 3,645 residents in Havering previously served in UK regular armed forces and 1,243 in UK reserve armed forces.

Lifestyle & Behaviours

- In 2022/23, based on the latest Sport England Survey data from OHID, 65.8% of adults in Havering (18+) were classified as **overweight or obese** using self-reported height and weight. This is in line with the England average (64%).
- Over the same period, Havering had one of the highest proportions of respondents reporting being **physically inactive**, at 27.9%, higher than both London (22.9%) and England (22.3%) averages.
- Havering's adult **smoking** prevalence over the most recent 3-year period (2021 to 2023) was 12.4%, similar to London (11.6%) and England (12.4%) averages.
- In 2023/24, the percentage of pregnant women smoking at time of delivery in Havering was 3.7%, similar to London average (3.9%), but lower than the England average (7.4%).
- The latest data (2023) shows that for every 100,000 deaths in Havering, 36 are related to **alcohol**. This death rate is similar to the London (34/100,000) and England (41/100,000) averages.
- Number of Havering residents in **treatment for substance misuse** has increased from 528 in 2020/2021 to 1,093 in Q2 2024. This was facilitated by offering additional capacity using a supplementary grant which will end in April 2025.
- Currently there are more than 400 patients (75 under CAHMS) in mental health care who have **co-occurring substance misuse** problem (aka Dual Diagnosis).
- **Prenatal vaccine coverage** in Havering has fallen in recent years, in the context of a national increase in pertussis (whooping cough) cases.

Integrated Health & Social Care

- During the 2021-23 period, the **under 75 mortality rate from all cancers** in Havering (116/100,000) was higher than London average (110 /100,000) but lower than England average (122/100,000). Under 75 mortality rate for colorectal cancer in Havering over the same period (12.1/100,000) was higher than both London (10.5/100,000) and England (11.9/100,000) averages.
- It is estimated that 5,265 residents could be having **diabetes** without knowing it. Around 14,000 residents currently do not know they have **hypertension** and there cannot seek help to stop the consequences.
- In 2023/24, the number of adults who were registered to a GP practice in Havering and had **depression or anxiety** disorder was 17% (49,665).
- According to GP records, 0.8% of the Havering adult population (2,073) have a **Severe Mental Illness** (SMI).
- In 2023/24, 1,368 Havering residents aged 18-64 received a total of 2,043 care packages support from Havering **Adult Social Care**

Recommendations

- Members and partners of the Havering HWB to endorse and support the implementation of the Havering Poverty Reduction strategy 2024.
- System partners to seek to maximise training and employment offer for local residents delivered as part of contract social value, through a standardised approach to considering this within procurement processes.
- Havering Council to explore and quantify any opportunities arising from the proposed amendments to the National Planning Policy Framework that will enable additional housing schemes that meet local need to be brought forward, including those arising through proposed changes to utilisation and definition of brownfield and grey belt land.

- Front line staff of the services including primary care should be offered Domestic Abuse Awareness training. Health Partners should consider how they can improve data sharing in relation to violence and domestic abuse
- As part of supporting a diverse local retail offer, Havering Council should consider any opportunities for further policies (including the new Local Plan) that may prevent further proliferation of hot food takeaways, alcohol-licensed premises, and other retail premises with negative health and wellbeing impacts, particularly in areas of highest deprivation.
- Using the Healthy Streets Scorecard as a starting point, the council should continue to bring forward proposals to implement and expand recommended measures and other complementary activities to improve road safety, increase active travel/modal shift and improve air quality.
- All partners to take steps to support efforts to encourage and facilitate modal shift, to support local ambitions to see 65% of trips in the borough being undertaken by active travel or public transport by 2041.
- In line with Havering Carers Strategy, HWB members are urged to continue efforts to increase identification of carers to ensure they can access available support.
- Prevention interventions and health and care services must be culturally sensitive to ensure equitable access and reduce health inequalities.
- The Council and NHS work with stakeholders, including residents, to implement a Borough-level place-based whole systems approach for tackling obesity in the borough, and an action plan that addresses the multiple causes of obesity, as well as providing support for those who are looking to lose weight. The aim should be to reshape the places where people live, work and play so that these places become health-promoting environments.
- Public Health to expand service provision ensuring availability of a full range of behavioural interventions and cessation aids, including vapes.
- Public Health to work with educational establishments and young people to raise awareness of harm from tobacco and vapes.
- With the support of the Planning, Community Safety Partnership, Combating Drugs Partnership and regional partners continue to implement project Adder and other areas to reduce substance misuse supply.
- ICB and Primary Care partners to identify feasible opportunities to increase vaccine coverage within primary care, secondary care and maternity services.
- NHS England, NEL Cancer Alliance and Havering GPs continue to improve cancer screening coverage, reduce health inequalities by improving access to those with Severe Mental Illness or Learning Disability.
- NEL Cancer Alliance to improve early diagnosis through further improving screening coverage, raising awareness of cancers with highest numbers of late diagnosis among the residents (lung, colorectal, upper GI, prostate), working with GPs to review opportunities for early detection and appropriate referrals, and strengthening diagnostic capacity including the use of the RDC (rapid diagnostic clinic) and targeted lung health check.
- Place Long-Term Conditions Group to strengthen the community infrastructure and awareness to improve the detection of hypertension, obesity, atrial fibrillation and prediabetes and to use transformation and innovation (which includes digital health/medical technologies) to speed up diagnosis and management of Long-Term Conditions.
- Place Community Mental Health Board to support individuals with mental health conditions to live, fulfilling, meaningful and healthy lives, and ensure equitable access

to mental health services, and doing so in a timely manner to prevent deterioration of mental health to crisis presentations
- ICB to support implementation of plans developed by the BHR Planned Care Transformation Board to reduce waiting times for planned care.

4.3 Introduction

About 60% of Havering's population is aged 18-64 years, and are considered to fall within the 'Living well' phase of the life-course. This is the life course phase in which people spend the majority of their lives, having been fundamentally shaped by the health, experiences and outcomes of the Starting well phase (covering early years, childhood and adolescence). An adult's experience of the Living well phase in turn plays a significant role in determining their health and wellbeing as they enter into older age, which will have implications for both the length and quality of life.

Given that the Living well phase broadly aligns with what is generally considered to be 'working-age', the health and wellbeing of this cohort also has significant implications for the national productivity. The Living Well chapter reflects on the diverse range of social, economic and environmental factors which can shape health and wellbeing across the full life course – the wider determinant of health. The influences of wider determinants can either be positive (protective) or negative (risk factors), with clustering of positive or negative factors often seen clustered in different areas. While estimates vary about the specific contribution that the wider determinants make to our overall health and wellbeing[23], there is broad consensus that action in these areas has the potential to yield significant improvements in population health. Addressing the conditions in which people are born, live and work will deliver benefits that are felt across the life course.

Improving population health is a shared responsibility; progress also depends on supporting people to live healthier lives. The communities we live and work in and the social networks we belong to influence our health behaviours because there is strong evidence that these social relationships and community networks serve as both physical and mental health assets.[24] Health behaviours and lifestyle are the second most important driver of health. They include smoking, alcohol consumption, diet, exercise, and response to screening programmes and vaccines. For example, while reductions in smoking have been a key factor in rising life expectancy since the 1950s, obesity rates have increased and now pose a significant threat to health outcomes.

Lastly, healthcare and social care play a crucial role in maintaining and improving an individual's health by providing services to prevent, diagnose, and treat illnesses, injuries, diseases and disability. This includes not only treatment but also preventative measures and linking with other aspects of population health so that people live well for longer.

In the sections below, we will summarise key findings about where we are in living well life course and make recommendations for sustaining current positive outcomes and improving further.

[23] https://www.health.org.uk/news-and-comment/blogs/estimate-contribution-healthcare-to-health#:~:text=One%20often%2Dquoted%20study%20from,eg%20whether%20care%20was%20timely).
[24] https://www.kingsfund.org.uk/insight-and-analysis/reports/vision-population-health

4.4 Wider Determinants of Health

Key findings

- As of 2019/20, the estimated net annual **household income** before housing costs in Havering was £35,331, compared to the London average of £37,864.
- The **unemployment rate** (working age population claiming out of work benefit) in Havering was 5% (7,989 people) in 2021/22 which was similar to England average (5.0%), and better than London average (6.5%). The long-term unemployment rate (1.8 per 1,000 working age population, 294 people) was similar to London average (1.9) in 2021/22.
- In 2023, the **Gross Weekly Pay** for full-time workers in Havering (£781.90) was lower than London average (£796.30).
- Havering has one of the largest employment gaps for adults aged 18 to 64 years with **learning disabilities,** with a difference of 80.7% against the employment rate of the general population (2022/23). This compares to 70.5% across London and 70.9% across England.
- 20% of residents in Havering aged 16 years and over reported having no **formal qualifications** in 2021, higher than the London and England averages, and 7th highest rate in London.
- In 2021, the proportion of Havering's population that reported having a **level 4 qualification or above** (29.5%) was below of the London (46.7%) and England (33.9%) averages.
- In 2022/23, 19.7 per 1000 households in Havering were owed a **duty under the Homelessness Reduction Act**, higher than London (15.8) and England (12.4) averages.
- Havering's current estimated **housing supply** between 2023/24 and 2027/28 is anticipated to deliver only 67% of that required.

Recommendations

- The members and partners of Havering HWB to endorse and support the implementation of the Havering Poverty Reduction strategy 2024.
- HWB partners to make service users aware that there are organisations that can support them in accessing benefits and other financial support.
- System partners should increase awareness amongst residents and employers of the Access to Work scheme and other support for people with physical or mental health condition/disability to stay in or return to work.
- System partners should maximise volunteering opportunities for local people (including through new local Giving scheme), and how volunteering roles can be linked into job opportunities.
- Partnership should increase the number of Supported Internship placements, to offer structured work-based programmes for 16-24 year olds with SEND, and promote this scheme to providers and local businesses.
- System partners should seek to maximise training and employment offer for local residents delivered as part of contract social value, through a standardised approach to considering this within procurement processes.
- The Havering council / Planning to explore and quantify any opportunities arising from the proposed amendments to the National Planning Policy Framework that will enable additional housing schemes that meet local need to be brought forward, including those arising through proposed changes to utilisation and definition of brownfield and grey belt land.

4.4.1 Deprivation and Income

Introduction

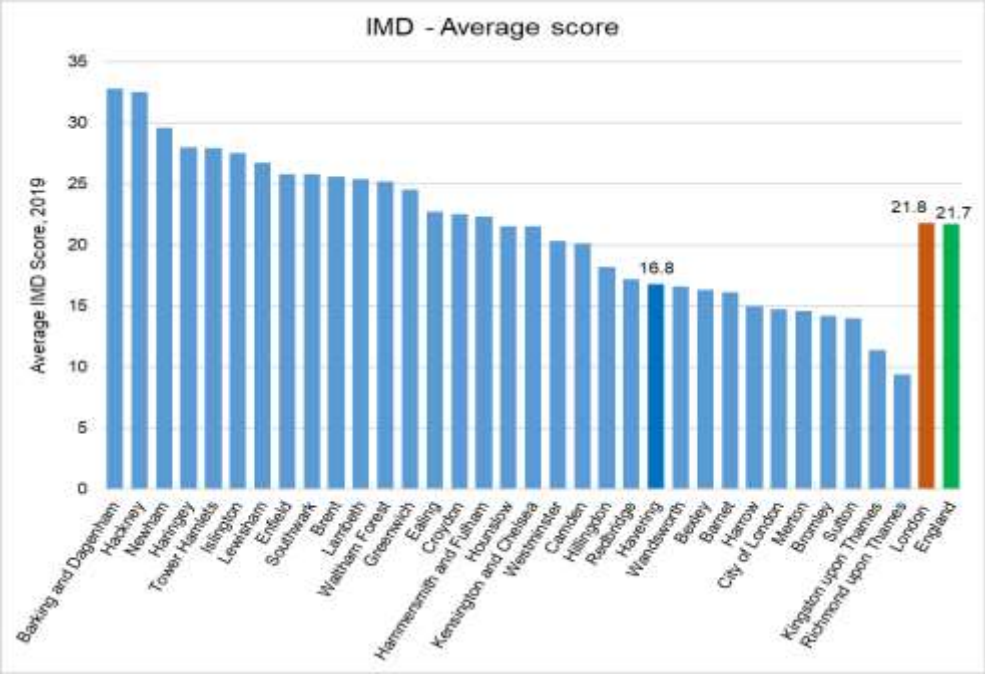
Deprivation describes living conditions where people lack resources – this can mean poverty (lacking income) but includes resources of all kinds, such as access to employment, training and housing. Income affects health in a variety of ways:

- living on a low income is stressful and directly impacts on physical and mental health
- an adequate income enables us to buy health-improving goods and participate more fully in society
- a low income can lead to increased unhealthy behaviours

Findings

The Index of Multiple Deprivation (IMD) is a measure that compares levels of deprivation between different areas across England. Havering overall has a lower deprivation score (16.8) than the London (21.8) and England (21.7) averages (Figure 11).

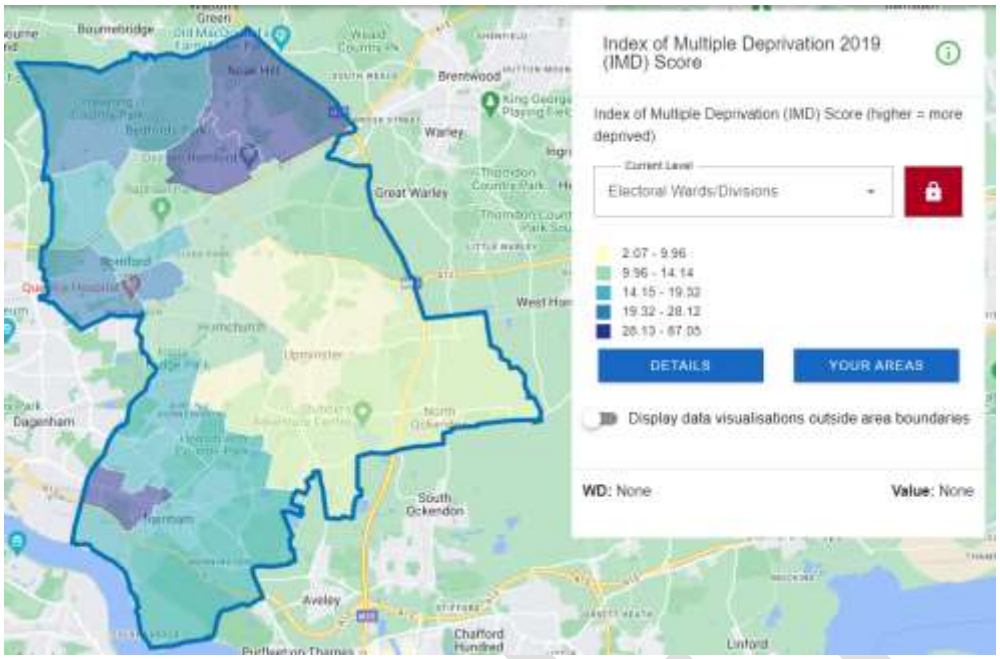
Figure 11: Average IMD (2019) Scores for London boroughs compared with the London and England averages.



Source: Ministry of Housing Communities & Local Government, Produced by LB Havering Public Health Intelligence

Nonetheless, there is a substantial variation in deprivation levels across the borough, with small areas in the north and along the western boundary being significantly more deprived (Figure 12).

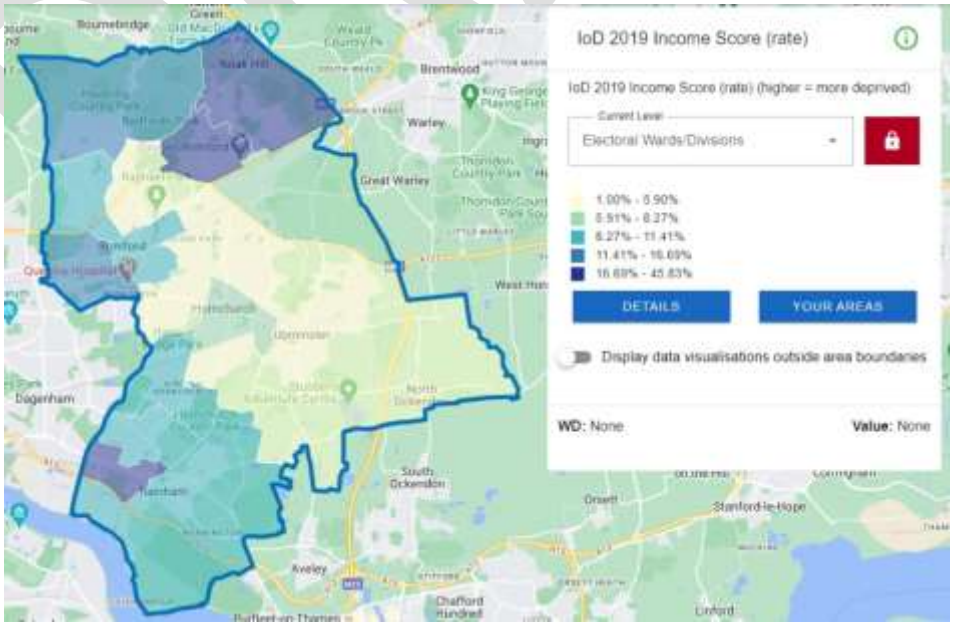
Figure 12: Map of Havering showing IMD (2019) scores by electoral ward.



Source: Ministry of Housing Communities & Local Government, Havering Local Insight.

As of 2019/20 net annual household income estimate before housing costs in Havering was £35,331, compared to £37,864 in London and £32,797 in England. Although average pay may be modest by London standards, the proportion of adults in Havering that are income deprived (10.8%) is below the national average (12.9%) and is the 8th lowest of the 32 London boroughs (Figure 13).

Figure 13: Map of Havering showing IoD (2019) Income scores by electoral ward.



Source: Ministry of Housing Communities & Local Government, Havering Local Insight.

The maps above depicting the Index of Multiple Deprivation (IMD) (Figure 12) and Income Score (Figure 13) show that the areas in the north and along the western boundary of the borough have substantially greater need and will need proportionally greater resources, to address inequitable access to services, and reduce inequality in life outcomes, including health inequalities.

Poverty Reduction Strategy[25] was published in Havering in 2024 and the strategy group continues to work to coordinate efforts to reduce poverty across all life courses. Work is also underway to develop and roll out the Joy directory, which will ensure that local people are made aware of and linked into all services that may be of support to them. Alongside this, work is underway to develop a 'Giving Scheme' to bring in much needed funding to the voluntary care sector enterprises, and investment in our communities affected by health inequalities.

Service Gaps / Unmet Needs

National levers such as economic policy, economic growth and funding distribution have overarching impact on local economy and the health of the residents. Cost of living crisis has been a major barrier for health and poverty reduction locally.

Recommendations

- The Havering HWB members and partners to endorse and support the implementation of Poverty Reduction strategy 2024.
- HWB partners to make service users aware that there are organisations that can support them in accessing benefits and other financial support.

4.4.2 Employment

Introduction

Work is of itself good for physical and mental health, and further benefits wellbeing through its association with higher income.[26] Good work is better for health than bad work - work that involves adverse physical conditions, exposure to hazards, a lack of control and unwanted job insecurity. People with poor health and / or disability are at particular risk of disadvantage in all its forms e.g. people living with a long-term condition, mental illness or mental and physical disability, are more likely to be living on a low income, be unemployed or in unsuitable housing putting them at additional risk of further decline.[27]

The ONS estimates that 2.8 million people in the UK aged 16-64 years were economically inactive because of long-term sickness in October to December 2023. While 74% of the general population in England are in employment, only 60% of people with a long-term conditions are in employment and 43% of people reporting a mental illness are in employment.

[25] https://democracy.havering.gov.uk/documents/s73389/9.1%20Poverty%20Reduction%20in%20Havering%20Strategy%20v4.1.pdf
[26] https://assets.publishing.service.gov.uk/media/5a7cd68640f0b6629523c1de/hwwb-is-work-good-for-you-exec-summ.pdf
[27] https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/articles/risingillhealthandeconomicinactivitybecauseoflongtermsicknessuk/2019to2023

Effective action to address such problems can improve health and wellbeing and hence reduce the need for health and social care.

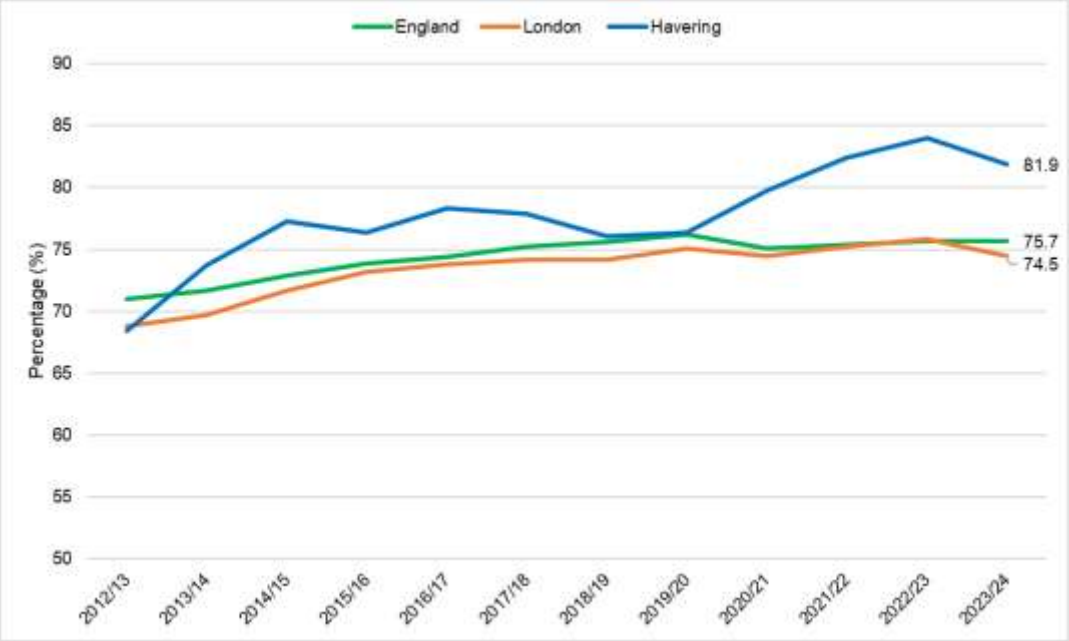
Recent and ongoing changes to the retail sector in favour of online sales and fewer administrative roles as automation and AI reduce staffing levels may alter established patterns of employment and require the acquisition of new skills and expertise.

Findings

- The employment rate in Havering is 81.9% which is above both London (74.5%) and England (75.7%) averages (Figure 14).[28]
- As of December 2024, 7,655 people in Havering (4.7% of the working age population, compared to 5.9% in London) were claiming Job Seekers Allowance (JSA) or Universal Credit for unemployment[27]
- Long-term unemployment rate in Havering (1.8 per 1,000 working age population, 294 people) was similar to London average (1.9) in 2021/22.[27]
- In Havering, 16 to 17 year-olds not in education, employment or training (NEET) was 2.4%, lower than the London (3.4%) and England (5.2%) averages (2022/23).[29]
- In 2022/23, Havering's economic inactivity rate (14.3%) was lower than London (20.8%) and England (21.4%) averages. Nonetheless only 5.8% of 16-64 who were economically inactive in Havering wanted a job as compared to London (16.9%) and England (17.5%) averages.[27]
- Excluding NHS Trusts and the Council, Havering has few large employers – but the number of local businesses, mostly small to medium enterprises (SMEs), grew by 47% in the last 10 years i.e. from 7,050 in 2013 to 10,350 in 2023.
- Gross Weekly Pay for full-time workers in Havering (£781.9) was lower than London average (£796.3) in 2023.[27]
- The percentage of Havering residents in senior official positions (Soc 2020 Group 1-3) is 53.7% which is lower than London average (63.1%) whereas the percentage of administrative and skilled trades occupations (Soc 2020 Groups 4-5) is 25.2%, which is higher than London average (15.1%). Groups 6-9 are similar to London.[27]
- Havering has one of the largest employment gaps for adults aged 18 to 64 years with learning disabilities, with a difference of 80.7% against the employment rate of the general population (2022/23). This compares to 70.5% across London and 70.9% across England.[27]
- The employment gap for adults with a physical or mental long term health condition compared to the general population was reported as 3.5% in 2022/23, compared to 10.2% across London and 10.4% across England.[27]
- The DWP has been providing grants to the Council, NELFT and CGL to improve opportunity for employment of vulnerable people.

[28] https://www.nomisweb.co.uk/
[29] https://fingertips.phe.org.uk/profiles

Figure 14: Percentage of people aged 16 – 64 years in employment in Havering, London and England, 2022/23



Source: NOMIS, Official Census and Labour Market Statistics, Produced by LB Havering Public Health Intelligence

Service Gaps / Unmet Needs

Employment opportunity for those with learning disability could be improved by member organisations depending on the severity of learning disability.

Recommendations

- System partners should increase awareness amongst residents and employers of the Access to Work scheme and other support for people with physical or mental health condition/disability to stay in or return to work.
- System partners should maximise volunteering opportunities for local people (including through new local Giving scheme), and how volunteering roles can be linked into job opportunities.
- System partners should work with Havering Chamber of Commerce to embed volunteering and apprenticeship opportunities across local businesses and identify other ways to support employment and training opportunities for local residents.
- The council and partners should work towards increasing the number of Supported Internship placements, to offer structured work-based programmes for 16-24 year olds with SEND, and promote this scheme to providers and local businesses.
- System partners to seek to maximise training and employment offer for local residents delivered as part of contract social value, through a standardised approach to considering this within procurement processes.
- Councils / NHS providers should work with the DWP to offer residents excluded from employment due to disability and / or ill health including mental illness the opportunity to gain confidence, skills, work experience and ultimately secure employment.
- HWB partners to support Havering Poverty Reduction Strategy and related programmes such as Individual Placement & Support (IPS for Substance Misuse) and increase

opportunity for volunteering, and mitigate social isolation and deskilling of human resources.
- System partners to seek to maximise training and employment offer for local residents delivered as part of contract social value, through a standardised approach to considering this within procurement processes.

4.4.3 Education

Introduction

Educational attainment plays an important role in shaping life-long health and wellbeing outcomes. By influencing opportunities, skills, employment, and earning potential, increasing educational attainment is associated with improved health behaviours and outcome measures such as life expectancy.

The foundations of educational attainment are laid from the early years of life. Early year's development and educational attainment of school-aged children are considered within the Havering Start Well JSNA chapter.

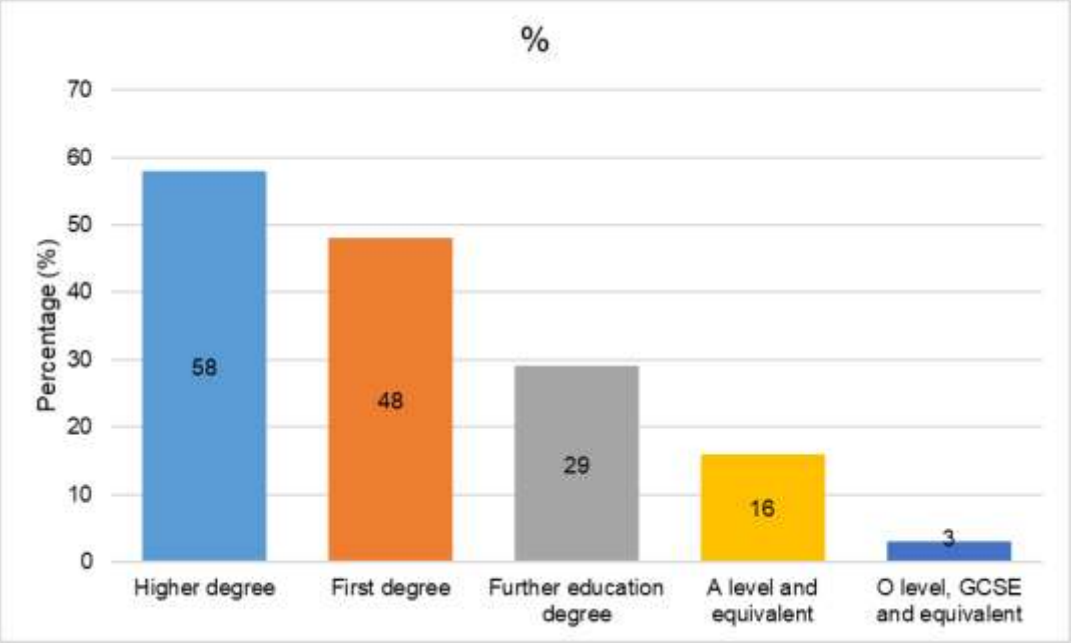
The impact of highest qualification achieved on employment outcomes is measurable from the early stages of people's career – nationally, people aged 20-25 years whose highest qualification is level 2 (GCSE grades 9-4) or lower are more likely to be unemployed than those with higher qualifications[30]. By 29 years old, men who have attended a form of higher education (generally leading to a degree or equivalent qualification) tend to earn 25% more than those with level 2 qualifications, and for women this increases to 50% higher earnings[31]. There is also evidence that such positive impacts on earnings for those with higher qualifications tend to continue across an individual's lifetime[32]. Data suggests that every additional level of qualification achieved contributes to an increase in earning potential, as demonstrated in figure 15 below:

[30] https://www.health.org.uk/reports-and-analysis/briefings/lifelong-learning-and-levelling-up-building-blocks-for-good-health

[31] https://www.gov.uk/government/publications/labour-market-value-of-higher-and-further-education-qualifications-a-summary-report/labour-market-value-of-higher-and-further-education-qualifications-a-summary-report

[32] https://www.gov.uk/government/publications/labour-market-value-of-higher-and-further-education-qualifications-a-summary-report/labour-market-value-of-higher-and-further-education-qualifications-a-summary-report

Figure 15: Percentage differences in hourly earnings of 25- to 29-year-olds, relative to those with lower level (below GCSE or level 1 equivalent), controlling for socio-economic background, sex and age, (UK, 2020-2022)



Source: Social Mobility Commission[33]

Findings

Responses to the 2021 Census indicate that 20% of residents in Havering aged 16+ have no formal qualifications, higher than the proportion across London and England, and 7th highest rate in London[34].

Havering also has higher proportions of residents reporting their highest qualification as level 1 or level 2 (up to GCSE or level 2 NVQ). London has a very high proportion of residents with level 4 qualification or above, reflecting a jobs market that includes a high concentration of high-skilled or graduate positions (tending to require level 6 qualifications or above) compared to other parts of the country[35]. The proportion of Havering's population with level 4 qualifications or above (29.5%) is below that of London (46.7%) and England (33.9%), a fact which may be driven by several factors, including:

- Fewer people choosing or being able to progress to level 4 qualifications or higher

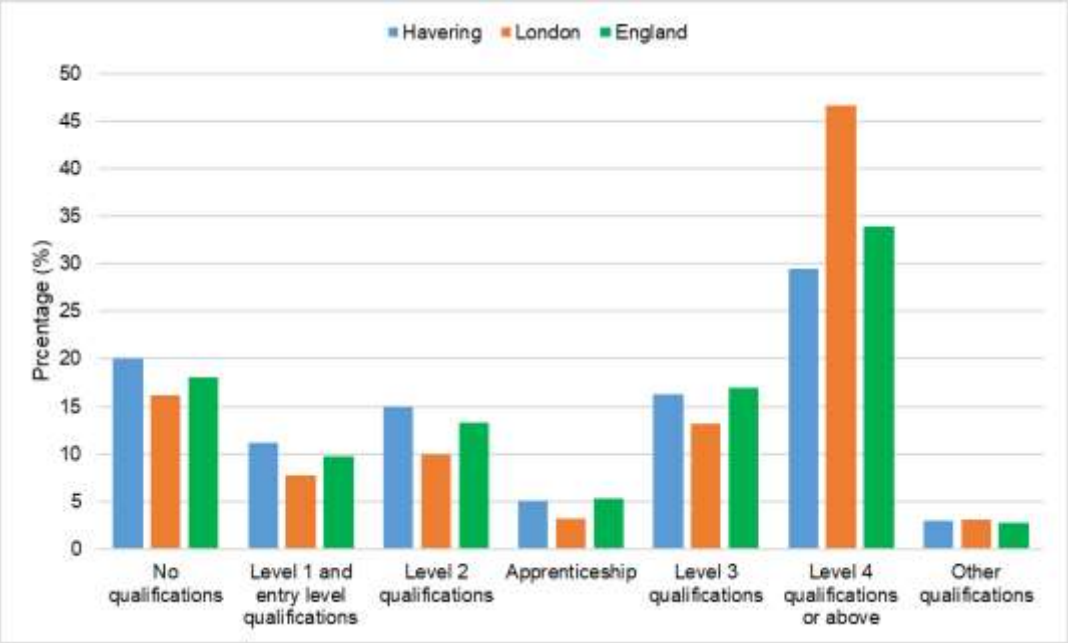
[33] https://socialmobility.data.gov.uk/intermediate_outcomes/work_in_early_adulthood_(25_to_29_years)/income_returns_to_education/latest#tab__Relative_differences__Visualisation

[34] Note: The ONS Labour Force Survey (LFS) has historically been used as source of up-to-date data on qualifications. There are recent concerns regarding the reliability of LFS results, particularly due to falling response rates since 2020. LFS results from 2023 estimated that 47.5% of Havering residents aged 16-64 had a level 4 qualification or above, markedly higher than the 2021 Census estimate. Conversely, the LFS estimated that 6% of Havering residents had no formal qualifications, much lower than the 2021 Census figure. This scale of difference is unlikely to represent true changes in qualifications between 2021and 2023 and may instead be attributable to the different populations to which the data applied (LFS 16-64 years, Census 16+ years) and declining and possibly skewed participation in LFS.

[35] https://ifs.org.uk/publications/changing-geography-jobs

- The absence of a university[36] offering a broad choice of courses within the borough resulting in people moving out of area to progress certain qualifications, before possibly settling elsewhere
- A lower concentration of high-skilled graduate-level in-borough employment opportunities compared to other parts of London (acknowledging that many residents commute out of borough for work).

Figure 16: Proportion of residents aged 16+ by highest level of qualification, in Havering, London and England, 2021 Census



Source: NOMIS, Official Census and Labour Market Statistics, Produced by LBH Public Health Intelligence

In terms of any differences in educational achievement between different population groups (aged 16+), the 2021 Census found that in Havering:

- There was limited difference between the educational attainment levels between males and females. Notably, a greater proportion of males aged 16+ reported having an apprenticeship qualification (8% vs 3% females), whereas a slightly higher proportion of females reported having no qualifications or level 1 qualifications (33% vs 29% of males), the latter point being strongly influenced by a greater proportion of women of older age cohorts reporting no qualifications. The proportion of males and females reporting a level 4 qualification or above was very similar[37].
- Adults aged 50 and over (particularly females) were more likely to report having no qualifications compared to younger cohorts, reflecting a combination of improvements

[36] Note, London South Bank University does have a campus in Harold Wood, which focuses on undergraduate courses in Adult Nursing and Mental Health Nursing, alongside Continuing Professional and Personal Development courses for those working in healthcare.
[37] Highest level of qualification by sex - Office for National Statistics

in education, increases in compulsory school age, and changing aspirations and social norms over time[38].

- People who identified as disabled under the Equality Act were more likely to report having no formal qualifications than those who did not identify as disabled (35% vs 17%) and were less likely to report having level 4 qualification or above (18% vs 32%)[39]. The proportion of disabled adults reporting no qualifications was higher in Havering than London (30%) and England (30%), while the rate reporting level 4 qualifications was lower (London 31%, England 23%)
- A greater proportion of people in Havering from Asian, black, mixed and other ethnic groups reported having a level 4 qualification or above compared to those identifying as white.[40] This is likely in part due to the relationship between increasing age with decreasing levels of educational attainment, with a greater proportion of residents in the borough from Asian, black, mixed and other ethnic groups being in the younger cohorts in which rates of qualifications tend to be higher. However, there may also be other social and cultural differences around career expectations and aspirations which may also influence rates of entry to higher education.

Beyond the achievement of academic qualifications, other forms of vocational education, training and development play a vital part in enabling people to access employment and to progress within and beyond their current role, both by supporting development of particular skills and through building confidence. National data from 2022 suggested that 10% of employers had at least one skill-shortage vacancy (a vacancy that is hard to fill due to a lack of skills, qualifications or experience among applicants), with skill-shortage vacancies accounting for a growing proportion of all vacancies (32% in 2022 compared to 21% in 2019)[41]. This demonstrates the importance of training and development to deliver a workforce that can meet the skills requirements of the current and future jobs market.

In spite of this, there has been decline in the proportion of employers across London that report providing workplace training to staff[42], while analysis of the Employer Skills Survey demonstrated a marked reduction in the investment in training per employee between 2011 and 2022 spend per head[43], likely to be in part driven by budget constraints and other economic factors.

Locally, there are a number of services supporting local residents to gain new skills for work. The Havering Adult College had 1,088 learners start on specific work-orientated courses in 2023/24 with the vast majority of these learners citing the reason for undertaking a course being to support them in returning to work. 56 of these learners also took part in a short employability-readiness courses during the same year. Improved links with Job Centre Plus has supported an increase in the numbers accessing these employability courses in 2024/25[44].

[38] Highest level of qualification by sex - Office for National Statistics
[39] Highest level of qualification by disability - Office for National Statistics
[40] Highest level of qualification by ethnic group - Office for National Statistics
[41] The Local Skills Improvement Plan for London: Helping Londoners get into better jobs by ensuring training matches employer demand – London Datastore
[42] The Local Skills Improvement Plan for London: Helping Londoners get into better jobs by ensuring training matches employer demand – London Datastore
[43] Employers spending a fifth less on employee training than a decade ago | New Economics Foundation
[44] Data from Havering Adult College, provided by LBH Education team

The Havering Works employment and skills service offers free support for local unemployed residents who are looking to get back to work, training or explore future career opportunities. The service had 224 adult learners engage with their employability services either through direct referral or via outreach activities within the community, exceeding the annual target of 200[45].

Service Gaps / Unmet Needs

Given the scale of opportunity for improving the education, training and skills of local resident into adulthood, there is a need to:

- raise aspirations amongst young people in Havering to encourage a greater proportion to remain in training and education beyond statutory school age, to support acquisition of both formal qualifications and other work-related skills.
- increase the awareness and uptake of existing education and training opportunities in the borough.
- encourage and enable more local employers, including statutory partners, to maximise the number of entry-level, apprenticeship or other development roles that support on the job training and development including achievement of formal qualifications.

These efforts should also seek to improve access to and engagement with education and training amongst those groups currently less likely to hold formal qualifications, or to access existing support services - this may include groups that face particular barriers to accessing education and/or employment.

There is a lower number of high-skilled job opportunities in Havering compared to other parts of London. Increasing the number of high skilled jobs, for example, through inward investment opportunities, can help to increase the number of people with higher qualifications living in the borough and contributing to the local economy.

Recommendations

- System partners to seek to maximise training and employment offer for local residents delivered as part of contract social value.
- Those working with children, young people and families to widely promote the Shaw Trust 'Prospects' information and advice programme to build confidence and prepare young people for work, particularly focusing on the 18-24 cohort who need to self-refer to the programme.
- Partnership to strengthen pathways to the Havering Works employment and skills advice service to residents and local employers, analysing uptake to identify any underrepresented population groups to inform this.
- LBH to explore appetite and value of convening a higher education partnership group, bringing together organisations involved in delivering education, training and support to local residents.
- Partnership to commit to supporting initiatives or interventions aimed at raising aspiration and promoting careers amongst young people and adults.
- LBH to continue to target inward investment opportunities that deliver an increasing number of high-skilled and professional roles in the borough.

[45] Data from Havering Works, provided by LBH Education team

4.4.4 Housing

Introduction

Poor housing conditions can have a detrimental effect on household members' physical, mental and social wellbeing. Many aspects of housing affect health – not only the quality of the house itself, but also housing affordability and fuel poverty, over-crowdedness, neighbourhood amenities and air quality, and residential stability.[46] Hence, high quality, affordable housing is a key element in ensuring the health and wellbeing of the population.

High housing costs put pressure on the household budgets of the many who are on moderate as well as low incomes. Difficulty paying the rent or mortgage can cause stress, affecting our mental health, while spending a high proportion of our income on housing leaves less for other essentials that influence health, such as food and social participation. Nonetheless, residents' housing situation in Havering compares favourably to elsewhere in London.

Findings

Housing costs have risen, although home ownership is more affordable in Havering (affordability ratio 10.9) than elsewhere in London (12.7), but worse than in England (8.3) more broadly. A smaller proportion of homes in Havering (12.7%) fail to meet the 'Decent Homes' standard compared to London (14.0%) and England (16.7%). On the other hand, private landlords are selling their properties as lettings are less profitable due to changes in tax rules and higher mortgage rates.

Houses in multiple occupation (HMO) are a part of the privately rented sector that causes particular concern, given the inherent additional risks of overcrowding and consequent impact on safety and health. Havering has a lower proportion of verified House of Multiple Occupation (HMOs) among its dwellings (0.2%) compared to London (1.7%) and England (0.7%). 937 council houses in Havering are known to be overcrowded (Table 2).

Table 2: Havering council housing type, 2024

Type	Total
Overcrowded	457
Overcrowded with additional priority	480
Total	**937**

Source: LBH Housing Choice and Application, July 2024.

Cold homes, whether due to poor design, inability to pay for heating or a combination of the two, can cause and worsen respiratory conditions, cardiovascular diseases, poor mental health, dementia, hypothermia and problems with childhood development. Havering has a lower proportion of households experiencing fuel poverty (9.3%) than London (11.9%) and England (13.1%). This figure has reduced since 2019, when it was 13.2%, despite the significant rise in fuel costs since 2022. This could be partly contributed by the work of Energy Doctors programme, home upgrade grant 2 (HUG2), energy company obligation scheme (ECO4), the awareness of income support through COVID support work, and other social housing decarbonisation scheme facilitated by LBH Housing.

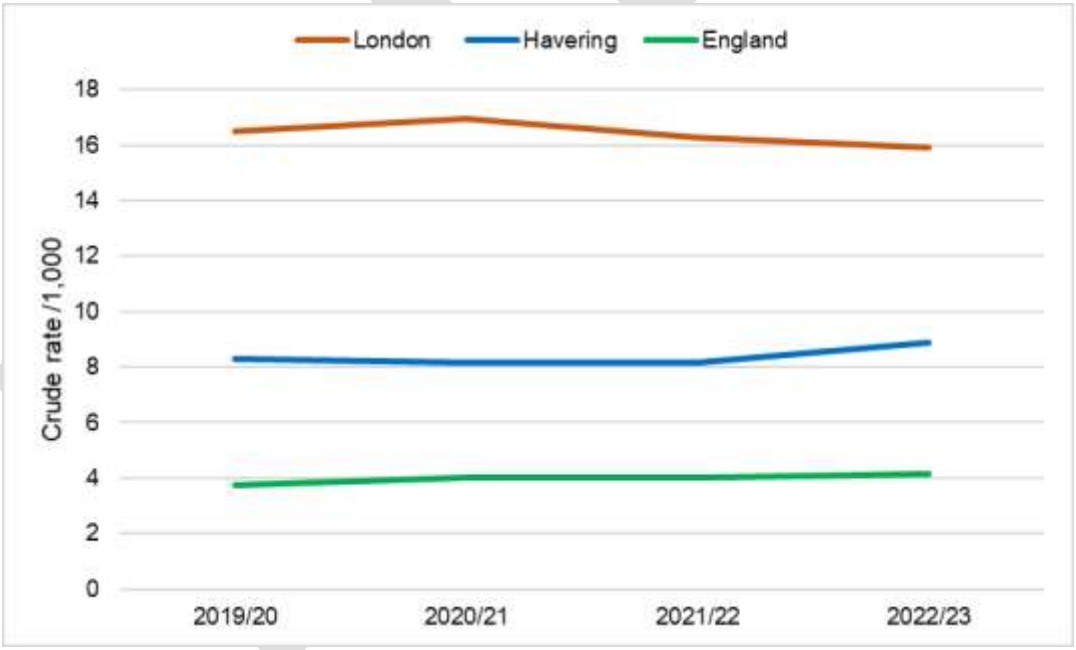
[46] https://www.health.org.uk/reports-and-analysis/briefings/moving-to-healthy-homes#:~:text=Housing%20affordability%20matters%20for%20our,as%20food%20and%20social%20participation.

Indoor air pollution is increasingly recognised as an important element in air pollution, as people spend around 80% of their time indoors. Poor ventilation can result in harmful pollutants and moisture being trapped in the property which, in turn, can damage the health of people and the house itself. In 2022, 4% of homes in England had a problem with damp, an increase since 2019. Rising energy costs have put additional pressure on household budgets.

The health outcomes of people experiencing homelessness is far worse than the general population, with the average age of death around 30 years lower for the homeless population than for the general population.[47] In Havering in 2022/23, 19.7% households are owed a duty under the Homelessness Reduction Act, higher than both London (15.8) and England (12.4) averages.

There were 957 households in temporary accommodation in Havering in 2022/23. This translates to a rate of 8.9/1,000 which is better than London average (15.9) but worse than England average (4.2). The number of households in hotels for temporary accommodation rose from 3 in 2019/20 to 396 in 2023/24. Nonetheless 1,007 families and 2,127 single people were relieved from homelessness in 2023/24.

Figure 17: Households in temporary accommodation, crude rate per 1,000 estimated total households



Source: OHID, based on Department for Levelling Up, Housing and Communities and Office for National Statistics data

Havering has a relatively low number of rough sleepers compared with many other London authorities. After a number of years of increases, the most recent figures show this has declined from 58 (2022/23) to 39 (2023/24).[48] Modular homes, office conversion and large

[47] NICE, Integrated health and social care for people experiencing homelessness. https://www.nice.org.uk/guidance/ng214

[48] https://data.london.gov.uk/dataset/chain-reports

development opportunities are being implemented or planned as a part of Romford Master Plan 2024.[49]

Service Gaps / Unmet Needs

New homes planned for next 5 years

Havering, like the rest of London, and many other parts of the country, does not have sufficient housing supply to meet demand. Due to a historic deficit of new supply against the local housing target and the resultant requirement to apply a 20% buffer to the target figure, between 2023/24 and 2027/28, Havering's housing target stands at 13,247 units. This equates to on average 2,649 units needing to be delivered each year to meet this target[50].

The current anticipated housing supply between 2023/24 and 2027/28 stands at 8,930 units – this is based on number of units deemed likely to be delivered by large scale schemes and an estimate of small-scale developments based on historic trends. As a result, Havering's current estimated housing supply between 2023/24 and 2027/28 is anticipated to deliver only 67% of that required (Table 3).

Table 3: Summary of Havering Housing Trajectory, 2023/24 - 2027/28.

Housing supply & targets	Units
Housing target (23/24 - 27/28)	7,973
Previous supply shortfall (16/17- 22/23)	3,066
Five year target plus previous shortfall	11,039
Five year target plus previous shortfall plus 20% buffer	13,247
Annualised housing target	2,649
Anticipated housing supply (23/24 - 27/28)	8,930
% of units required anticipated to be delivered (23/24 - 27/28)	**67%**

Source: London Borough of Havering 2022-23 Housing Trajectory and 5 Year Land Supply[51]

Recommendations

- The council and partners should work together to support the building of decent and affordable housing, raise awareness around ventilation and insulation, and support those who are becoming homeless.
- Havering Council to deliver up to a 1,000 good quality temporary accommodation units over the next 5 years to support the exit of families and singles in hotel.
- The council and partners should work together to deliver bespoke housing options for people leaving hospital or wards with complex needs i.e. supported housing accommodation and modular housing. Partners to collaborate to deliver modular housing solutions as a step-down arrangement supporting people to live independently in the community.

[49] https://democracy.havering.gov.uk/documents/s75622/Romford%20Masterplan%20-%20Appendix%201%20-%20Draft%20Romford%20Masterplan%20SPD.pdf
[50] Annex 1 - Authority Monitoring Report 2022-2023 - Housing Trajectory and 5 Year Land Supply
[51] https://www.havering.gov.uk/downloads/file/6512/annex-1-authority-monitoring-report-2022-2023-housing-trajectory-and-5-year-land-supply

- The council and partners should consider long-term regeneration proposals where 1% of housing provision under s106 are provided to people with clinical needs where they can receive clinical intervention in the communities.
- The council and partners should work together to design and develop psychologically informed environments to support health and well-being of people/ households experiencing trauma related to homelessness.
- The council /planning should explore and quantify any opportunities arising from the proposed amendments to the National Planning Policy Framework that will enable additional housing schemes that meet local need to be brought forward, including those arising through proposed changes to utilisation and definition of brownfield and grey belt land.
- The council to continue actively monitoring quality of local authority housing through regular stock condition surveys to ensure that repairs and maintenance programme and HRA business plan can effectively prioritise those properties in need of improvement or repair.

4.5 Places & Communities

Key findings

- Incidents of **anti-social behaviour** (ASB) saw a 16% increase in 2023, compared to 2022. An increase in ASB calls to police was seen in 15 of 20 Havering wards. Domestic abuse (DA) in Havering has seen a steady increase over the past 3 years (668 per quarter in 2021 to 746 per quarter in 2022) and now constitutes 14% of reported crime
- 23.4% of Havering's population live in the poorest performing 20% of areas on the 2024 **Access to Healthy Assets & Hazards Index.**
- In 2022, it was estimated that the equivalent of 6.4% of all-cause deaths amongst adults aged 30 and over in Havering were attributable to exposure to PM2.5 **air pollution**.
- In Havering, the number of **premises licensed to sell alcohol** per square km (5.2) in 2021/22 was higher than England average (1.26 per km^2), but significantly below the London average (13.7 per km^2)
- In 2023, 68 people were **killed or seriously injured on roads** in Havering.
- Havering scored 1.97 out of a possible 10 on the 2024 **Healthy Streets Score card** assessment. This is the fifth lowest score in London, though represents a slight increase from 2023 score of 1.77.
- The **digital exclusion risk** index of Havering residents (2.8) is slightly higher than London average (2.7).
- The percentage of adult **carers** (65 years and over) who have as much **social contact** as they would like (22.7%) is lower than both London (27.7%) and England (28.8%) averages.
- Percentage of adult carers (Age18 years and over) who have as much social contact as they would like (25.3%) is lower than both London (27.5%) and England (28.0%) averages
- In Havering, 2% of the population identify with one of the **LGBTQ+** orientations.
- 3,645 residents in Havering previously served in UK regular armed forces and 1,243 in UK reserve armed forces.

Recommendations

- HWB members should continue to support the work of Violence Reduction Strategic group and Combating Drugs Partnership. Havering CDP and substance misuse provider should support the Integrated Offender Management (IOM) scheme
- Front line staff of the services including primary care should offer Domestic Abuse Awareness training. Health Partners consider how they can improve data sharing in relation to violence and domestic abuse
- Relevant LBH departments should work with developers to ensure that the health and wellbeing implications of new large-scale developments and regeneration programmes are considered as early as possible in the planning process and are sufficiently scrutinised via a robust Health Impact Assessment to ensure that health benefits can be maximised and any risks sufficiently mitigated.
- As part of supporting a diverse local retail offer, relevant LBH teams should consider any opportunities for further policies (including the new Local Plan) that may prevent further proliferation of hot food takeaways, alcohol-licensed premises, and other retail premises with negative health and wellbeing impacts, particularly in areas of highest deprivation.
- Using the Healthy Streets Scorecard as a starting point, LBH should continue to bring forward proposals to implement and expand recommended measures and other complementary activities to improve road safety, increase active travel/modal shift and improve air quality.
- All partners to take steps to support efforts to encourage and facilitate modal shift, to support local ambitions to see 65% of trips in the borough being undertaken by active or public transport by 2041.
- In line with Havering Carers Strategy, HWB members should continue efforts to increase identification of carers to ensure they can access available support.
- HWB members should continue to support efforts to tackle social isolation in general, but particularly amongst older residents, as part of wider efforts to improve the mental health and independence of older people.
- Prevention interventions and health and care services should be culturally sensitive to ensure equitable access and reduce health inequalities.

4.5.1 Community Safety

Introduction

Crime, particularly violent crime, impacts negatively on the health of victims and the wider community.[52] Fear of crime and antisocial behaviour has wider effects, deterring residents from using assets in the community and reducing social interaction. Local action to reduce crime and the harm caused is coordinated by the Havering Community Safety Partnership (HCSP). The Local Authority, on behalf of the HCSP, undertakes an annual CSP Strategic Assessment.

The council has a strategy[53] to reduce the incidence of violence and knife crime. The Serious Violence Duty has been live since January 2024 and applies to all statutory partners including

[52] https://www.health.org.uk/evidence-hub/our-surroundings/safety/relationship-between-neighbourhood-crime-and-health#:~:text=In%20addition%20to%20the%20direct,poorer%20mental%20and%20physical%20health.

[53] https://www.havering.gov.uk/community-1/serious-violence-strategy

Health providers whilst the delivery of the Serious Violence Strategy sits under the governance of the Havering Community Safety partnership. There are cross cutting themes which need to be considered by the Health and Well Being Board due to the serious impact violence has on the health and wellbeing of Havering residents

A relatively small proportion of (repeat) offenders, many of whom struggle with drug dependency, account for a high proportion of solved crimes. A holistic support package, involving a range of partners including drug treatment services, mental health services, housing services etc., may be effective in reducing reoffending and the harm caused to these individuals, their families and the wider community.

- Evidence suggests that high level of worry about crime was associated with higher odds for loneliness. Worry about crime was linked to loneliness in women but not men.[54]
- Early prison release will also add demand onto the already stretched services such as substance misuse service provider and the Police.

Findings

Domestic Abuse (DA) in Havering has seen a steady increase over the past 3 years (668 per quarter in 2021 to 746 per quarter in 2022) and now constitutes 14% of reported crime[55]. This is the only crime type Havering reported to reach a rate (34.5 /1,000) similar to London average (34.5) and higher than England average (30.6).

Anti-Social Behaviour (ASB) saw a 16% increase in 2023, compared to 2022. An increase in ASB calls to police was seen in 15 of 20 Havering wards.[56]

According to the data from calendar year 2023, Havering despite the 3rd largest borough with busy economy with easy links to central London and M25 and Essex, has remained a lower ranking (26th among 32 London boroughs) for the total number of notifiable crimes (TNO) and 24th for the total number of recorded violent crimes. The most prevalent crime groups were violence against the person, followed by theft (Table 4). St Edwards's Ward has the highest number (3,185) and rate (305.3 per 1,000 population) of TNOs in Havering. The highest number of re-offenders were in the 15-17 and 40-44 age groups.

Table 4. Crime rates per 1,000 population in Havering compared to London and England.

Crime Type	Havering	London	England
Burglary	5.0	6.4	
Domestic abuse related indcidents and crimes	34.5	34.5	30.6
Drug dealing offences	3.8	4.2	
Knife crime	1.2	1.7	
Robbery	2.1	3.9	
Theft	18.4	33.1	
Violence against the person	25.7	28.7	

Source: Havering CSP/ Crime in England, 2023

[54] https://www.sciencedirect.com/science/article/pii/S2352827322002956
[55] Havering Community Safety Partnership
[56] Havering Community Safety Partnership

Service Gaps / Unmet Needs

Health partners are encouraged to regularly participate in the delivery of DV MARAC (Domestic Violence Multiagency Risk Assessment Conference).

Recommendations

- Health and Social Care Partners especially the providers of mental health services and substance misuse services should participate in Community Safety Partnerships and contribute to the delivery of agreed plans and strategies such as ASB policy.
- HWB members should continue to support the work of Violence Reduction Strategic group and Combating Drugs Partnership. Havering CDP and substance misuse provider should support the Integrated Offender Management (IOM) scheme
- Relevant representatives of health and care organisations should participate in the delivery of DV MARAC (Domestic Violence Multiagency Risk Assessment Conference).
- Health providers should support the roll out of the IRISi project[57] across GP practices in Havering. Health providers to explore the provision of onsite IDVA and domestic abuse advisors.
- Front line staff of the services including primary care should be offered Domestic Abuse Awareness training to enable them to sign post victims / survivors to appropriate services. Health Partners should consider how they can improve data sharing in relation to violence and domestic abuse

4.5.2 Healthy Places

Introduction

The built and natural environment are part of the wider determinants of health and wellbeing, having a significant influence on physical and mental health, and on health inequalities[58]. Some of our most pressing health challenges, including obesity, poor mental health issues and physical inactivity are influenced by our environment. This underlines the importance of leveraging every opportunity within the work of the Council, NHS and other partners to support the delivery of health promoting and protecting environments and ensuring that health is effectively considered within planning and delivery of regeneration and infrastructure projects[59].

Factors which can shape the health of a local area include things such as:

- Availability of safe, affordable, high-quality housing
- Quality and accessibility of open spaces
- Availability of high quality, nutritious food
- Provision and accessibility of community assets
- Levels of air pollution, noise pollution and other forms of nuisance

[57] https://irisi.org/iris6b-london/
[58] https://www.gov.uk/government/publications/phe-healthy-places/phe-healthy-places
[59] https://www.england.nhs.uk/wp-content/uploads/2019/09/phip-executive-summary.pdf

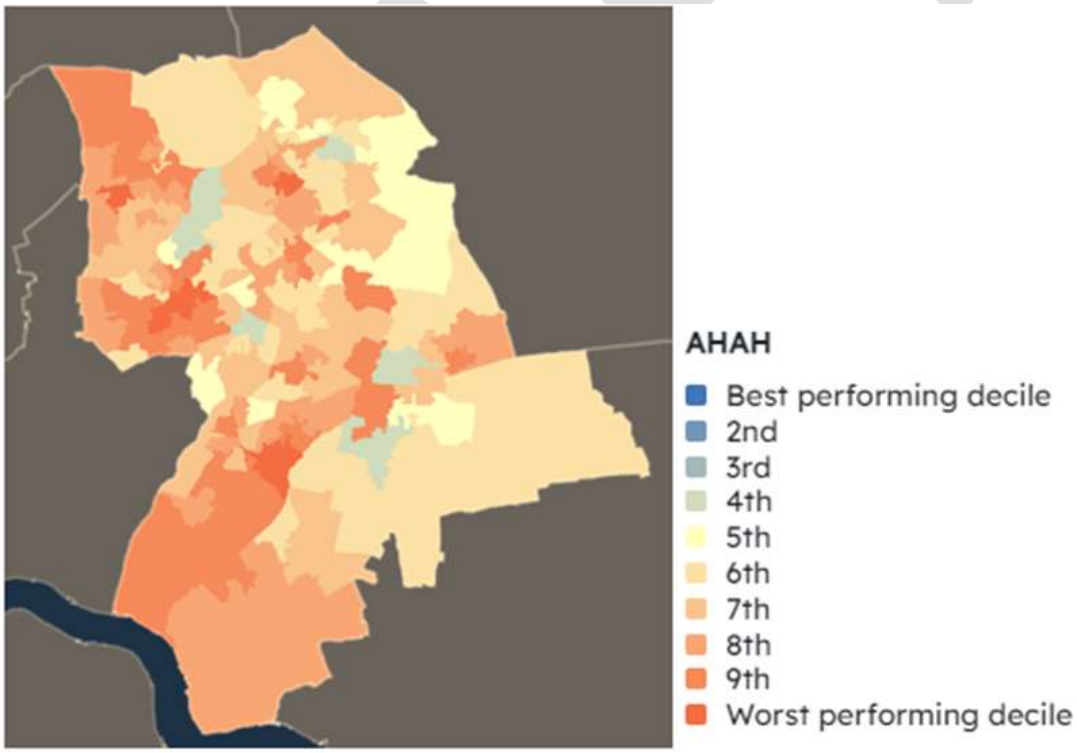
Findings

Access to Healthy Assets & Hazards Index

The Access to Healthy Assets and Hazards (AHAH) index is a composite measure used to assess how 'healthy' neighbourhoods are[60]. The AHAH index combines the scores of metrics across four key domains; Retail environment (access to fast food outlets, pubs, tobacconists, gambling outlets), Health services (access to GPs, hospitals, pharmacies, dentists, leisure services), Physical environment (access to Blue Space and Green Space), and Air quality (based on levels of a number of key pollutants).

23.4% of Havering's population live in LSOAs which score in the poorest performing 20% in England on the 2024 AHAH index. This is the fifth lowest proportion in London, and well below the London figure of 58.5%, with outer London boroughs tending to perform more favourably than inner London boroughs. Havering has no LSOAs within the highest performing 20%.

Figure 18: Access to Healthy Assets and Hazards (AHAH) Index score 2024 – Havering LSOAs compared to UK[61]



Source: Consumer Data Research Centre, 2024

Air quality

There is now well-established evidence that adverse health effects, including mortality, are associated with localised concentrations of outdoor air pollutants. In the short term, exposure to elevated levels of air pollution can cause acute exacerbations of asthma and other

[60] https://data.cdrc.ac.uk/dataset/access-healthy-assets-hazards-ahah
[61] https://data.cdrc.ac.uk/dataset/access-healthy-assets-hazards-ahah#data-and-resources

respiratory conditions, which in turn can drive an increase in respiratory and cardiovascular hospital admissions and mortality. In the longer term, studies have shown an association between air pollution and reduced life expectancy and development of health conditions such as coronary heart disease, stroke and respiratory disease[62]. Although air pollution can be harmful to anyone, it is also a significant driver of health inequalities, with a GLA report on air pollution in London[63]) finding:

People that live in more polluted areas are more susceptible to the ill effects and tend to face higher levels of economic deprivation, disadvantage and pre-existing medical conditions[64].

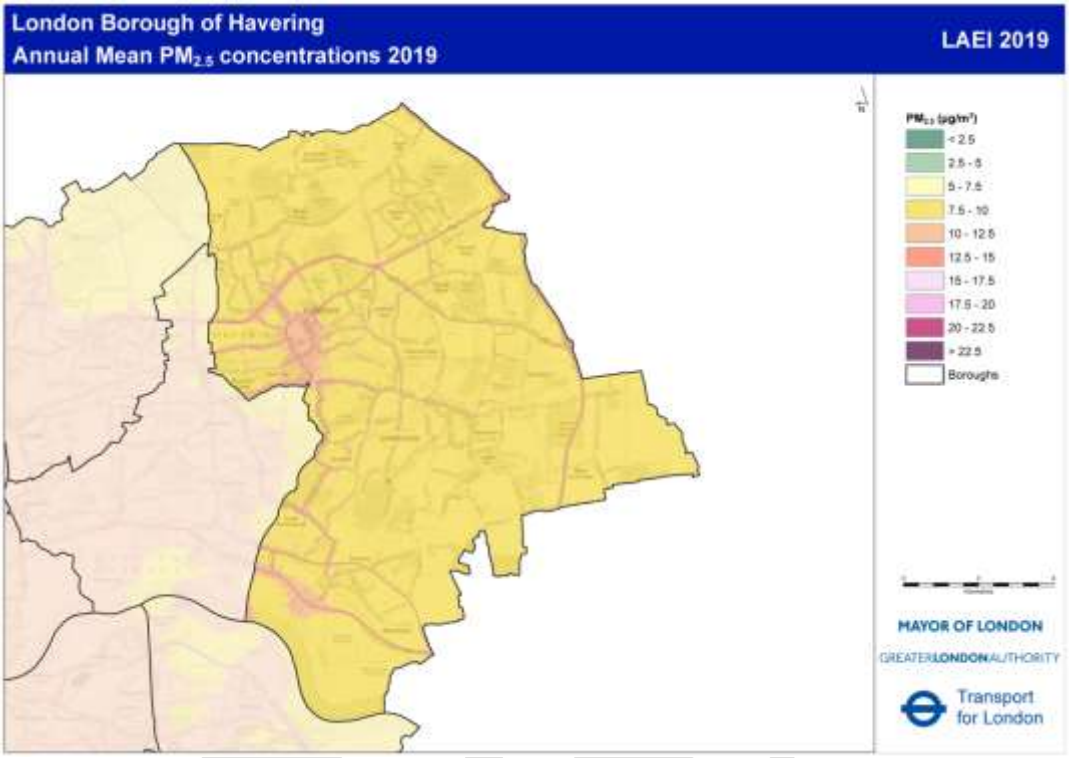
- Some groups are biologically more susceptible to the ill-effects of air pollution, including children, older people, pregnant women, and those with pre-existing health conditions.
- Areas with the lowest levels of key air pollutants have a disproportionately white population. Inequalities in exposure to air pollution experienced between ethnic groups are much more pronounced in Outer London.

Particulate matter (PM) is a key pollutant in urban areas, associated with a range of man-made activities including fuel combustion and tyre and brake wear. It is considered to be one of the most harmful air pollutants, and an important contributor to morbidity and mortality. Fine (small) PM, known as PM2.5, is therefore often used as a metric for assessing the potential health impacts of air pollution[65].

Levels of PM2.5 in Havering are generally low in comparison with much of the rest of London. There are however areas of higher concentration along key transport routes within the borough, linked to emissions from motor vehicles.

[62] https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution
[63] https://www.london.gov.uk/programmes-strategies/environment-and-climate-change/environment-and-climate-change-publications/air-pollution-and-inequalities-london-update-2023
[64] https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution
[65] https://www.gov.uk/government/publications/particulate-air-pollution-health-effects-of-exposure/statement-on-the-differential-toxicity-of-particulate-matter-according-to-source-or-constituents-2022

Figure 18: Annual Mean PM2.5 concentrations across Havering, 2019



Source: Greater London Authority (GLA)

As a means of estimating the local health impacts of PM2.5, modelling has sought to quantify the proportion of all-cause mortality attributable to exposure. In 2022, it was estimated that the equivalent of 6.4% of all-cause deaths amongst adults aged 30 and over in Havering could be attributable to exposure to PM2.5[66]. This does not mean that 6.4% of deaths occurred wholly as a result of air pollution, but rather that this could be the cumulative impact on mortality across the population. The Havering estimate is lower than London (7.1%) but higher than England (5.8%), reflecting the different annual PM2.5 concentrations across these geographies[67].

While previous estimates of mortality seem to suggest a decline in PM2.5 attributable mortality since 2018 (the rate for Havering was estimated at 8.4% in 2018), caution is needed when considering apparent trends over time. This is because the approach to modelling attributable mortality has been updated and improved over time[68].

Healthy High streets

A healthy high street can make it easier for people to access healthy foods, support community cohesion and social interaction and provide access to health services. However, high streets

[66] https://fingertips.phe.org.uk/search/pollution#page/6/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/93861/age/230/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1
[67] https://fingertips.phe.org.uk/search/pollution#page/6/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/93861/age/230/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1
[68] https://fingertips.phe.org.uk/search/pollution#page/6/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/93861/age/230/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

can also be a home to businesses which can have a detrimental effect on health69, the effect of which can be compounded where there is a high density of these outlets. Previous analysis commissioned by the Faculty of Public Health concluded that retail outlets posing the greatest risk to health included high-cost credit providers, gambling venues, fast-food outlets and off licenses70.

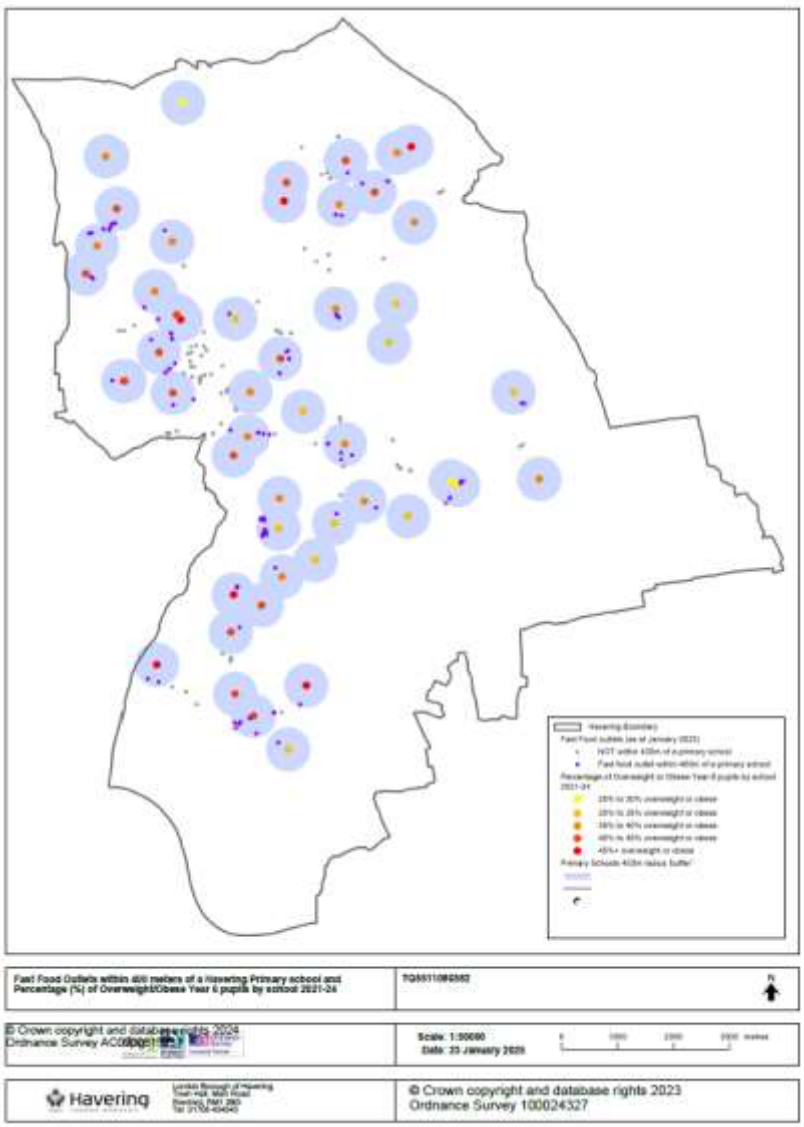
Studies have shown that the density of licensed premises can have an impact on rates of violence and alcohol-related disorder in the night-time[71] which can pose a risk to health and life. There is also growing evidence that greater alcohol availability is associated with alcoholism.[72] There is however also recognition that licensed venues offering on-site consumption, such as pubs and bars, can often be places that support positive benefits around social interaction and community cohesion[73].

The number of premises licensed to sell alcohol per square km (5.2) in Havering in 2021/22 was higher than England average (1.26), but significantly below the London average (13.7 per km^2). There are areas of the borough with particularly high density of licensed venues, such as Romford Town Centre. These higher density areas are likely to comprise a mixture of on-premises (pubs, bars) and off-premises (off-licenses, supermarkets) outlets.

There is a clear relationship between levels of deprivation and density of hot food takeaways offering predominately high fat, sugar and salt (HFSS) products, and in turn an association with the negative consequences of poor diet, including overweight and obesity and type II diabetes[74]. There are a total of 211 premises in Havering recorded as operating as a takeaway[75]. While not all of these premises may be offering meal choices that are predominately HFSS, it is reasonable to assume that this is likely to the primary offering from a reasonable proportion of these outlets. The map below shows that there is a clustering of takeaway premises in areas with highest footfall (such as Romford Town Centre), and within more deprived areas (Harold Hill, Rainham).

[69] https://www.rsph.org.uk/static/uploaded/b6f04bb8-013a-45d6-9bf3d7e201a59a5b.pdf
[70] https://www.rsph.org.uk/static/uploaded/dbdbb8e5-4375-4143-a3bb7c6455f398de.pdf
[71] https://www.ias.org.uk/report/licensing-in-practice-the-availability-of-alcohol-in-uk-society/
[72] https://www.lancaster.ac.uk/users/ext-rel/press/LU%20Text/Submissions/Pdf%27s/RESConf2016-724.pdf
[73] https://www.rsph.org.uk/static/uploaded/dbdbb8e5-4375-4143-a3bb7c6455f398de.pdf
[74] https://assets.publishing.service.gov.uk/media/6756e67b43b2de5fee8dae87/cmo-annual-report-2024-health-in-cities.pdf
[75] Data provided by LBH Public Protection Licensing Team

Figure 19: Takeaway premise locations in relation to Havering primary schools



The map above also shows that a significant proportion of takeaways sit within a 400m radius of a primary school (113 of 211 – 53.6%). Revised policy within the London Plan from 2017 prevents further proliferation of hot food takeaways within these 400m zones. The Government's National Policy Planning Framework (2024) features strengthened language to support local authorities to take further action to prevent takeaway proliferation in "other places where children and young people congregate" and "in locations where there is evidence that a concentration of such uses is having an adverse impact on local health, pollution or anti-social behaviour"[76].

[76] https://assets.publishing.service.gov.uk/media/675abd214cbda57cacd3476e/NPPF-December-2024.pdf

The most recent data from the Gambling Commission suggests that there are 43 premises licensed for on-site gambling, adult gaming or bingo in Havering.[77] These venues are concentrated in the Romford area – for example, during the course of a roughly 10-minute walk down South Street through the centre of the Romford ring-road, the public will pass 9 venues licensed for gambling activities.

Service Gaps / Unmet Needs

A key challenge relating to healthy places is that historically, places such as town centres and residential areas have not necessarily been developed with and wellbeing implications health in mind, often emerging gradually over time in a less planned way.

Significant programmes of regeneration and development (such as those planned for Romford, outlined in the Romford Masterplan) offer a critical opportunity to fundamentally re-shape local areas in ways that better recognise and respond to the established evidence about the impact of the local built environment on health and wellbeing.

Ensuring that the health and wellbeing opportunities and implications of new development and regeneration schemes are fully identified, articulated and acted on is an essential part of delivering healthier places for local residents.

Regarding licensed premises, there is scope to consider whether local licensing policies can be strengthened to further protect residents, particularly from vulnerable populations, from associated risk of health and wellbeing harms.

Recommendations

- LBH to work with developers to ensure that the health and wellbeing implications of new large-scale developments and regeneration programmes are considered as early as possible in the planning process and are sufficiently scrutinised via a robust Health Impact Assessment to ensure that health benefits can be maximised and any risks sufficiently mitigated.
- LBH and developers to take steps to ensure that new developments are meeting the requirement to be air quality neutral.
- LBH and health and wellbeing partners to actively promote the AirText service to residents and local services.
- LBH to implement Transportation (section 5.5.3) recommendations that support modal shift and active travel to support reductions in vehicle emissions that contribute to poor air quality.
- As part of supporting a diverse local retail offer, relevant LBH departments to consider any opportunities for further policies (including the new Local Plan) that may prevent further proliferation of hot food takeaways, alcohol-licensed premises, and other retail premises with negative health and wellbeing impacts, particularly in areas of highest deprivation.
- Drawing on learning to be gathered through the Clockhouse Superzone project, explore the feasibility of implementing the healthy catering commitment and a healthier retail scheme in other parts of the borough, particularly in the vicinity of schools and deprived areas.

[77] https://www.gamblingcommission.gov.uk/public-register/premises/download

4.5.3 Transportation

Introduction

The quality and accessibility of transport infrastructure and the adequacy of transport services can have a direct impact of health and wellbeing; the availability of well connected, safe and pleasant walking and cycling routes can enable active travel, while efforts to reduce and calm motorised traffic can reduce road accidents and associated emissions. Wider, indirect impacts of good quality transport links include enabling people to access employment, education, and health care services, while supporting people to maintain social connections – all things which support good physical and mental health and wellbeing[78].

For some people, particularly for those with limited mobility or health conditions, access to a car remains important, if not essential. However, policies that prioritise car use and underinvestment in other forms of transport and infrastructure can mean it is more difficult for those without a car to travel easily – those without cars are disproportionately those on low-incomes and young people[79].

Killed and seriously injured (KSI) casualties on England's roads

Reducing road danger is a public health priority and is key to increasing physical activity through active travel, improving air quality and supporting decarbonisation. In 2023, 68 people were killed or seriously injured on roads in Havering. The majority of those killed or seriously injured were passengers in a car (21), pedestrians (13), motor cyclists (17) or pedal bike users (12). A further 583 people were casualties in lower severity road traffic incidents – these predominately involved car passengers[80]

Expressed per 1 billion vehicle miles, the number of KSI incidents in Havering in 2023 equated to a rate of 60.9 – the lowest rate in London, and lower than estimates for London (187.5) and England (91.9)[81] There has been no statistical change in the rate of KSI incidents in Havering in the last 5 years. This may in part reflect the relatively small number of incidents that occur each year. However, significant progress is still needed to deliver on the Mayor of London and TfLs[82] for all deaths and serious injuries from road collisions to be eliminated from London's streets by 2041.

Previous analysis published by TfL[83] identified inequalities surrounding the frequency and outcome of KSI incidents:

- Almost twice as many people living in the most deprived 30 per cent of London are involved in KSI collisions than people living in the least deprived 30 per cent
- A greater proportion of incidents occur on roads in the 30 per cent most deprived areas

[78] https://www.health.org.uk/reports-and-analysis/briefings/how-transport-offers-a-route-to-better-health
[79] https://www.health.org.uk/reports-and-analysis/briefings/how-transport-offers-a-route-to-better-health
[80] https://maps.dft.gov.uk/road-casualties/index.html
[81] https://fingertips.phe.org.uk/search/KSI#page/4/gid/1/pat/6/ati/502/are/E09000016/iid/93754/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1
[82] https://tfl.gov.uk/corporate/safety-and-security/road-safety/vision-zero-for-london
[83] https://content.tfl.gov.uk/inequalities-in-road-danger-in-london-2017-2021.pdf

- More men are injured than women, with this difference increasing with deprivation and injury severity
- Young adults aged between 16 and 30 are more frequently killed or seriously injured, or slightly injured, than any other age group.

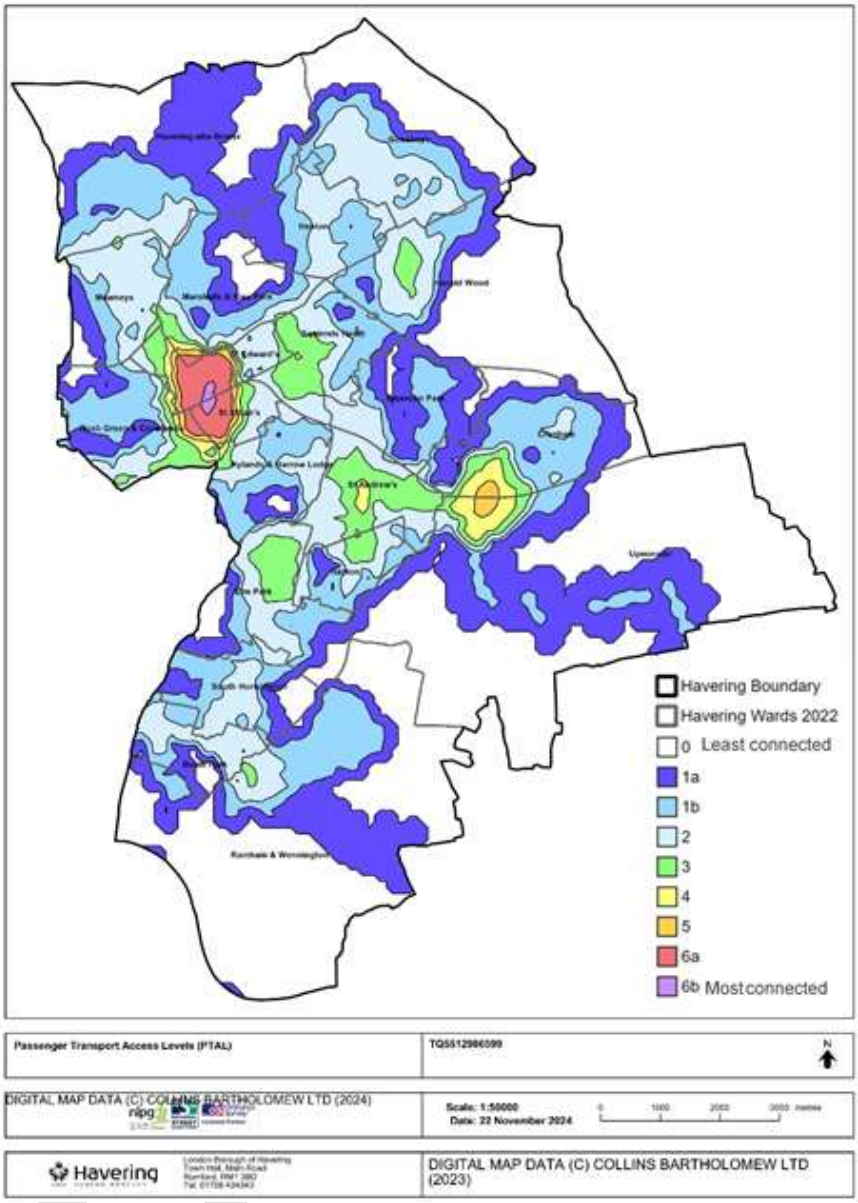
Public Transport Accessibility Levels

Public transport accessibility levels (PTALS) are a measure of the accessibility of the public transport network within small geographical areas, taking into account walk access time and service availability and reliability. Each 100m by 100m square in the borough is graded between 0 and 6b, where a score of 0 is very poor access to public transport, and 6b is excellent access[84].

As can be seen in figure 20, while there is a clustering of areas with excellent and very good accessibility (notably in and around Romford town centre, and to a lesser extent, Upminster), much of Havering is considered to have moderate to poor public transport accessibility. This reflects a similar pattern seen across other outer London boroughs, in part reflecting the more rural, less densely populated nature of some localities, but equally lower investment in these areas compared to areas of inner London.

[84] https://data.london.gov.uk/dataset/public-transport-accessibility-levels

Figure 20: PTALS scores across Havering, 2024



Source: Transport for London, 2024

Provision of public rapid charge devices per 100,000 population

As of July 2024, Havering had one of the lowest numbers and rate per head of total publicly available EV charging devices[85] in London (81 devices, 30.6 per 100,000 population, compared to outer London (140.8 per 100,000), London (233.6 per 100,000) and England (97.4 per 100,000)[86]. Havering has a higher proportion of homes with off street parking than other parts of London (particularly inner boroughs), meaning there is greater potential for home owners to have installed their own private charging points, for which government grants are available.

[85] Devices may have a number of connectors at varying speeds
[86] electric-vehicle-public-charging-infrastructure-statistics-july-2024.ods (live.com)

Of the 81 devices publicly available in the borough, 50 offer rapid charging (50kW and above), giving Havering the 10th highest rate of rapid charging devices in London (18.9 per 100,000, compared to 15.0 per 100,000 across North East London, 13.7 per 100,000 across London and 18.1 per 100,000 across England. Improving EV charging infrastructure supports the process of transitioning from petrol or diesel powered vehicles to fully electric models. While this will yield benefits in terms of net reductions in tailpipe emissions, electric vehicles still contribute to forms of particulate pollution through tyre and break wear and will still be involved in KSI collisions. As such, efforts to improve EV infrastructure should be balanced with those to continue to promote and facilitate modal shift to safe active or public transport methods, as outlined in the Havering Active Travel Strategy 2024-41.

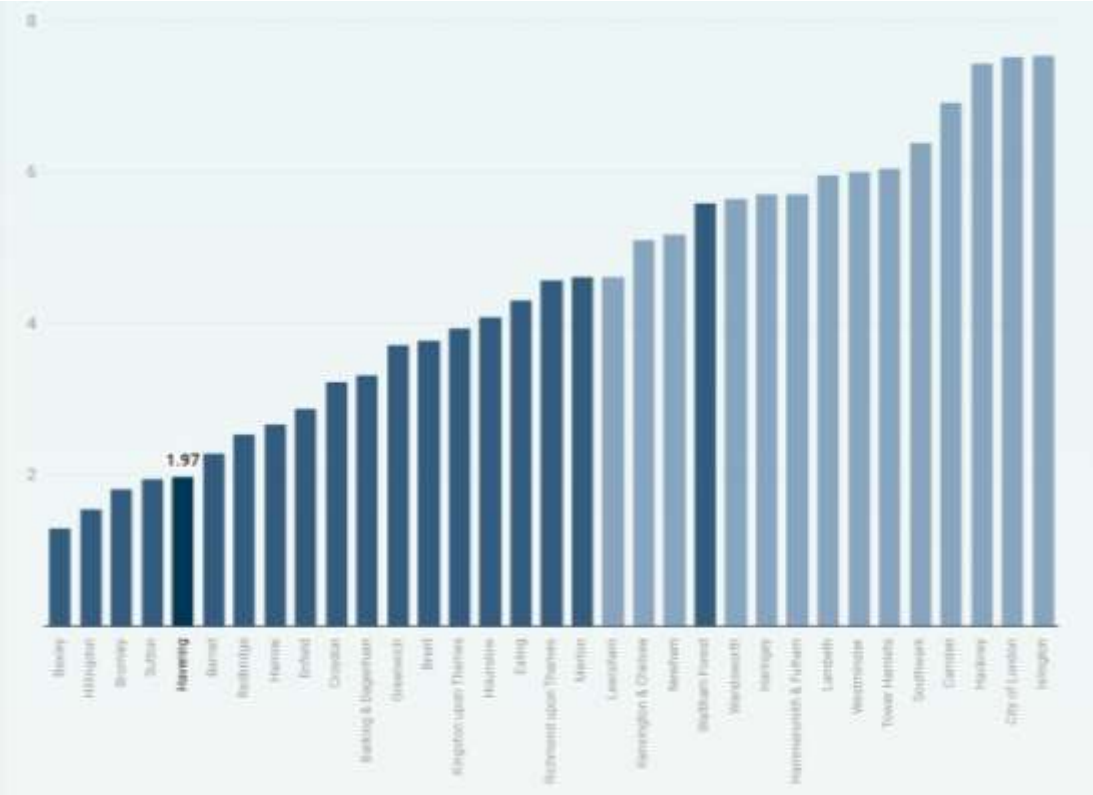
Healthy Streets Scorecard

The Healthy Streets Scorecard, developed by the London Healthy Streets coalition, provides a composite measure which seeks to quantify local action to address air quality, physical inactivity, noise pollution and road casualties, and enable comparisons between London boroughs[87].

Havering scores poorly against the overall 2024 Healthy Streets Score card assessment, with a combined score of 1.97 out of a possible 10 – this is the fifth lowest score in London, though represents a slight increase from 2023 score of 1.77. Though outer London boroughs tend to perform lower on the scorecard measure (reflective of the differing geography and population density) Havering remains well below the best performing outer London boroughs.

[87]Indicators included in the composite measure are: % of borough covered by Low Traffic Neighbourhoods, % of boroughs road network covered by 20mph Speed Limits, % of boroughs road network covered by Controlled Parking Zones, % of boroughs road network with Physically Protected Cycle Track, level of school engagement with TfL Travel for Life programme, proportion of schools with a School Street, % of bus routes given priority over other traffic (e.g. bus lanes), % trips taken by active or public transport, rates fatal and serious road casualties amongst those walking and cycling and car ownership rates.

Figure 21: London Boroughs Healthy Streets Scorecard - overall scores for 2024 Scorecard data for Havering and other London boroughs



Source: London Boroughs Healthy Streets Scorecard[88]

Of the measures considered within the scorecard, Havering performs very well on TfL Travel for Life scheme participation, with 49% of schools enrolled, the 3rd highest proportion in London. There has also been a notable increase in the number of School Streets in recent years (increasing from 5% of schools in 2022 to 19% in 2024), though coverage remains below the London average of 23% and well below the top performing London borough (50%).

Havering has particularly low scores against several of the other measures:

- Just 10% of borough-controlled streets have a 20 miles-per-hour speed limit, one of the lowest proportions in London, compared to London average of 59%.
- Low Traffic Neighbourhoods coverage is low, at 13% compared to a London average of 26%.
- Bus priority coverage is just 8%; this compares to 18% in Ealing, the outer London borough with the highest coverage.
- Despite positive improvements to some cycle track provision in Romford town centre, only 1% of the borough's road network provides protected cycle lanes;
- Car ownership remains high at 102 cars per 100 households, but in a London-wide trend, this is decreasing year-on-year (1.8%-point reduction from 2023).

[88] Note: Dark blue: Outer London boroughs, light blue: Inner London boroughs
https://www.healthystreetsscorecard.london/your_borough/havering/

While the borough's urban/rural makeup will be likely to keep the Havering's score below those achieved by inner London boroughs on some of the measures, based on other outer London boroughs, there is still opportunity to increase the local implementation of some of the measures proposed.

Service Gaps / Unmet Needs

A significant challenge in delivering increases in the use of active or public transport methods is the relatively poor public transport connections seen in many parts of the borough (as demonstrated by local PTALS scores).

While connectivity into London has improved in recent years following the launch of the Elizabeth line service, there remain many areas of the borough where public transport is limited, with north-to-south travel being a particular challenge.

While the planned introduction of Superloop 2 in 2025 will see an additional link between south Havering and Romford (and west across North East London), this will not address the connectivity issues faced by those residents outside the borough's main transport hubs.

As previously noted, Havering has a lower rate of public EV charging points compared to other parts of London. However, LBH will be delivering nearly two hundred further public EV charging points from 2025, which should markedly increase access in the borough.

Recommendations

- Using the Healthy Streets Scorecard as a starting point, LBH to continue to bring forward proposals to implement and expand recommended measures and other complementary activities to improve road safety, increase active travel/modal shift and improve air quality.
- LBH to ensure that future allocations of TfL Local Implementation Plan (LIP) funding continue to be prioritised for interventions which best support the delivery of health and wellbeing benefits, in areas where they are most needed.
- LBH to continue to identify opportunities to enhance the EV charging infrastructure, including use of community infrastructure levy (CIL) monies where appropriate.
- LBH to continue to lobby TfL to explore any opportunities to improve public transport provision in the borough as a means of supporting modal shift.
- All partners to take steps to support efforts to encourage and facilitate modal shift, to support local ambitions to see 65% of trips in the borough being undertaken by active or public transport by 2041.

4.5.4 Social Connectivity

Introduction

Social networks with family, friends, work colleagues, neighbours etc. can mitigate some of life's challenges and setbacks e.g. ill-health, relationship breakdown, job loss, experience of crime etc. Some groups and communities may be less likely to have strong networks and hence less resilient. ONS[89] have identify three distinct cohorts as being more likely to self-report loneliness:

- Widowed older homeowners living alone with long-term health conditions.
- Unmarried, middle-agers with long-term health conditions.
- Younger renters with little trust and sense of belonging to their area.

Social isolation is a risk factor for mental illness particularly in older residents. Social prescribers working in GP practices, and local area coordinators are well placed to assist individual residents to build social networks. At community level, Havering Council has established community hubs in Harold Hill and Rainham, the borough's most disadvantaged communities, along with a virtual hub. The community hubs are designed with the community, with the intention of improving access to statutory services and support from the voluntary care sector (VCS) organisations. The hubs provide an information service across the wider determinants of health including debt, housing, work, education as well as health and social care services and access to immediate support including a community food shop, access to computers and the internet alongside training and skills opportunities. Community hubs complement the 1:1 support provided by local area coordinators to individual residents.

Findings[90]

- The percentage of adult social care users of age 65+ who have as much social contact as they would like in Havering in 2022/23 was 36.7% which was similar to London average of 35.7% but lower than England average of 41.5%.
- The percentage of Havering's adult carers (65+ years) who had as much social contact as they would like (22.7%) in 2022/23 was lower than both London (27.7%) and England (28.8%) averages.
- Percentage of Havering's adult social care users (Age18+) who had as much social contact as they would like (43.0%) in 2022/23 was better than London average (39.7%) but similar to England average (44.4%).
- The Percentage of Havering's adult social carers (Age18+) who had as much social contact as they would like (25.3%) in 2022/23 was lower than both London (27.5%) and England (28.0%) averages

Service Gaps / Unmet Needs

Digital exclusion risk index of Havering residents (2.8) is slightly higher than London average (2.7). Havering libraries and voluntary care sector have been supporting residents to be more digitally literate and support them with online forms as interim solution while they are on their way to digital literacy.

[89] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10
[90] https://fingertips.phe.org.uk/profiles

Recommendations

- Support efforts to tackle social isolation in general, but particularly amongst older residents, as part of wider efforts to improve the mental health and independence of older people. Mental health services should be made more accessible for older people.
- Service users and carers should be offered JoyApp and other support to help reduce social isolation.
- In line with Havering Carers Strategy, continue efforts to increase identification of carers to ensure they can access available support.
- Marketing tools such as MOSAIC or Acorn, could be used to identify digitally excluded communities and improve access to health information and services.

4.5.5 Communities with specific needs

Introduction

A community is a group of people joined together by a common interest, characteristics or experience.[91] Health inequalities could exist due to the differences in opportunities and practices related to health common to the community that one belongs to. In addition, a stronger recognition of the role communities can play in and their greater involvement in efforts to improve health and wellbeing are needed if there is to be a successful move to a population health approach and a reduction in health inequalities. As part of this shift in focus, integrated care systems need to take the role communities can play in improving and sustaining good health seriously, working at the place and neighbourhood level where the link to communities is strongest.

There are many 'assets' within communities, such as skills and knowledge, which can be mobilised to promote health and wellbeing. From a health care perspective, communities have great insight and intelligence on what they need from health services, and on what works in improving health. Linked to this, directly engaging people from the most marginalised groups and those most likely to be affected by health inequalities is important in addressing these inequalities through both formal health services and other means.

Findings

LGBTQ Community

According to the ONS Census 2021, the majority of Havering residents aged 16 and above (91%) identify as straight or heterosexual. In total, 2% identify with one of the LGBTQ+ orientations ("Gay or Lesbian", "Bisexual" or "Other sexual orientation") (Table 5).

[91] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/communities-and-health

Table 5: Detailed breakdown of sexual orientation in Havering for residents aged 16 and over, 2021.

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

Source: ONS Census, 2021.

Ex-armed forces personnel

According to the 2021 census, 3,645 residents in Havering previously served in UK regular armed forces and 1,243 in UK reserve armed forces. In general, the health of the military population is good compared with the general population, due to the expected physical fitness required to join the armed forces. Nonetheless, the higher levels of occupational physical activity for armed forces personnel though point to a higher prevalence of musculoskeletal injury. In addition, smoking rate and drinking rate could be higher than the general population.[92] The prevalence rates of mental illness roughly equate to the general population with slight increases in reported mental health illness amongst combat troops and reservists. Early service leavers – those who leave prior to four years of service – and reservists have been found to have a higher risk of developing mental health problems than their peers.

NHS England has enshrined the principles of the Armed Forces Covenant into the NHS Constitution, meaning the armed forces population should not experience disadvantage in accessing health services where they live due to their increased mobility in comparison with the general population. These frequent moves give rise to a need to ensure they have a "level transfer when moving between different provider waiting lists" to ensure that when accessing treatment "the NHS will ensure that in line with the Armed Forces Covenant[93], those in the armed forces, reservists, their families and veterans are not disadvantaged in accessing health services in the area they reside".

Traveller population

There were 192 caravans occupied by travellers in Havering as at January 2023, an increase by 34 from the previous year (158) (see Table 6). Only 30 were on authorised sites while 57 were tolerated[94]. The total number of caravans has been consistent over the last two years and the number with permanent planning permission is increasing.

[92] https://www.kcl.ac.uk/research/kcmhr

[93] https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/our-services/armed-forces-and-families-health-care/

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

Table 6: Count of Traveller Caravans in Havering, Last Seven Counts, January 2020 to January 2023.

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

Source: Ministry of Housing, Communities & Local Government and Department for Levelling Up, Housing and Communities, UK

Refugees and asylum seekers

As of 30 June 2024, 662 Ukrainians under Homes for Ukraine programme, 53 Afghans under Afghan Resettlement programme and 181 asylum seekers were accommodated in Havering[95]. Refugees and asylum seekers can have complex health needs. These may be influenced by experiences prior to leaving their home country, during transit or after arrival in the UK. Holistic and person-centred care is essential to support resilience and help them adapt to life in the UK. Common health challenges include:

- untreated communicable diseases
- poorly controlled chronic conditions
- maternity care
- mental health and specialist support needs.

Despite this, there is no evidence that refugees and asylum seekers use a disproportionate share of NHS resources, and migrants in the UK and elsewhere in Europe tend to use fewer services than native populations[96].

Service Gaps / Unmet Needs

Services will need to be culturally sensitive to be able to ensure access to people from diverse backgrounds and vulnerability.

[95]LBH Havering Crisis Response team

[96]https://www.who.int/publications/i/item/report-on-the-health-of-refugees-and-migrants-in-the-who-european-region-no-public-health-without-refugee-and-migrant-health

Recommendations

- Prevention interventions and health and care services should be culturally sensitive to ensure equitable access and reduce health inequalities.
- Local Area Coordinators approach is required to support complex needs of vulnerable communities.
- Local health plans should consider community assets and community-centred approaches that build on individual and community.
- Services should involve those at risk of social exclusion in designing and delivering interventions that address inequalities in health.

4.6 Health Behaviours & Lifestyle

Key findings

- In 2023/24, 21% of children aged 4-5 (reception year) in Havering were overweight or obese, this was similar to the England average (22.1%).
- In 2023/24, 38.4% of children aged 10-11 (year 6) in Havering were overweight or obese, this was significantly higher than the England average (35.8%)
- The Havering's adult smoking prevalence over the 2021-23 period was 12.4%, similar to London (11.6%) and England (12.4%) averages.
- In Havering smoking prevalence is higher among the main white population (40.3%) as compared to all other groups according to the 2023 GP data.
- In 2023/24, the percentage of pregnant women smoking at time of delivery was 3.7%, similar to London average (3.9%), but lower than England average (7.4%).
- Smoking rates in Havering vary across age groups. It is highest among 31-35 age group (19%) and lowest among adolescents aged 12-15 (0.1%).
- The latest data (2023) shows that for every 100,000 deaths in Havering, 36 are related to alcohol. This rate is similar to the London (34/100,000) and England (41/100,000) averages.
- Number of Havering residents in **drug and alcohol treatment** has increased from 528 in 2020/2021 to 1,093 in Q2 2024. But this was supported by buying additional capacity with supplementary grant which will end in April 2025.
- Currently there are more than 400 Havering patients (75 under CAHMS) in mental health care who have **co-occurring substance misuse** problem (aka Dual Diagnosis).
- Havering's **chlamydia detection** rate amongst young people has consistently been below London and England averages and the national target, limiting opportunities to interrupt transmission in the community.
- In 2021, 33.7% of women aged 15-24 years in Havering accessing a termination of pregnancy were recorded as having received at least one prior termination.
- In Havering, **prenatal vaccine coverage** has fallen in recent years, in the context of a national increase in pertussis (whooping cough) cases.
- In Havering, cancers are the number one **cause of difference in life expectancy due to inequality** among women.

Key recommendations

- The Council and NHS should work with a wide range of stakeholders, including residents, to implement a Borough-level place-based whole systems approach for tackling obesity in Havering, as outlined in the Havering Healthy Weight Strategy.
- The Council and NHS should work with stakeholders, including residents, to develop a more intensive neighbourhood-level place-based whole system approach in Heaton and Gooshays wards, where there are inequalities in rates of obesity coupled with greater disadvantage, as outlined in the Havering Healthy Weight Strategy.
- Public Health should expand service provision ensuring availability of a full range of behavioural interventions and cessation aids, including vapes.
- Public Health should work with educational establishments and young people to raise awareness of harm from tobacco and vapes.
- With the support of the Planning, CSP, CDP and partners should continue to implement project Adder and priority areas in the Combating Substance Misuse Strategy to reduce substance misuse supply.
- ICB and Primary Care partners should identify feasible opportunities to increase vaccine coverage within primary care, secondary care and maternity services.
- NHS England, NELCA and Havering GPs should continue to improve cancer screening coverage, reduce health inequalities by improving access to those with SMI and LD.
- LBH, ICB, NHS and other partners should commit to delivery against actions outlined in the North East London Sexual and Reproductive Health Strategy, and accompanying local action plan.
- The council should work with local partners to review existing community-based SRH provision to identify any opportunities to strengthen or diversify this offer.

4.6.1 Healthy Weight

Introduction

Obesity rates in Havering are very high for both children and adults, either similar to or above the London and England averages. Importantly, evidence shows that children who are obese are more likely to be obese in adulthood[97], underlining the whole life-course implications the issue of excess weight. Overweight and obesity is cutting lives short and negatively impacting the quality of life of Havering residents.

Nationally, it is estimated that the impacts of obesity cost the NHS £6.5 billion per year[98], while the wider impacts of overweight and obesity have been estimated to cost society £98 billion per year[99].

Obesity is a complex issue, caused by multiple factors that interact with each other; the modern-day changes in the circumstances where we live, work and play that now make us more likely to opt for unhealthy options of foods and less likely to be physically active. In short, it is largely the circumstances where we live, known as 'the system', which has resulted in the increasing rates of overweight and obesity.

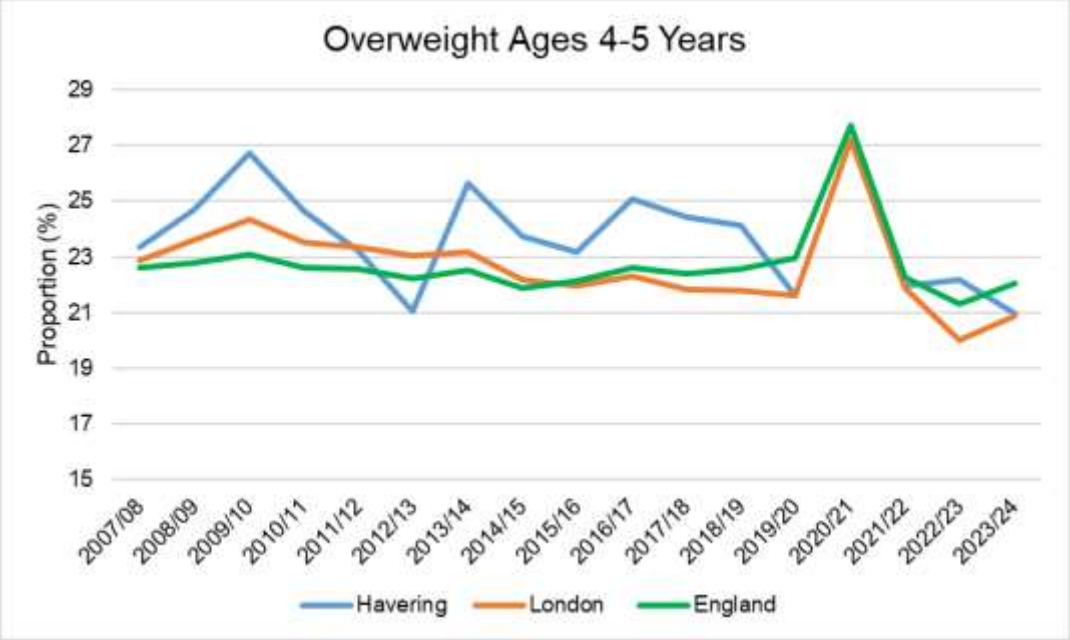
[97] https://stateofchildhealth.rcpch.ac.uk/evidence/prevention-of-ill-health/healthy-weight/
[98] https://healthmedia.blog.gov.uk/2023/06/07/government-plans-to-tackle-obesity-in-england/
[99] https://institute.global/insights/public-services/unhealthy-numbers-the-rising-cost-of-obesity-in-the-uk

The Havering Obesity Health Needs Assessment[100] sets out key information and evidence regarding overweight and obesity in the borough, some of the key findings of which are summarised below. The needs assessment was used to inform the *Havering Healthy Weight Strategy 2024-2029: Everybody's Business*[101], a whole systems approach to maintaining healthy weight. It sets out why healthy weight is an issue that needs urgent attention, the scale of the problem, the evidence for tackling the issue, and recommendations for action.

Key Findings

In 2023/24, 21% of Havering children aged 4-5 (reception year) were overweight or obese, this was in line with the England average (22.1%). Amongst children aged 10-11 years (year 6), the rate was 38.4%, significantly higher than the England average (35.8%)[102].There has been no significant change in the prevalence of Reception aged or Year 6 aged overweight or obesity in Havering in the last 5 years.

Figure 22: Proportion of children aged 4 – 5 years who were overweight or obese, 2007/08 – 2023/24, Havering, London and England.



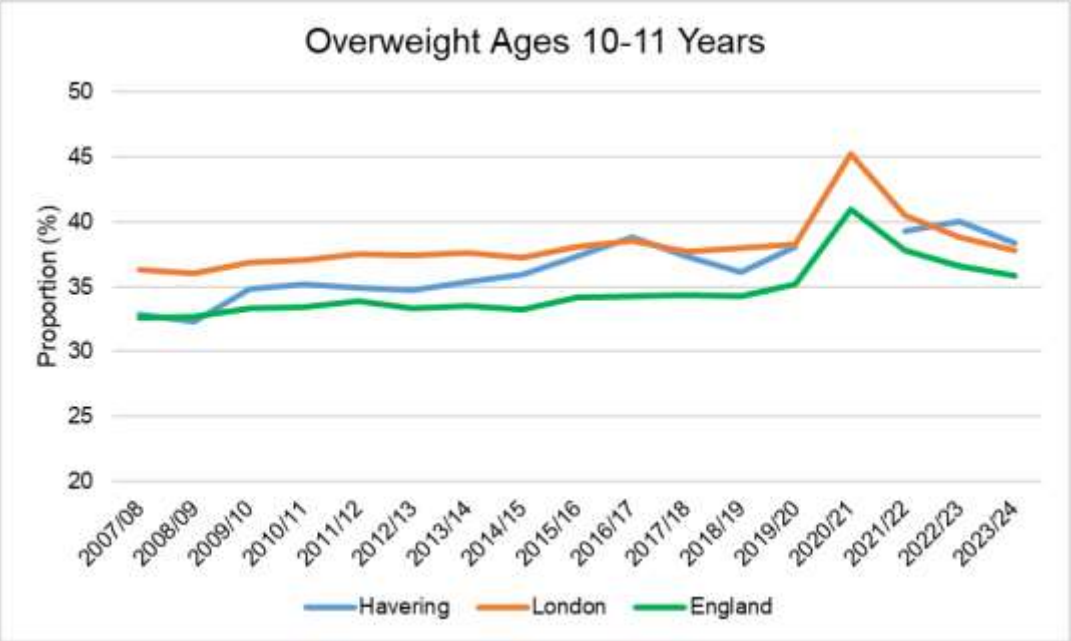
Source: OHID, Produced by LBH PHI

[100] https://consultation.havering.gov.uk/public-health/healthy-weight-strategy-consultation/supporting_documents/Havering%20Obesity%20Health%20Needs%20Assessment%20V1.0.pdf

[101] https://www.havering.gov.uk/downloads/file/6794/havering-healthy-weight-strategy-2024-2029-everybody-s-business

[102] https://fingertips.phe.org.uk/profile/national-child-measurement-programme

Figure 23: Proportion of children aged 10 – 11 years who were overweight or obese, 2007/08 – 2023/24, Havering, London and England.



Source: OHID, Produced by LBH PHI

In 2022/23, based on the latest Sport England Survey data from OHID, 65.8% of adults in Havering (18+) were classified as overweight or obese using self-reported height and weight[103]. This is in line with the England average (64%).

National estimates from Cancer Research UK suggest that 36% of the adult population may be obese by 2040[104]. If trends continue then the combined prevalence of overweight and obesity may reach 71% by 2040[105].There are stark inequalities in relation to the prevalence of overweight and obesity, with some groups disproportionately impacted, including[106]:

- people living in deprived areas,
- older age groups,
- some black and minority ethnic groups
- people with learning and physical disabilities.

Physical inactivity is one of the leading risk factors for mortality, being associated with 1 in 6 deaths in the UK [107].The most recent Active Lives Adult Survey conducted in 2021/22 found that 61% of respondents aged 16+ in Havering reported meeting the minimum recommended

[103]https://www.sportengland.org/research-and-data/data/active-lives/active-lives-data-tables
[104]https://www.cancerresearchuk.org/sites/default/files/tipping_the_scales_-_cruk_full_report11.pdf
[105]https://www.cancerresearchuk.org/sites/default/files/cancer-stats/adult_overweight_and_obesity_prevalence_projections_18-05/adult_overweight_and_obesity_prevalence_projections_18-05.pdf
[106]https://consultation.havering.gov.uk/public-health/healthy-weight-strategy-consultation/supporting_documents/Havering%20Obesity%20Health%20Needs%20Assessment%20V1.0.pdf
[107]www.gov.uk/government/publications/physical-activity-applying-all-our-health

levels of physical activity. This was one of the lowest proportions reported across London, and lower than London (66.8%) and England (67.3%) averages [108].

Conversely, Havering had one of the highest proportions of respondents reporting being physically inactive, at 27.9%, higher than both London (22.9%) and England averages (22.3%)[109]. There are known inequalities in participation in physical activity across England, including[110]:

- Men are more likely to report meeting minimum recommended levels of physical activity than women;
- People tend to become less physically active with increasing age;
- Levels of activity are also associated with deprivation; 55% of adults in the 30% most deprived areas achieved 150 minutes of activity per week, compared to 68% in the 30% least deprived areas.

Service Gaps / Unmet Needs

The Havering Healthy Weight Strategy action plan articulates a range of partnership actions deemed necessary to address key gaps and unmet needs in relation to healthy weight. There continues to be opportunities to strengthen and expand existing weight management or healthy-weight related service provision, including those services targeted at groups known to be disproportionately affected such as children and young people and those with disabilities.

However, given the scale of challenge in relation to population rates of overweight and obesity, it is recognised that these kinds of services are only part of the wider response required, hence the need for continued partnership commitment to implementing and sustaining a whole-systems approach. The Healthy Weight strategy is first year of implementation. It is recognised that more work is still needed to ensure the actions and principles of the strategy are effectively embedded across the work of the council and wider partnership, to support longevity and maximise impact.

In relation to physical activity, guidance from the Chief Medical Officer identifies that at a population level, the greatest health and wellbeing benefits will be accrued by increasing the number of people who are currently sedentary/inactive to beginning to participate in some level of physical activity[111]. Activities to promote and enable active travel (see section 4.5.3) offer an important means to support this, but consideration should be given to any further opportunities provide/facilitate more structured physical activity, particularly for groups that may face barriers to participation.

Recommendations

- Council and NHS work with a wide range of stakeholders, including residents, to implement a Borough-level place-based whole systems approach for tackling obesity in Havering, as outlined in the Havering Healthy Weight Strategy.

[108] Active Lives data tables | Sport England
[109] Active Lives data tables | Sport England
[110] Active Lives data tables | Sport England
[111] UK Chief Medical Officers' Physical Activity Guidelines

- Council and NHS work with stakeholders, including residents, to develop a more intensive neighbourhood-level place-based whole system approach in Heaton and Gooshays wards, where there are inequalities in rates of obesity coupled with greater disadvantage, as outlined in the Havering Healthy Weight Strategy.
- Learning from implementing the intensive neighbourhood-level place-based approach in Heaton and Gooshays wards to inform future waves of neighbourhood-level place-based approaches in the Borough.
- LBH to adopt and implement a new physical activity strategy, to support residents to be more physically active.

4.6.2 Smoking

Introduction

Smoking is a behaviour often formed at young age, often addictive, driven by the tobacco industry through advertising, ease of access [112], visibility and also normalised by society. Smoking causes serious harm to the health of both smokers and non-smokers and is the most important cause of preventable ill health such as cancer, heart and lung diseases and leads to premature deaths. 72% of lung cancer cases in the UK are caused by smoking. [113] In pregnancy smoking increases the risk of harm to the unborn baby such as increased risk of miscarriage, premature birth, stillbirth and low birth-weight. In both men and women smoking is a major risk factor for impotence[114] and in women it is also associated with increased risk of early natural menopause[115].

Because smoking is so harmful, differences in smoking prevalence across the population translate into major differences in death rates and illness. Smoking is the single largest driver of health inequalities in England. Higher smoking prevalence is associated with almost every indicator of deprivation or marginalisation.[116]In Havering Smoking varies by gender, ethnicity, across age and socioeconomic groups with close links to deprivation.

Findings

Smoking Prevalence

- Data from Office for Health Improvement and Disparities (OHID)[117] shows adult smoking prevalence in Havering has fluctuated in recent years.
- Smoking prevalence in adults (1 year range) in 2023 was 10.9%, a 5% drop from 15.9% in 2022
- Adult smoking prevalence over 3-year period (2021 to 2023) was 12.4%, similar to London (11.6%) and England (12.4%) averages.
- Smoking prevalence is higher among the white population at 40.3% compared to all other groups according to the 2023 GP data.
- Percentage of pregnant women smoking at time of delivery was 3.7% in 2023/24, similar to London average (3.9%), but lower than England average (7.4%)
- Smoking rates vary across age groups, highest among 31-35 age group, at 18.9% and lowest among adolescents aged 12-15, at 0.1%. Prevalence remains high between ages

[112] https://news.cancerresearch.org/2022/04/01/health-inequalities-why-do-people-smoke-if-they-know-it'sbad-for-them
[113] https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/lung-cancer/risk-factors#heading-Two
[114] https://pubmed.ncbi.nlm.nih.gov/29523476/
[115] https://pubmed.ncbi.nlm.nih.gov/29020262/
[116] https://ash.org.uk/uploads/ASH-Briefing_Health-Inequalities.pdf
[117] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132886/pat/6/par/E12000007/ati/402/are/E09000016/yrr/1/cid/4/tbm/1

of 36-50 (17-18%) and then gradually declines from 51 – 55 (16.9%) down to 5.4% in those aged 76 and older. [118]

Hospital admissions & smoking-attributable deaths

- Between 2017 and 2019, over 900 people in Havering died from smoking-attributable causes, translating to 198 deaths per 100,000 people—higher than London's rate (171) but lower than England's (202)[119]
- During the 2019-2022period, Havering had 1,452 hospital admissions attributable to smoking (993 per 100,000), lower than both London (1,152) and England (1,398) averages. In the same year, there were 530 emergency hospital admissions in Havering for COPD (363 per 100,000), similar to London (358) and lower than England (415)[120]
- Smoking is the largest avoidable risk factor for cancer. Between 2017 and 2019, Havering recorded 393 smoking-attributable deaths from cancer (88.4 per 100,000), higher than London's average (76.5) but lower than England (89.6).
- Between 2021 to 2023, Havering recorded 299 deaths from lung cancer (40.5 per 100,000), just slightly lower than London (41.8) and lower than England (47.5) [121]
- During the 2020- 2022 period, Havering recorded 342 deaths from COPD (45 per 100,000), higher than both London (39) and England (42.8).
- Over the 2017 -2019 period, there were 123 smoking-attributable deaths from heart disease in Havering (27.2 per 100,000), higher than London (25.2) but lower than England (29.3).[122]

Economy & Environmental Impact

- Smoking costs Havering £256 million per year whilst revenue from cigarettes and hand rolled tobacco taxation (excluding VAT) brings in about £40.6 per year according to Action against Smoking and Health (ASH).[122]
- About 970 people in Havering are estimated to be out of work.[123]
- Environmental impact associated with smoking is evident in every stage of the tobacco supply chain –from deforestation for cultivation, manufacturing and packaging to cigarette butt litter. According to Keep Britain Tidy research, smoking related litter make up 66% of all littered items[124]

[118] https://consultation.havering.gov.uk/public-health/tobacco-harm/supporting_documents/Havering%20Tobacco%20Harm%20Reduction%20Needs%20Assessment%202024%20FINAL.pdf
[119] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/0/gid/1938132887/pat/6/par/E12000007/ati/402/are/E09000016/yrr/1/cid/4/tbm/1/page-options/ine-ao-0_ine-yo-1:2023:-1:-1_ine-ct-59_ine-pt-0
[120] https://ashresources.shinyapps.io/ready_reckoner
[121] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132887/pat/6/par/E12000007/ati/402/are/E09000016/yrr/1/cid/4/tbm/1
[122] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132887/pat/6/par/E12000007/ati/402/are/E09000016/iid/93750/age/202/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0
[123] https://ashresources.shinyapps.io/inequalities_dashboard/
[124] https://www.keepbritaintidy.org/smoking-related-litter

Inequalities

- Smoking is major driver of persistent health inequalities with certain demographics groups in Havering more disproportionately affected by smoking than others. People in more disadvantaged areas are more likely to smoke and less likely to quit. This underscores the association between smoking prevalence and socioeconomic status and the need to tailor intervention according to different groups.
- In 2022, higher smoking rates were seen among Havering male residents (22.5%) compared to females (8.5%).
- In 2019/20, 69.7% of adults in Havering treated for substance misuse (all opiates) were smokers, higher than London average (68.2%) but lower than England average (70.2%). Over the same timeframe, 60% of adults in Havering admitted to treatment for alcohol and non-opiates were smokers. This was lower than both London (61.5%) and England (64.6%) averages.
- In 2014/15, smoking prevalence in adults with Serious Mental Illness (SMI) in Havering was 39.4%, higher than London (38.9%) and slightly lower than England (40.5%).
- In 2023, the proportion of smokers working in a routine or manual occupation in Havering was 14.4% compared to those in managerial/professional (11.4%) or intermediate professions (11.1). This figure was lower than London (15.2%) and England (19.5%) averages. However, there has been an increase from figures reported in 2021 (11.4%).
- Nationally, smoking rates in people living in social housing are double the average. 26% of the population of smokers in England live in social housing. [125] For Havering, 22.5% of adult smokers are living in social housing, a figure notably higher than the smoking rates among those who own a mortgage (14.3%) and those who own their homes (12%). [126]

Vaping

According to the NHS, Nicotine vaping is substantially less harmful than smoking. Vaping exposes users to far fewer toxins and at lower levels than smoking cigarettes. Switching to vaping significantly reduces exposure to toxins that can cause cancer, lung disease, and diseases of the heart and circulation like heart attack and stroke. These diseases are not caused by nicotine, which is relatively harmless to health. Vaping is one of the most effective tools for quitting smoking.

Vaping is not completely harmless and is only recommended for adult smokers, to support quitting smoking and staying quit. Non-smokers and young people under 18 should not take up vaping. In Great Britain, the number of vape users has significantly grown from around 800,000 in 2012 to 5.6 million in 2024, equating to 11% of the population, the highest rate ever.

The biggest concern nationally and locally currently is the growing trend among young people vaping. Whilst vaping is less harmful than smoking cigarettes and can help smokers to quit, vaping is becoming widespread, driven by concerted marketing to the young and widespread availability of disposable vapes though these types of vapes will be banned effectively in 2025 under new legislation.

[125] https://ashresources.shinyapps.io/inequalities_dashboard/

[126] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/7/gid/1938132886/pat/6/par/E12000007/ati/402/are/E09000016/iid/92443/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/ine-yo-1:2022:-1:-1_ine-ct-137_ine-pt-0_ine-ao-0

- A national survey of young people in 2024 show 18% of 11–17-year-olds tried vaping, with around 980,000 children exposed to vape promotion.
- A Havering Youth Wellbeing Census (2023) revealed that 12% of Havering pupils have experimented with vaping. Youth exposed to vaping are at risk of developing chronic respiratory issues like coughing, bronchitis and exacerbation of asthma, along with potential long-term cardiovascular consequences. Additionally, unintended ingestions of vaping liquids, especially among children are a concern, highlighting the importance of child-proof packaging. Furthermore, vaping can lead to nicotine dependence, which can adversely affect brain development, particularly in adolescents.
- Havering faces several challenges in reducing vapes use among young people due to widespread promotion and advertisements deliberately designed to appeal to young people with sweet flavours and colourful packaging. Additionally, there is limited capacity locally to tackle illicit and underage sale through robust enforcement measures.

Service Gaps / Unmet Needs

Stop smoking support was previously very limited with the focus in Havering on pregnant women that smoke and the provision of a stop smoking helpline. As smoking has become a bigger priority nationally and subsequently locally, it was necessary to develop support services for the Havering residents that continue to smoke. New stop smoking services have now been established within the borough including a universal service and two specialist services focussing on some of our key high smoking prevalence groups such as those with serious or long term mental health conditions, men, people living in deprived parts of the borough, people in social housing, in routine and manual occupations, pregnant women and new parents, and people with substance addiction.

However, some of the targeted priority groups such as routine and manual workers or people with addiction, and other priority groups such as 'White Other' (Roma, Gypsy, Eastern Europeans) and young people need more research to understand how the services can meet their needs and how they can be reached most effectively through communication and engagement efforts.

Havering has recently commissioned research for smokers in routine and manual occupations to understand how we can meet their needs and tailor our promotions and services for them. It is important to continue to gather insights from priority groups.

Recommendations

The tobacco harm reduction needs assessment outlined a set of recommendations to help drive forward the ambition for a smoke-free borough, as well as tackle vaping among young people[127]. The main recommendations include:

- System partners should expand service provision and ensure availability of the full range of cessation aids.
- Services should prioritise tailored support for groups with high smoking prevalence
- Services should improve data collection including ward-level data to facilitate targeted interventions

[127] https://consultation.havering.gov.uk/public-health/tobacco-harm/supporting_documents/Havering%20Tobacco%20Harm%20Reduction%20Needs%20Assessment%202024%20FINAL.pdf

- Public Health and partners should provide training for health and social care staff to improve knowledge and skills and referrals mechanisms into services, where appropriate.
- Service providers should ensure culturally and linguistically sensitive services that are accessible to those with learning disabilities and the homeless
- Public health and partners should continue to raise awareness of tobacco harm and local stop smoking services through campaigns that align with the national annual campaigns such as Stoptober, No Smoking Day, New Year
- Public health and partners should provide tailored information resources and support to families on dangers of second-hand smoke, especially in households with pregnant women and children.
- Public health and partners should collaborate with community organisations to better reach underrepresented groups.
- Public health should work with trading standards to address illegal vapes and cigarettes
- Public health should work with educational establishments and young people to raise awareness of the harms of smoking and vaping
- Public health and partners should conduct a separate needs assessment on vaping in Havering

4.6.3 Substance misuse

Introduction

Substance misuse is the abuse of alcohol, drugs and other substances that affect perception, consciousness, understanding, mood or emotion. Drug use increases crime, damages people's health, puts children and families at risk and reduces productivity. It affects everyone, with the most deprived areas facing the greatest burden. In London, offenders are less likely to have a drugs need than in other regions.[128] Nonetheless, London accounts for 24% of all recorded drug offences in England & Wales. 8% of boys & 10% of girls of secondary school age in London have taken drugs in the last year. Drug overdose patients were most likely to be aged 26-35, with 57% under 35. 38% of patients were female.

To increase the capacity in local drug treatment systems, the central government provides local public health directorates a Supplemental Substance Misuse Treatment and Recovery (SSMTR) grant for 3 years since 2022/23. In 2025/26, it will be replaced by Drugs and Alcohol Treatment and Recovery Improvement Grant (DATRIG) which also consolidates the Inpatient Detoxification (IPD) grant which Havering previously received, and two other housing grants which Havering did not and will not receive.

In Havering, Combating Drugs Partnership (Havering CDP), a multi-agency forum was fully formed in August 2022 to lead the local response to deliver the Government's 10-year drugs strategy and to monitor the progress based on the National Combating Drugs Outcomes Framework. The CDP in Havering works together to:

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

[128] MOPAC Evidence & Insight, 2024. A problem Profile of Drugs in London.

One major emerging and dangerous problem is synthetic opioids such as Illicit fentanyl and isotonitazene which are many times more potent than heroin, and are seen as an adulteration or contamination of heroin and other drugs, causing additional drug-related deaths in England. Havering CDP has produced a synthetic opioid preparedness plan and this synthetic opioids incident response (SOIR) protocol will link the preparedness plan to the Borough Resilient Forum.

However, there is one significant positive recent development in London. Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery)[129] in London aims to support and steer people away from a life of substance misuse, focusing on prevention, education, and treatment in addition to enforcement. Long term objectives include removing the market of drug supply, reducing the demand on the MPS, Probation, Courts, health care and negating the devastating impact of drugs on London's communities.

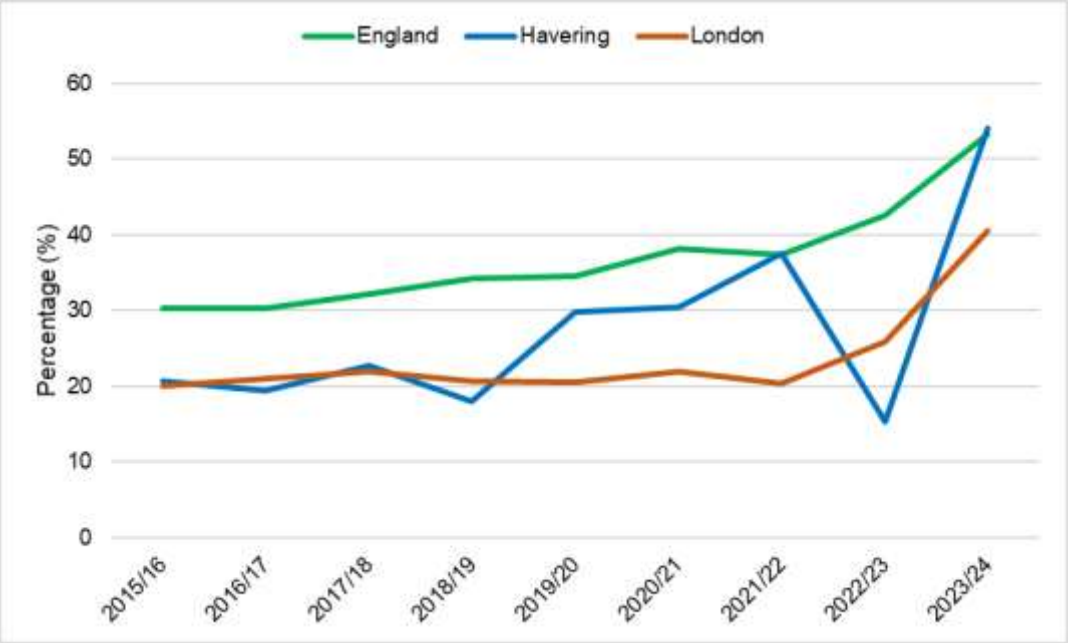
Findings

- Alcohol-related deaths among males have also been rising in the last three years. The latest data (OHID, 2023) showed that for every 100,000 deaths in Havering, 58 were related to alcohol. This death rate was similar to the London average (54 out of every 100,000 deaths).
- Deaths from drug misuse in Havering was 2.0 per 100,000 during the 2021-23 period which was lower than London average (3.8 per 100,000) and England (5.5 per 100,000).
- Number in Havering residents in treatment has increased from 528 in 2020/2021 to 1,093 in Q2 2024[130]. But this was supported by buying additional capacity with supplementary grant which will end in April 2025. In recent years, around 7 patients have received inpatient detoxification or residential rehabilitation.
- Local mental health provider, NELFT, and drug treatment provider, CGL, mutually provide outreach to meet the needs of Havering residents with co-existing mental health and substance misuse. In 2022/23, 81.4% of service users in CGL were also receiving treatment for their mental health, compared to 70.3% in London and 74.8% in England.
- Successful completion of alcohol treatment in 2023 was 36.8%, slightly better than London average (33.7%) and England average (34.2%). The rate for non-opiate was 32.9%, again slightly higher than London average (28.0%) and England (29.5%). Nonetheless, successful completion of opiate treatment in 2023 was 4.2% which was lower than both London (5.2%) and England (5.1%) averages[131]
- Cessation or change in cannabis use in young people in treatment in September 2024 was 38.0%, similar to London average (39.0%).[134]
- Drug possession crime rate in (Jan-Dec 2024) in Havering was 2.5 per 1,000 which was similar to London average (2.8 per 1,000). Drug trafficking crime rate in the same period was 1.4 per 1,000, which is lower than London average (1.3/ 1,000)[132]
- Local treatment provider, CGL, works with Probation and prison services (CSP) to improve Continuity of Treatment for those in contact with the Criminal Justice System, with a focus on drug use which drives crime and to reduce reoffending.

[129] https://www.gov.uk/government/publications/project-adder/about-project-adder
[130] CGL Havering, 2024
[131] https://www.ndtms.net/
[132] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingseptember2024/relateddata

- Around half of Havering residents released from prison engage in community treatment (Figure 24). Reoffending rate among adults (20.7%, Oct 2021 to Sep 2022) was slightly lower than the London average (22.0%).

Figure 24: Percentage of adults with substance misuse treatment need who successfully engage in community based structured treatment following release from prison, Havering, London and England, 2015/16 – 2023/24



Source: OHID/ NDTMS, Produced by LBH PHI

Hospital admissions for substance misuse among adults aged 25+ between Aug 2023 and Jul 2024 was 29.1 per 100,000, which was higher than the London average (22.1 per 100,000).[133]

Overall the hospital admissions for alcohol related conditions (narrow) rate in Havering is similar to the England average trend. In 2022/23, Havering's rate was 334 per 100,000 population which was lower than the London (420/100,000) and England (475/100,000) averages.[136]

The need for better housing and employment support for people dependent on drugs and alcohol is a core part of the current 10-year national drugs strategy.[134] DWP and LBH Housing are supporting drug recovery through their work. 86.6% of drug treatment service users in Havering are in stable accommodation in Q2 2024, higher than London average (82.0%). 31.0% were in paid work higher London average (25.0%). DWP provides Individual Placement Support grant to improve employment opportunities to the service users of substance misuse and mental health. CGL is the lead provider for the IPS service for Havering, Redbridge and Barking & Dagenham from October 2024 and are using innovative methods to facilitate employment of service users of substance misuse service.[136]

[133] https://fingertips.phe.org.uk/profiles

Service Gaps / Unmet Needs

- Although the number in treatment has increased from 528 in 2020/2021 to 1,093 in Q2 2024, treatment capacity will not be able to match the underlying demand with available resources.
- Unmet need for opioid and crack use (OCU) in September 2024 was 64.2% which was lower than the London average (71.5%). Unmet need for alcohol treatment for the same period was 74.3% which was slightly lower than the London average (78.5%)[135]

Recommendations

- With the support of the Planning and Community Safety Partnership (CSP), Combating Drugs Partnership (CDP) continues to implement project Adder, and other priorities to reduce substance misuse supply.
- The HWB members and the Integrated Care Partnership (ICP) to support the work of the members of CDP in establishing world class treatment and recovery system.
- Where t resources cannot meet the demand, participation in drug and alcohol treatment should be prioritised at supporting those who are more socially deprived.

4.6.4 Sexual Health

Introduction

Sexual and reproductive health covers a broad range of health matters, from sexually transmitted infections (STIs) and contraception to relationships and conception. Good sexual and reproductive health is a fundamental part of everyone's health and wellbeing. Poor sexual and reproductive health, including the experience of sexually transmitted infections, unwanted pregnancy or unhealthy relationships can have wide-ranging public health consequences, impacting not only individuals but families and society as a whole[136].

Sexual and reproductive health issues impact different groups in society unequally. For example, some STIs cause more health problems in certain groups (young people, men that have sex with men, those of black ethnicities[137]), whilst some groups face greater barriers to accessing sexual and reproductive health services.

The North East London Sexual and Reproductive Health strategy (2024-29)[138] identifies a number of shared priorities:

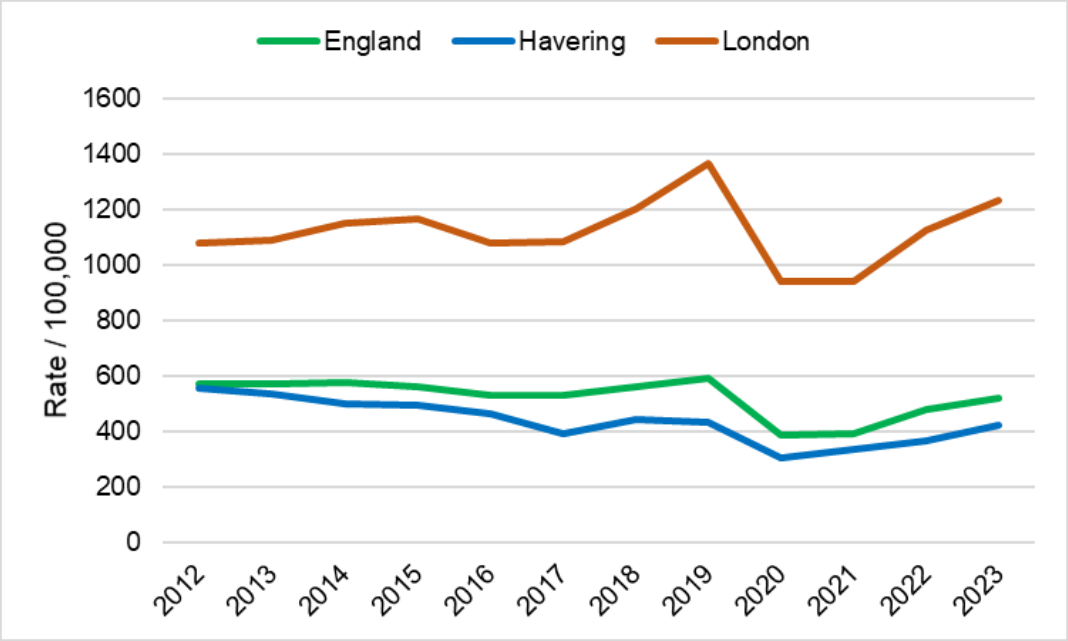
- Priority 1: Healthy and fulfilling sexual relationships
- Priority 2: Good reproductive health across the life course
- Priority 3: High quality and innovative STI testing and treatment
- Priority 4: HIV - towards zero and living well with HIV

[135]LBH Drugs and Alcohol Dashboard
[136]House of Commons Library (2024) Sexual and reproductive health statistics for England
[137]Health matters: preventing STIs - GOV.UK
[138]North East London Sexual and Reproductive Health Strategy(2024-29)

Findings

New sexually transmitted infection (STI) diagnoses

Figure 25: New STI diagnoses (excluding chlamydia cases amongst those aged under 25 years), Havering, London and England, 2012– 2023



Source: OHID, Produced by LBH PHI

2023 in Havering 1,110 new STI diagnoses (excluding chlamydia diagnosed amongst under 25s), giving rate of 419 per 100,000. Havering continues to have STI diagnosis rate below the England rate (520 per 100,000) and well below the London rate (1,229 per 100,000). Following a marked drop in STI diagnoses in 2020 as a result of Covid-19 restrictions, there has been a gradual increase in diagnosis rates across Havering, London and England, with rates now having returned to close to pre-pandemic levels. It is important to note that STI diagnosis rates are reflective of both the level of infection in the population but also testing rates and patterns.

Nationally, STI diagnoses much more common in deprived areas. Some groups, including gay, bisexual and men that have sex with men (GBMSM), young people and those in inclusion health groups tend to face higher burden of STIs.

Chlamydia detection rate per 100,000 15-24-year-olds

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and infertility[139].

[139] https://fingertips.phe.org.uk/search/chlamydia#page/6/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/90776/age/156/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

The chlamydia detection rate among under 25-year-olds is a measure of chlamydia control activity, aimed at interrupting transmission and preventing the associated negative health outcomes. An increased detection rate is indicative of increased control activity, rather than a measure of the level of infection or associated morbidity[140].

Havering's chlamydia detection rate has consistently been below London and England averages. In 2023, 321 new chlamydia diagnoses were detected amongst Havering residents of ages 15-24 years, giving a detection rate of 1,123 per 100,000; significantly lower than detection rates of 1,739 per 100,000 across London and 1,546 per 100,000 across England. Despite a downward trend in previous years, in 2022/23 Havering also had higher rate of hospital admissions for PID compared to London and England, which to some extent may represent the impact of un-diagnosed and un-managed chlamydia and other STI infections.

HIV diagnosed prevalence rate per 1,000 15-59-year-old

Havering's HIV prevalence rate (the number of people living with diagnosed HIV) amongst 15-59 year olds in 2023 was 2.2 per 1,000 residents. This was lower than the rates for London (5.3 per 1,000) and England (2. per 1,000)[141]. A local authority HIV prevalence between 2 and 5 per 1,000 is considered high, with rates above 5 per 1,000 considered very high.

Havering's HIV prevalence rate has remained relatively stable since 2015, with the number of Havering residents accessing HIV care ranging from between 302 and 334 during this period[142]. This is reflected in the low number of new cases of HIV diagnosed each year amongst Havering residents (≤25 cases per year since 2015), giving Havering one of the lowest HIV incidence rates in London in 2023[143]

The diagnosed HIV incidence gives an indication of levels of onward HIV transmission but will also be influenced by volumes and patterns of HIV testing.

The roll out of opt-out HIV testing in emergency departments in high prevalence areas since 2022 has contributed to the identification of previously undiagnosed cases of HIV that might otherwise have not sought testing through other routes, as well as enabling people who had previously disengaged from HIV treatment services to be brought back into care. The growth in HIV cases identified by this route may lead to increases in HIV incidence and prevalence at local, regional and national levels – this would be a positive outcome, on the basis that more people would be aware of their HIV status and could access the necessary treatment to achieve viral suppression and prevent onward transmission.

Under 18 conception rate

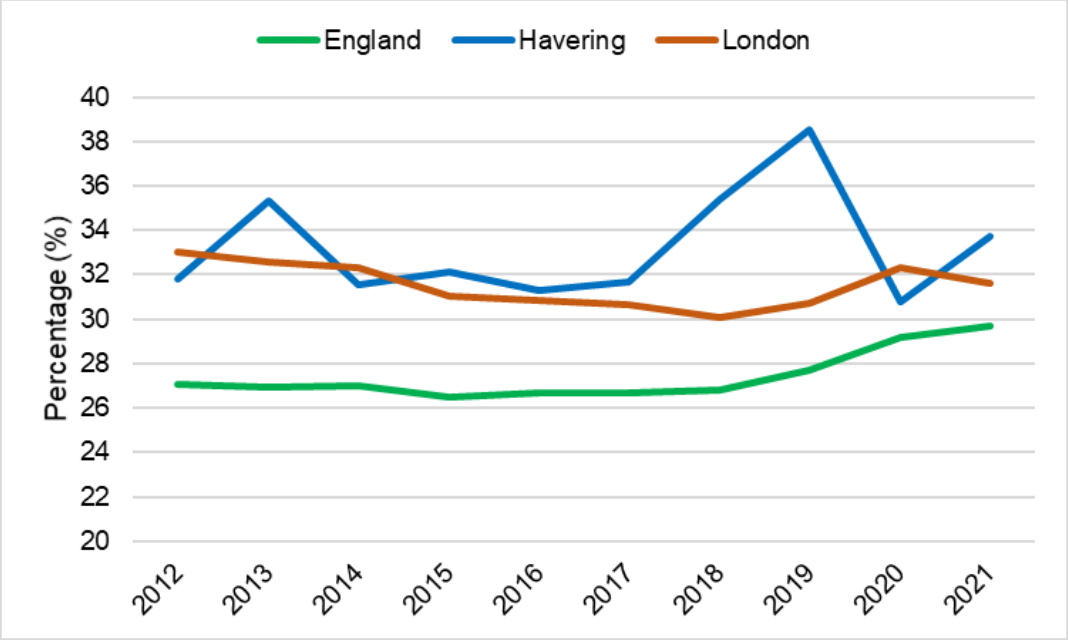
Teenage pregnancy is associated with poor outcomes for young women and their children. For mothers, there is a higher risk of poor educational attainment, social isolation and poorer mental and physical health, which will have implications for their lives as they move into

[140] https://fingertips.phe.org.uk/search/chlamydia#page/6/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/90776/age/156/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1
[141] https://fingertips.phe.org.uk/search/hiv#page/4/gid/1/pat/6/ati/502/are/E09000016/iid/90790/age/238/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1
[142] https://fingertips.phe.org.uk/search/hiv#page/4/gid/1/pat/6/ati/502/are/E09000016/iid/90790/age/238/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1
[143] https://fingertips.phe.org.uk/search/HIV#page/3/gid/1/pat/6/par/E12000007/ati/502/are/E09000016/iid/91818/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

adulthood[144]. In 2021, there were 57 recorded conceptions[145] amongst females aged 15-17 years of age in Havering – this equates to 12.5 conceptions per 1,000 females aged 15-17 years, reflecting a continued downward trajectory in under 18 conceptions seen nationally, regionally and locally. Havering's under 18 conception rate was slightly higher than the rate for London (9.5 per 1,000) and lower than the rate for England (13.1 per 1,000), though rates were considered statistically similar. Of recorded conceptions amongst under 18s in 2021, 42 (73.7%) led to a legal abortion, with the remaining 15 conceptions resulting in either a live or still birth[146].

Under 25 repeated abortions

Figure 26: Percentage of abortions in women aged under 25 years that involve a woman who has had a previous abortion in any year, Havering, London, England, 2012 – 2021



Source: OHID, Produced by LBH PHI

In 2021, 134 women in Havering aged 15-24 years accessed an abortion, having had at least one prior abortion at any time. These 134 women represent 33.7% of all 15-24 year olds accessing an abortion during the year. This proportion was similar to the London figure (31.6%), and slightly higher than the England proportion (29.7%) though still considered statistically similar.

Together, a high proportion of under 18 conceptions resulting in termination and a high proportion of women under 25 accessing repeat abortion may be indicative of a lack of access to easily available and acceptable contraceptive methods for young people, contributing to unplanned pregnancies.

[144] https://stateofchildhealth.rcpch.ac.uk/evidence/health-behaviours/conceptions-in-young-people/
[145] Recorded pregnancies that result in one or more live or still births, or a legal abortion.
[146] https://fingertips.phe.org.uk/search/abortion#page/4/gid/1/pat/6/ati/502/are/E09000016/iid/90731/age/173/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Service Gaps / Unmet Needs

The bulk of the specialist integrated sexual health service provided by BHRUT is currently delivered at Barking Hospital, with a limited contraception service currently running from Queen's hospital once per week and limited contraception and sexual health services provided from Ilford Exchange twice per week. Geographical access for Havering residents is therefore likely to be more challenging than for residents in other boroughs, which is likely to be contributing to lower levels of service access and impacting on health outcomes.

There are also opportunities to strengthen the current provision of community-based sexual and reproductive health services, including expanded provision of long-acting reversible contraception (LARC) within primary care and emergency hormonal contraception (EHC) within pharmacies and a potentially enhanced offer from these venues. Work is also needed to explore opportunities to strengthen the local SRH offer for young people.

Recommendations

- LBH, ICB, NHS and other partners to commit to delivery against actions outlined in the North East London Sexual and Reproductive Health Strategy, and accompanying local action plan.
- LBH to work with local partners to review existing community-based SRH provision to identify any opportunities to strengthen or diversify this offer.
- LBH to work with BHRUT integrated sexual health service to identify opportunities to improve service access for Havering residents, particularly young people and those from vulnerable populations.
- LBH and partners to improve visibility and awareness of full suite of SRH provision amongst residents.

4.6.5 Vaccination

Introduction

Among healthy adults in the living well life course, only pregnant women are included in the NHS Vaccination Programme.[147]

Pregnant women are recommended to have two vaccines: influenza vaccine during flu season and a pertussis (whooping cough) vaccine between weeks 20 and 32 of pregnancy, to provide their infant with protection from birth. Infants under 3 months are at highest risk of severe disease and too young to be fully vaccinated.

Pertussis cases have recently risen across England, with 9 reported deaths in infants between January and June 2024. Infants are at high risk for severe morbidity and mortality from pertussis disease during early infancy. Vaccination against pertussis in pregnancy has emerged as the ideal strategy to protect infants during these early, vulnerable, first months of life.[148]

[147] https://www.nhs.uk/vaccinations/nhs-vaccinations-and-when-to-have-them/
[148] https://www.gov.uk/government/publications/vaccination-against-pertussis-whooping-cough-for-pregnant-women/pertussis-whooping-cough-vaccination-programme-for-pregnant-women

When pre- conditions exist, such as diabetes, vaccinations can prevent against illnesses that can be very serious. GP's have a responsibility to provide flu vaccinations to those 'at-risk' with the following underlying conditions[149]:

- a serious heart or chest complaint, including asthma and COPD
- serious kidney disease
- diabetes
- lowered immunity due to disease or treatment such as steroid medication or cancer treatment
- if you have ever had a stroke

Findings

Prenatal pertussis vaccine coverage has fallen across England in recent years, and was 58.9% in March 2024. Coverage in London is markedly lower than in other regions, and monthly coverage in NEL ICB is lower (34.5%) than for London as a whole (40.9%), for March 2024. Havering's prenatal Pertussis vaccine uptake in 2023/24 was low at 32.2%.[150]

Flu vaccine coverage among pregnant women has also fallen, from 45.2% in 2018/19 to 35% in 2022/23, across England. The flu vaccine uptake among pregnant women in Havering overall was 24.2% with 33.1% among pregnant women in a high clinical risk group.[153]

Havering's flu vaccine coverage of at risk individuals in 2023/24 was 37.1% which was lower than England average (41.4%).[151]

Service Gaps / Unmet Needs

Vaccination data for pregnant women could be an underestimate as the data recording onto electronic patient records is known to be incomplete and NHS England are working to improve data collection.

Recommendation

NHSE, ICB and Primary care work together to increase vaccine coverage within primary care, secondary care and maternity services, and reduce health inequalities related to vaccination uptake.

[149]This list is subject to change with time. Please check on NHS website.
[150]https://assets.publishing.service.gov.uk/media/5a7f757bed915d74e33f68fd/PrenatalPertussis_annual_vaccine_coverage_estimates_CCG__2_.xlsx
[151]https://fingertips.phe.org.uk/profiles

4.6.6 Cancer Screening

Introduction

NHS cancer screening programmes can help to diagnose cancer or risk of cancer earlier and improve the likelihood of successful treatment. There are three national cancer screening programmes in England.

- Cervical screening
- Breast screening
- Bowel screening.

In Havering, cancers are the number one cause of difference in life expectancy due to inequality among women. Both breast cancer screening and cervical cancer screening programmes detect a third of respective cancers among women.[152]

Cancer screening programmes achieve better coverage in Havering than elsewhere in NEL ICB areas. Despite this, bowel screening detects only 10-15% of colorectal cancer as in other areas. NHS England and National Screening Committee have reflected on the yield from bowel screening and are currently working on improving access to FIT testing for older age groups with symptoms and lowering the diagnostic threshold of FIT testing across England.

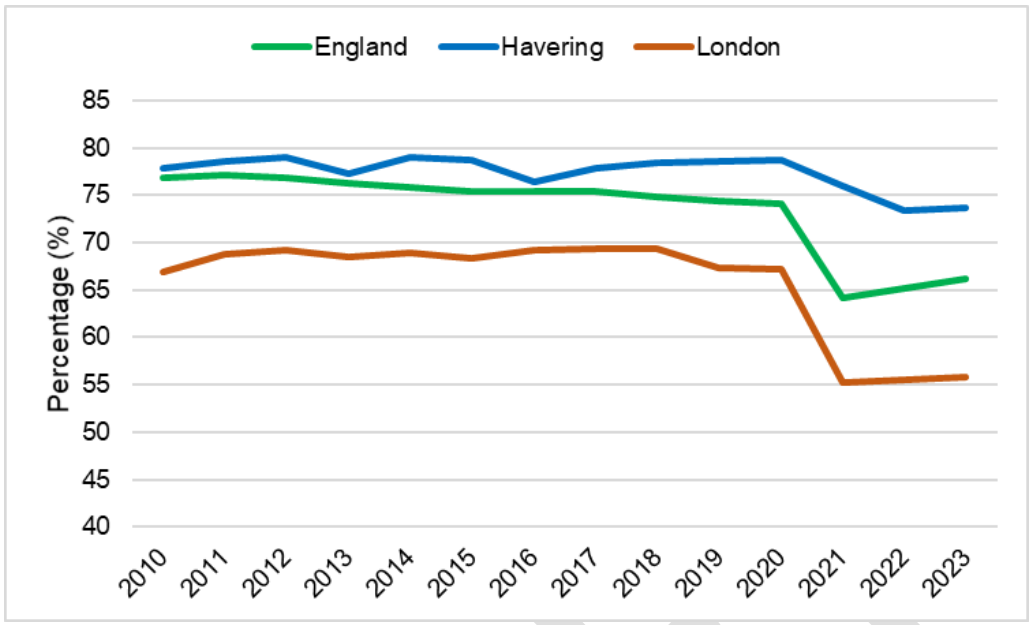
Breast screening occurs every 3 years for women aged 50-70 years. Target coverage is 70%. NHS is currently undertaking a trial on women of ages 47-73 years. Cervical screening for women aged 25-49 is done every 3 years and for those aged 50-64 every 5 years. The national target coverage is 80%.

Findings

Havering's coverage for breast cancer in 2023 was 73.7% (21,092 women). There has been a drop in the coverage since the pandemic but the coverage is now on an upward trend (Figure 27).

[152] https://digital.nhs.uk/ndrs

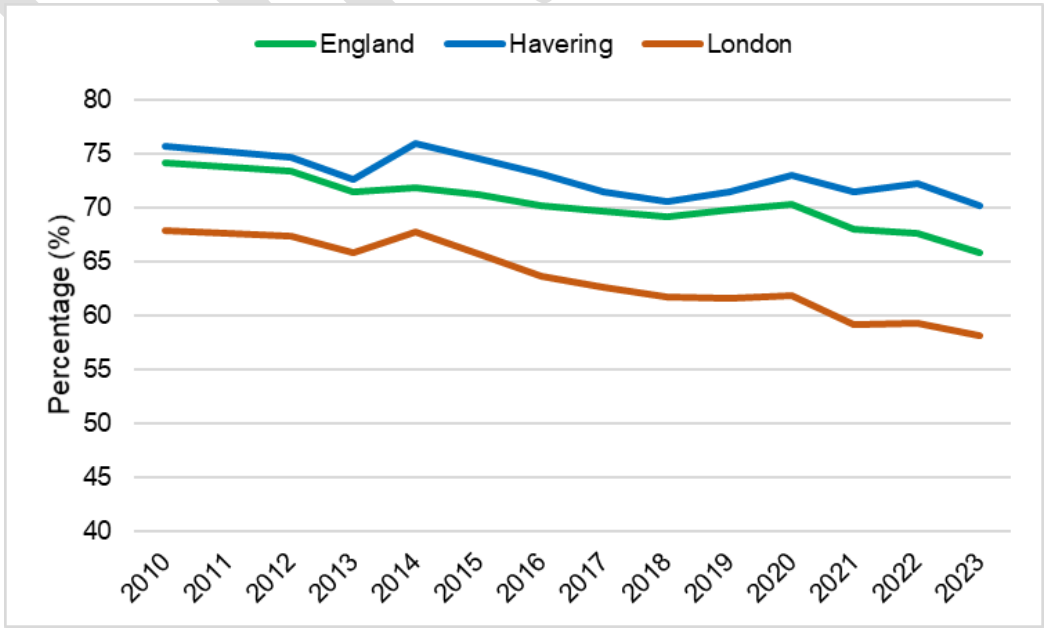
Figure 27: Breast cancer screening coverage, Havering, London, England, 2010 – 2023



Source: OHID, Produced by LBH PHI

Cervical screening coverage for women aged 25 to 49 year-olds in Havering was one of the highest in London in 2023 with 70.2% coverage (35,369 women in 3 years) but it is slowly dropping (Figure 28). Nonetheless, thanks to the HPV vaccination, the new diagnosis of cervical cancer has been dropping to under publishable numbers.

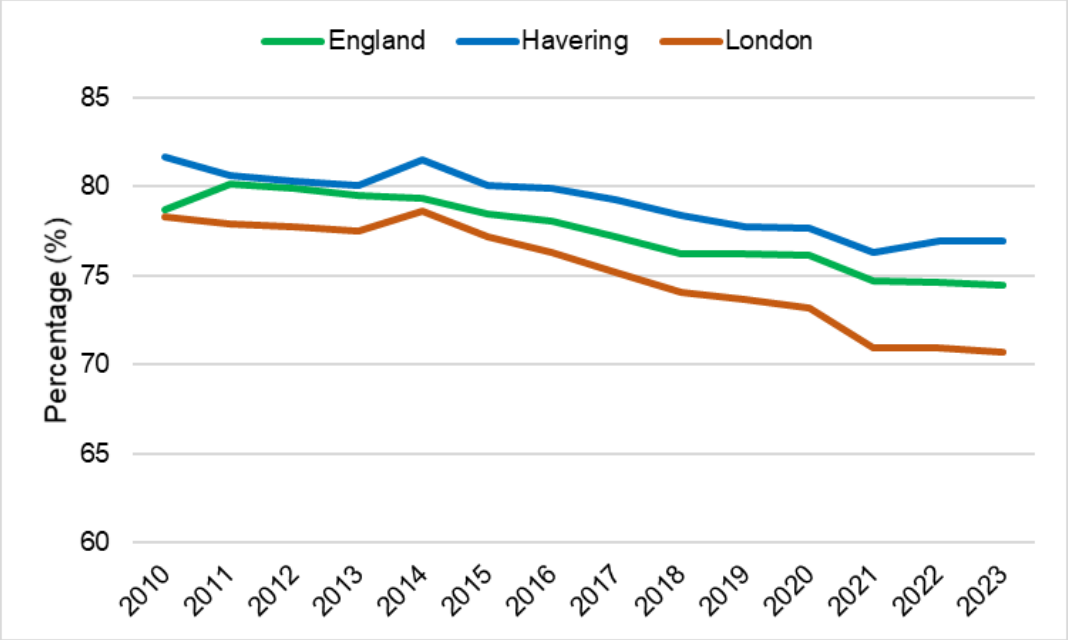
Figure 28: Coverage of cervical cancer screening (25-49 year olds, round length 3 years), Havering, London, England, 2010 – 2023



Source: OHID, Produced by LBH PHI

Cervical screening coverage for women aged 50 to 64 year-old women in Havering was the highest in London in 2023 with 76.9% coverage (18,876 women in 5 years) but it is also slowly dropping (Figure 29).

Figure 29: Cervical screening coverage for women aged 50 to 64, Havering, London, England, 2010 – 2023



Source: OHID, Produced by LBH PHI

Service Gaps / Unmet Needs

Bowel cancer screening detects up to 15% of bowel cancers[153] thus patient presentation to the GPs and subsequent GP referrals are crucial in early diagnosis and treatment of bowel cancers.

Recommendation

NHS England, NELCA and Havering GPs continue to improve cancer screening coverage and reduce health inequalities by improving access for those with Severe Mental Illness (SMI) and Learning Disability.

[153] https://www.nboca.org.uk/wp-content/uploads/2024/02/NBOCA-SotN.pdf

4.6.7 Health Screening

Introduction

Health screening[154] is a way of finding out if people have a higher chance of having a health problem, so that early treatment can be offered or information given to help them make informed decisions.

- Screening can detect a problem early, before you have any symptoms.
- Finding out about a problem early can mean that treatment is more effective.
- Finding out you have a health problem or an increased chance of a health problem can help people make better informed decisions about their health.
- Screening can reduce the chance of developing a condition or its complications.
- Some deaths from abdominal aortic aneurysms, bowel cancer, breast cancer and cervical cancer can be prevented.

17,141 people are recorded as having diabetes in Havering in 2022/23. People living with diabetes are at risk of sight loss and blindness, and in 2022/23, 5 patients were recorded to have lost their eye sight due to diabetes. Annual diabetic eye screening (DES) is recommended for everyone with diabetes aged 12 and over, to identify the risk of sight loss from diabetes.[155]

Abdominal aortic aneurysm or AAA (triple A) is a bulge or swelling in the aorta which is the main blood vessel that runs from the heart to the abdomen. If AAA is left to get bigger, it could burst and cause life-threatening internal bleeding. Abdominal aortic aneurysm (AAA) screening aims to reduce AAA related mortality among men aged 65 to 74.[156]

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. Public Health England estimated that for every 6 to 10 NHS Health Checks completed, one person is identified as being at high risk of CVD. Health checks also provide an opportunity to encourage people to tackle lifestyle related risk factors before they cause ill health and connect them with sources of support that might assist them to achieve change. A high take up of NHS Health Check among those with higher risk backgrounds is important to identify early signs of poor health leading to opportunities for early interventions.[157]

Findings

Diabetic eye screening (DES) uptake in 2022/23 in NEL ICB was 74.6% which was lower than London (78.3%) and England (79.1%) averages. DES attendance was lower among the under 40s population in London, North East London and England. In terms of ethnicity, uptake among Pakistanis, any other White group and not stated are slightly lower than other groups.[158]

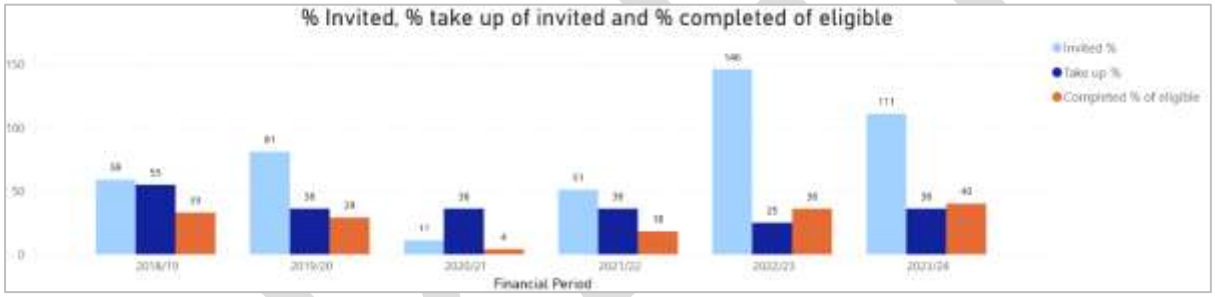
[154] https://www.nhs.uk/conditions/nhs-screening/
[155] https://www.nhs.uk/conditions/diabetic-eye-screening/
[156] https://phescreening.blog.gov.uk/2017/01/20/abdominal-aortic-aneurysm-screening-across-the-uk/
[157] https://fingertips.phe.org.uk/profile/nhs-health-check-detailed
[158] https://www.england.nhs.uk/london/

Abdominal Aortic Aneurysm Screening Coverage among men aged 65-74 years in Havering in 2022/23 was 85.6% (1,178 patients) which was better than both London (75.1%) and England (78.3%) averages.

NHS Healthcheck performance has increased to above pre-pandemic levels as most local GPs are supporting NHS Health check as a part of prevention. In 2023/24, 40% of the eligible persons completed NHS Healthcheck. Since local GPs invite more than the eligible number for the year, the uptake percentage was artificially lower than the completion rate (Figure 30).

In Q1 2023/24, 211 residents with 10% risk of a heart disease and stroke in 10 years and above of whom 33 with above 20% risk; 161 new hypertension and 294 obesity cases were identified and given advice and treatment as required. According to local Havering data, men and "other" ethnic groups were the groups with low conversion (attendance after invitation) rate.

Figure 30: NHS Healthcheck invitation and completion against the eligible population by quarter. 2018/19 to 2023/24.



Source: Havering NHS Healthcheck Dashboard.

Service Gaps / Unmet Needs

Marshall PCN has the lowest completion rate of NHS Healthcheck and public health are working with the practices to understand and tackle related challenges.

Recommendations

- To facilitate the Diabetic Eye Screening (DES) uptake by working age group, weekend appointment capacity should be increased. Other improvement plans underway include a web-based booking system, additional methods of result communication and contacting serial non-attenders.
- NHS HC should be linked with other preventive programmes such as NHS Diabetes Prevention Programme, Stop Smoking Services and weight management so that the impact of the programme will be higher.
- Targeted promotion of men and practices not delivering NHS Healthcheck is recommended.

4.7 Integrated Health & Social Care

Key Findings

- A very high percentage and number of the cancers of the lung, colon and rectum were diagnosed at late stages (3 and 4) in 2019-21. A high percentage of the cancers of oesophagus, pancreas, stomach and oral cavity were also diagnosed at late stages.
- Havering's Mortality rate from all cancers (241/100,000) in 2023 was higher than the London average (226/100,000) but lower than the England average (247/100,000).
- Mortality rate from prostate (49.2/100,000), oesophageal (11.2/100,000), and bladder (9.1/100,000) cancers in Havering were higher than London averages (prostate 40.3, oesophageal 8.1, bladder 7) during the 2021-23 period.
- Under 75 mortality rate from all cancers (116/100,000) in Havering during the 2021-23 period was higher than London average (110 /100,000) but lower than England average (122/100,000). Under 75 mortality rate for colorectal cancer in Havering over the same period (12.1/100,000) was higher than both London (10.5/100,000) and England (11.9/100,000) averages.
- 7.9% of Havering residents (17,141 residents) were recorded to have diabetes in 2022/23. It is estimated that 5,265 residents could be having diabetes without knowing it.
- Around 14,000 Havering residents currently do not know they have hypertension and therefore cannot seek help to stop the consequences.
- Atrial fibrillation detection and management has led to reduction in stroke admissions. Despite the high proportion of older population, hospital admissions from stroke in Havering in 2022/23 was 121 per 100,000 (300 in number from 365 in 2019/20) which was lower than the England average (168/100,000)
- Hospital admissions from uncontrolled long-term conditions (LTC) overall in Havering was similar to the England average but previously it has been better than England average.
- Results from Long-COVID surveys carried out by Healthwatch Havering, working with Public Health Havering, NELFT, Havering North PCN and others, show that there is a need for support for those affected by Long COVID.
- In 2023/24, the number of adults who were registered to a GP practice in Havering and had depression or anxiety disorder was 17% (49,665).
- According to GP records, 0.8% of the Havering adult population (2,073) have severe mental illness.
- In 2023/24 only 60.2% of pregnant women in Havering received their antenatal booking appointment within the first 10 weeks of pregnancy.
- Pregnant women in Havering had a higher rate of access to specialist perinatal mental health services between 2020/21 - 2022/23 (101 per 1,000 pregnant women) than the London (74.4 per 1,000) and England (77.8 per 1,000) averages.
- During 2023/2024, around a quarter of pregnant women in Havering were found to be obese or severely obese at 15 weeks gestation, with around a further third recorded as overweight.
- In 2022/23, the rate of hospital admissions from Ambulatory Care Sensitive Conditions (ACSCs) in Havering (89.9/100,000) was similar to the England average (91.9), but previously it was better than the England average.
- In 2023/24, 1,368 Havering residents aged 18-64 received support from the Havering Adult Social Care. 733 were male and 635 were female. Altogether they received 2,043 care packages. Both the demand and complexity has been rising.
- As of April 2024, 30 residents in mental health residential or nursing placements and 136 residents were under residential or nursing learning disability placements.

- More than 320 clients with LD or MH were in direct payment, around 250 were receiving supported living and 84 were receiving Homecare placement.
- Average residential home placement cost has risen by +£167 per week as compared to 2022-23, and supported living by +£200 per week (due to the higher complexity of need and other factors).
- In 2023/24, 4,483 residents aged 65+ were receiving support from Havering Adult Social Care. 1,504 were male and 2,979 were female. Altogether they received 6,655 care packages.
- In 2021/22, 282 residents aged 65+ were admitted permanently to residential or nursing care homes. This was the third highest number in London and equivalent to a rate of 606 per 100,000 permanent admissions to care homes which is significantly higher than the average rates for London (401/100,000) and England (539/100,000).
- Among Havering residents aged 65 years and over who needed a placement (3,160), most were in homecare placements (1,697), which has the lowest cost per placement (£20,171 per annum) but the highest percentage increase in per unit cost.
- Supported living has the highest average annual placement cost (£65,410 per annum) closely followed by nursing placement (£61,352) and residential care (£53,409). The increase in the number of users is highest with supported living and residential care. The intensity of need has become higher as the cost on 1:1 services more than tripled in 3 years (£2.52M in 2021 to £8.23M in 2023/24).

Recommendations

- NEL Cancer Alliance and Havering partners should work towards improving early diagnosis through better screening coverage, raising awareness of cancers with highest numbers of late diagnosis among the residents (lung, colorectal, upper GI, prostate), working with GPs to review opportunities for early detection, appropriate referrals, and strengthening diagnostic capacity including the use of the RDC (rapid diagnostic clinic) and targeted lung health check.
- Long-term Conditions group should strengthen the community infrastructure and awareness to improve the detection of hypertension, obesity, atrial fibrillation and prediabetes and to use transformation and innovation (which includes digital health/medical technologies) to speed up diagnosis and management of LTCs.
- Long-term Conditions group should review and improve where necessary the current approach to the delivery and monitoring of long-term conditions (e.g., diabetes, long-covid) to ensure access to effective care, self-management and peer support.
- Havering Community Mental Health Board should support individuals with mental health conditions to live, fulfilling, meaningful and healthy lives, and ensure equitable access to mental health services, and doing so in a timely manner to prevent deterioration of mental health to crisis presentations
- Partnership to commit to delivering against a place-based maternal and neonatal action plan, seeking to maximise impact through collaborative action.
- Planned care Group should support implementation of plans developed by the BHR Planned Care Transformation Board to reduce waiting times for planned care.
- The ICB UEC Group should enable same day access to urgent care in the community whenever possible, and, if a visit the Emergency Department is needed, to provide a positive experience
- Population health management (PHM) approach should be used to identify the avoidable risk factors for learning disability and other care packages; and to recommend most effective mental health and physical support interventions, including the use of technology for better and efficient care.

4.7.1 Cancers

Introduction

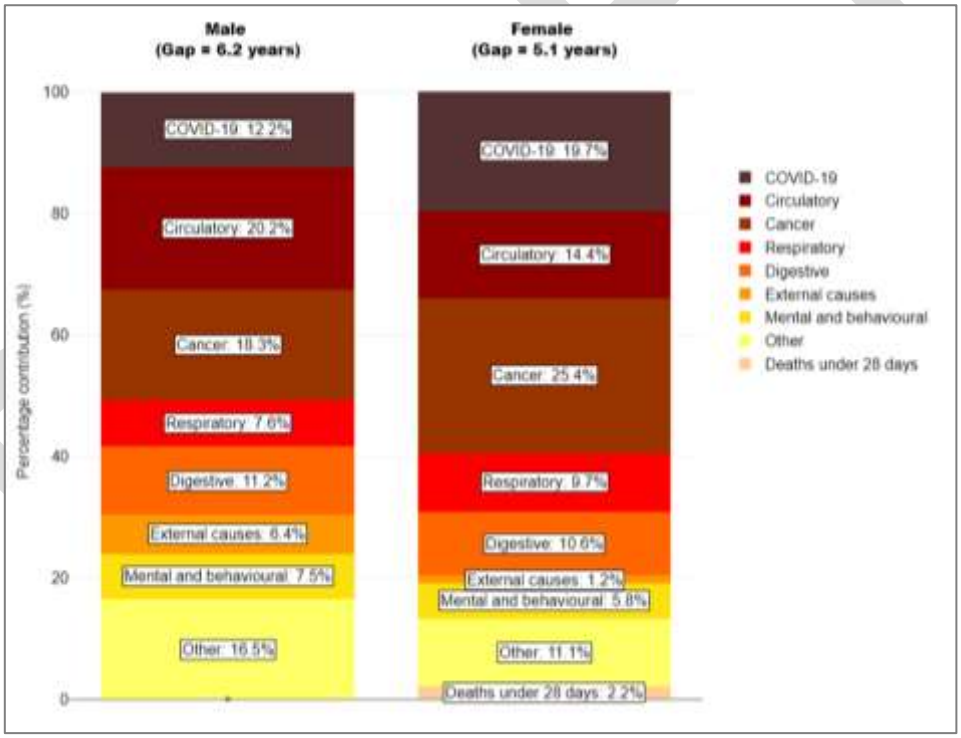
A person's risk of developing cancer depends on many factors, including age, genetics, and exposure to risk factors. Around 4 in 10 UK cancer cases every year could be prevented, that's more than 135,000 every year. Smoking accounts for 15% of all cancer cases.

In England, 45% of patients diagnosed with cancer have surgery to remove the tumour as part of their primary cancer treatment. 27% of patients have radiotherapy, and 28% have chemotherapy (CRUK).

Findings

In Havering, cancer is the second cause of life expectancy gap between the most and least deprived for men and first cause of the gap for women (Figure 31).

Figure 31: Breakdown of the life expectancy gap between the most and least deprived quintiles in Havering by cause of death, 2020 – 2021.



Source: OHID & Department of Levelling Up, Housing and Communities.

Prevalence & Incidence

- 22% of people with cancer (10,637 in number out of 46,580) in NEL live in Havering.
- All Havering PCNs have a significantly higher prevalence of cancer than NEL average.
- The high prevalence may be due to higher proportion of older people, past smoking or second-hand smoking, alcohol use and emerging obesity.

- In 2021/22, 21% of new cancer cases (1,616) in NEL Cancer Alliance areas were from Havering. The crude incidence rates of cancer in all four PCNs in Havering were higher than the NEL average.

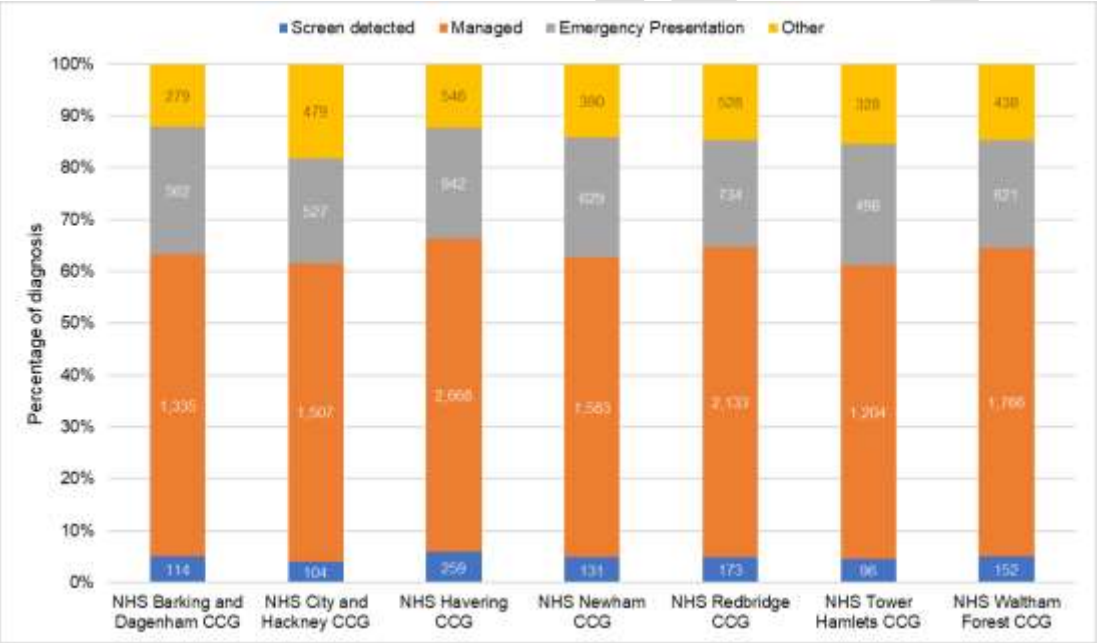
Diagnosis

In 2017 (latest data available) Havering had a slightly higher proportion of diagnosis at emergency presentation (21%) than England average (18%). Nonetheless within the ICB, the crude rate of cancers diagnosed via a non-emergency admission route in Havering PCNs are the highest in the ICB.[159]

Route to diagnosis

Both the number (259) and proportion of cancers diagnosed through screening in Havering (6%) are the highest in NEL (2017, latest data for this breakdown). 61% (2,668) of new cancer diagnoses were from GP referrals and 942 (21%) were diagnosed through emergency admissions (Figure 32).

Figure 32: Route to diagnosis by legacy CCGs in North East London, 2017



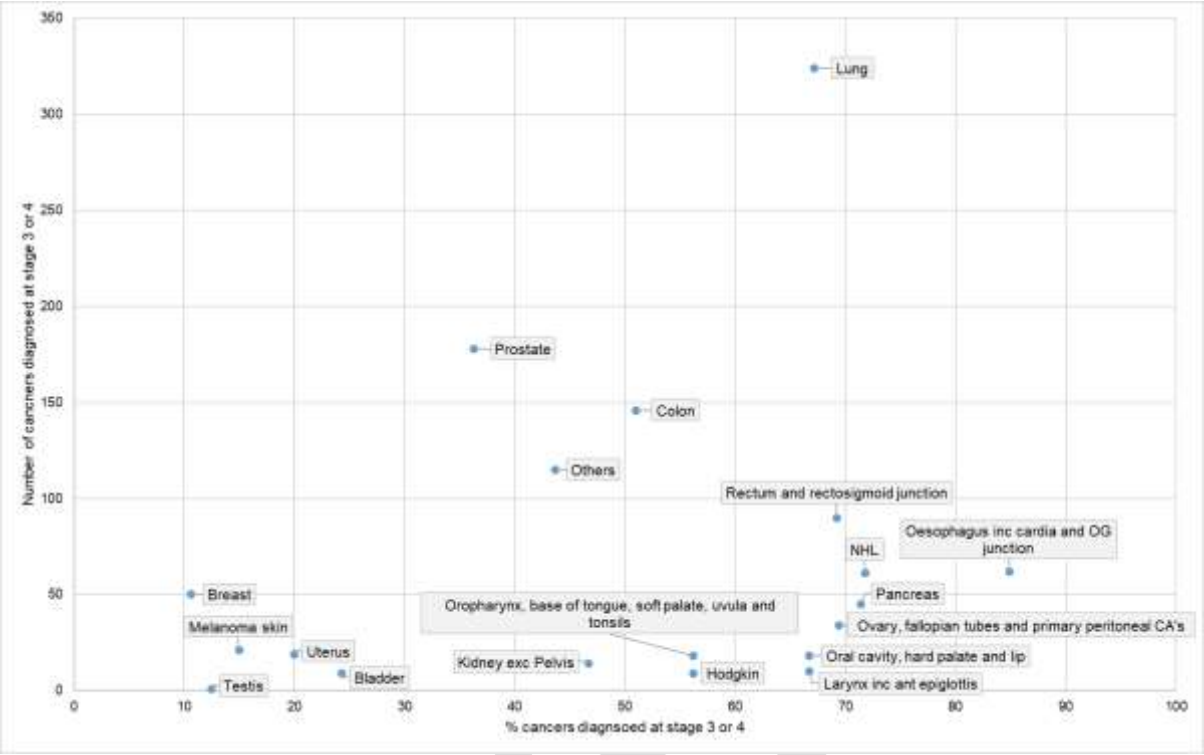
Source: NDRS Online.

Late diagnosis: Number and Percentage of cancers detected at stages 3 and 4

In 2019-21, a very high percentage and number of the cancers of the lung, colon and rectum in Havering were diagnosed at late stages (3 and 4). A high percentage of the cancers of the oesophagus, pancreas, stomach and oral cavity were also diagnosed at late stages (Figure 33).

[159] NDRS Online

Figure 33: Cancers diagnosed at Stages 3 and 4 by number (Y axis) against percentage (X axis), Havering, 2019-21



Source: NDRS, 2019-21.

Mortality and Premature mortality from common cancers[160]

- Havering's mortality rate from all cancers (241/100,000) in 2023 was higher than the London average (226/100,000) but lower than England average (247/100,000).
- Havering's mortality rate from lung cancer (40.5/100,000) was lower than the London (41.8/100,000) and England (47.5/100,000) averages in 2021-23, a drop from 47.8/100,000 in 2020-22.
- Havering's mortality rates from prostate (49.2/100,000), oesophageal (11.2/100,000), and bladder (9.1/100,000) cancers were higher than London averages (prostate 40.3, oesophageal 8.1, bladder 7) in 2021-23.
- Havering's under 75 mortality rate from all cancers (116.1/100,000) in 2021-23 was higher than London average (110/100,000) but lower than England average (122/100,000).
- Under 75 mortality rate for colorectal cancer in Havering over the same period (12.1/100,000) was higher than both London (10.5/100,000) and England (11.9/100,000) averages.

Excess premature deaths due to cancers in adults with SMI

Havering's excess under 75 mortality rate due to cancer in adults with severe mental illness (SMI) in 2021-23 (165%) was higher than both London (154%) and England (130%) averages.

[160] https://fingertips.phe.org.uk/profiles

Service Gaps / Unmet Needs

For lung cancer and bowel cancer to be diagnosed early and for improved survival, thoracic surgical and endoscopy capacities need to be significantly increased from current levels.

Recommendations

- LBH and partners should continue with prevention interventions such as smoking cessation and dietary awareness.
- Data on the stages at diagnosis for cancers in Havering should be utilised to prioritise cancer awareness survey and campaigns (lung, rectum, upper GI, pancreas, NHL). A local focus group study on the public and professional knowledge and behaviour towards the above cancers is highly recommended.
- NHS England, NEL Cancer Alliance and Havering GPs should continue to improve cancer screening coverage and if possible, beyond target for bowel cancer.
- Work to develop tailored communication, building on our local Place based Partnership approach to target these communities to improve screening uptake.
- Diagnostic capacity, endoscopy capacity, thoracic surgery capacity should be increased substantially and endoscopy threshold should be revised.
- NEL cancer alliance (NELCA) and partners should continuously improve 62-day standard for Havering residents.
- NELCA should obtain and review local survival data and work towards improving survival rates where they are lower than the European standard.

4.7.2 Long Term Conditions

Introduction

Long-term conditions (LTC), also known as chronic conditions, are those health conditions that require ongoing treatment or management over a period of years or decades. They may not be able to be cured or reversed but can be controlled with the use of medication and therapies.[161] Many LTCs may cause few symptoms initially, whilst increasing the risk of serious acute events long-term, such as heart attack or stroke, which can lead to premature death or long-term disability. This may mean that people are less likely to seek help at an early stage of their condition and LTCs may remain undiagnosed and unmanaged. Moreover, of those that do have a diagnosis, many do not receive all the treatments that would benefit them.[162] Many LTCs are associated with lifestyle related risk factors such as unhealthy diet, smoking and low levels of physical activity. Some LTCs are also linked to environmental exposures e.g. the risk of chronic obstructive pulmonary disease (COPD) and asthma are increased by regular exposure to poor air quality. The prevalence of lifestyle and environmental risk factors tend to be higher in disadvantaged communities and are the immediate cause of significant inequalities evident regarding many LTCs.

Secondary prevention aims to reduce or reverse the negative impacts of LTCs. The effects of many LTCs, such as diabetes, may be reversed or prevented through effective secondary

[161] https://www.england.nhs.uk/wp-content/uploads/2014/09/ltc-infographic.pdf
[162] https://www.patients-association.org.uk/long-term-conditions

prevention and also could lead to substantial improvements in quality of life.[163] Tertiary prevention for LTCs refers to efforts to reduce the negative impacts on health and quality of life for those with LTCs and prevent further complications. This is particularly challenging as individuals may have more than one LTCs affecting their lives.[164]

More than one in four adults nationally live with two or more LTCs (Multiple Long Term Conditions)[165] Persistent symptoms following a clearance of COVID-19 infection is commonly termed as 'long COVID' but has also been referred to as 'ongoing symptomatic COVID-19' and 'post-COVID-19 syndrome'. It is estimated that approximately 11% of patients with long COVID will need specialist assessment and management for specific long-term complications and therefore can be considered as a long-term condition.[166]

Findings

- Hospital admissions from uncontrolled LTC overall in Havering was similar to the England average but previously it has been better than England average. e.g., Hospital admissions rate for diabetes in 2023 was 218 per 100,000. The number of admissions (577) was an increase from 385 in 2020.[167]

*All data reported below were sourced from OHID & NHS England[168]

- Atrial fibrillation detection and management has led to reduction in stroke admissions. Although Havering has older population who are at much higher risk, the rate of hospital admissions from stroke in Havering in 2022/23 was 121 per 100,000 (300 in number, a reduction from 365 in 2019/20) which was lower than the England average (168 /100,000).
- 2.4% of Havering residents (6,414 in number) were recorded to have coronary heart disease in 2022/23.
- Havering's hospital admissions for myocardial infarction in 2023 was 207 per 100,000. The number of admissions has been increasing (548 in 2023 from 469 in 2019).
- Havering's prevalence of heart failure was 0.8 per 100,000 (2,062 residents) in 2022/23
- Havering's under-75 mortality rate from circulatory diseases (72.2/100,000) in 2022 was slightly lower than the London (75.0/100,000) and England (77.8/100,000) averages.
- In 2022/23, 14.4% of the population (39,211 residents) in Havering was recorded to have hypertension.
- Around 14,000 Havering residents currently do not know they have hypertension and therefore cannot stop the consequences.
- Havering's rate of deaths involving hypertension was 197 per 100,000 in in 2022/23, which was similar to London average (199 /100,000) but higher than the England average (141/100,000)
- In 2022/23, 7.9% of Havering residents (17,141 residents) were reported to have diabetes.
- In 2022/23, it was estimated that 5,265 Havering residents could be having diabetes without knowing it.
- In 2022/23, 1.6% of Havering patients (4,402) were reported to have COPD, higher than the London average (1.0%) but lower than England average (1.8).

[163] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund/integration-resource-library/prevention
[164] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund/integration-resource-library/prevention
[165] https://evidence.nihr.ac.uk/collection/making-sense-of-the-evidence-multiple-long-term-conditions-multimorbidity/
[166] https://committees.parliament.uk/writtenevidence/12345/pdf/
[167] https://www.local.gov.uk/our-support/research-and-data/lg-inform-data-benchmarking
[168] https://fingertips.phe.org.uk/profiles

- Over the 2020-22 period, Havering's death rate from COPD was 45 per 100,000 populations which was higher than the London average (39/100,000) but similar to England average (43/100,000)
- Havering's Under 75 mortality rate from respiratory diseases (34.5/100,000) in 2022 was higher than the London (26.1/100,000) and England (30.7/100,000) averages.

Service Gaps / Unmet Needs

Results from Long-COVID surveys carried out by Havering Healthwatch, working with Public Health, NELFT, Havering North PCN and others, show that there is a need for support for those affected by Long COVID. Patients can be referred to the NELFT Long COVID clinic where clinical indicators suggest that is needed but the opportunity for setting up Peer Support Groups is still being explored.

Recommendations

- Due to the strong link between modifiable lifestyle factors (such as alcohol, smoking and obesity) and long-term conditions; effective, culturally sensitive primary prevention which reflects the distribution of risk factors within the community can reduce the overall burden of long-term conditions and narrow health inequalities.
- Havering Place-based Partnership (PbP) should continue to implement health inequalities programmes linked to Core20plus5.
- LTC group and PbP to improve the Community infrastructure for the detection of hypertension, obesity, atrial fibrillation and prediabetes should be strengthened.
- LTC group to use transformation and innovation (which includes digital health/medical technologies) to speed up diagnosis and management of LTCs.
- NHS Diabetes Programme, NHS Health check programme, weight management, National diabetes prevention programme (DPP), diabetes remission programme and community stop smoking service should work closely to support those with highest need.
- Due to the high volume of need around hypertension management, primary care should be supported by new model of care e.g., support of clinical pharmacists.
- The ICS should review and amend where necessary the current approach to the delivery and monitoring of diabetes care (including 8 care processes) to ensure that all effective care is consistently provided.
- ICB and partners should continue the momentum in the improvement of the management of heart disease and cardiac rehabilitation.
- Services in primary care (e.g., DS, LES and VCS) should be mapped and made known for professionals and patients using JoyApp.
- ICB and partners should continue to improve access and uptake of flu vaccination, and COVID vaccination to those who are at risk.
- Self-management and peer support should be mapped and promoted in a number of channels to meet the diverse needs. Patient activation methods could be applied.
- Development of a Peer Support Group network should continue to be explored.
- Borough partnerships should work with primary care clinicians and with the public to raise awareness of long COVID, opportunities for self-care and appropriate referral for specialist assessment.

4.7.3 Mental Health

Introduction

Mental health is shaped by interactions among biological, psychological, social and environmental factors—including social conditions, support systems, education, occupation, neighbourhood environments, individual lifestyle choices and healthcare access.[169] Both common mental health conditions (CMDs), like anxiety and depression, and severe mental illness (SMI), including schizophrenia and bipolar disorder, impact well-being. Recognising this, the Health and Social Care Act 2012 established mental health as equally important as physical health.[170] Since 2019, the NHS has increased funding for mental health services annually, including in Havering.[171]

Mental illness can lead to social isolation, relationship difficulties and can increase the risk of suicide and other self-harm.[172] In 2022/23, it was the leading cause of working days lost in the UK[173], costing England an estimated £300 billion in 2022.[174] In 2017, 15.9% of Havering adults were estimated to have a CMD, below the London average of 19.3% and similar to the national rate (16.9%).[175] In 2023/24, 17% (49,665 patients) of GP-registered patients were reported as having depression or anxiety[176] while 0.8% (2,073 patients) were diagnosed with an SMI.

Age: Among GP registrations, adults aged 50-69 have the highest CMD rates, while SMI is most prevalent in those aged 50-59.

Gender: Women report CMDs more often than men, but men are less likely to seek help,[177] are underrepresented in Talking Therapies[178] and more likely to use harmful coping mechanisms.[179] For SMI, GP records show higher prevalence among men.

Ethnicity: White British individuals have the highest CMD rates in Havering, while Black populations show higher SMI rates. People of African/Caribbean descent are overrepresented in psychiatric care.[180]

[169] https://doi.org/10.1007/s11920-018-0969-9
[170] https://commonslibrary.parliament.uk/mental-health-achieving-parity-of-esteem/
[171] https://northeastlondon.icb.nhs.uk/wp-content/uploads/2024/07/NEL-ICB-Annual-report-and-accounts-2023-24.pdf
[172] https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968#:~:text=Mental%20illness%20is%20a%20leading,disease%20and%20other%20medical%20conditions
[173] https://www.hse.gov.uk/statistics/dayslost.htm
[174] https://www.centreformentalhealth.org.uk/publications/the-economic-and-social-costs-of-mental-ill-health/#:~:text=Review%20of%20methodology%20and%20update%20of%20calculations&text=This%20analysis%20finds%20that%20the,due%20to%20mental%20ill%20health.
[175] https://fingertips.phe.org.uk/common-mental-disorders
[176] North East London Integrated Care Board Analysis 2024.
[177] https://www.gov.uk/government/calls-for-evidence/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper
[178] https://www.mentalhealth.org.uk/explore-mental-health/statistics/men-women-statistics
[179] https://committees.parliament.uk/work/7858/mens-health/
[180] https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

LGBTQ+: Mental health issues are disproportionately higher in the LBGTQ+ community, with nearly half of transgender individuals having considered suicide.[181]

Learning Disabilities: Mental health issues among adults with learning disabilities are often overlooked and misattributed to their disability. 40% of adults with learning disabilities estimated to experience mental health problems at any given time.[182]

Substance misuse: In 2022/23, 87.7% of those entering alcohol treatment and 81.4% of those entering drug treatment also received mental health support.

Rough Sleeping: Adults who are rough sleepers face higher rates of mental ill health, often because of poor socioeconomic outcomes and co-occurring challenges, including substance misuse, physical health issues and history of trauma.

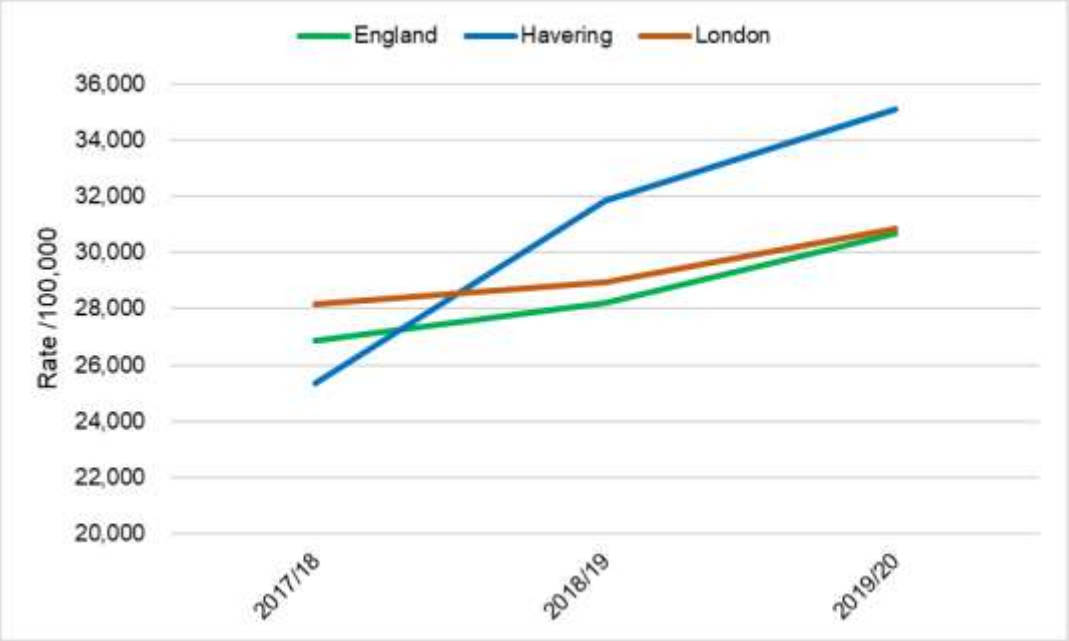
Prison population: An estimated nine out of ten people in prison have a mental health condition, substance misuse issue, or dual-diagnosis needs.[183]

Havering offers extensive mental health support to meet the diverse needs of residents, with services spanning primary care, community and voluntary sector services and specialist support. The following examples highlight local efforts to target and improve mental health outcomes:

- Havering Mental Health and Wellness Teams provide targeted support for adults 18-65 with significant mental health difficulties, including conducting adult social care assessments and interventions. From October 2023 to August 2024, they averaged receiving 186 referrals per month and increased the number of routine referrals assessed within 6 weeks from 83.1 to 93.9%. On average, for every three residents in Havering (35,106/100,000 population; approximately 89,140 contacts), there is one community and outpatient mental health attendance in 2019/20 (Figure 34). This increasing use of community mental health services may have helped reduce inpatient hospitalisations, as Havering is one of the boroughs with the lowest use of inpatient mental health services (179/100,000 compared to 276/100,000 London average) (Figure 35).
- Talking Therapies (formerly IAPT) provide support for individuals with anxiety and depression. In 2023/24, Havering averaged 594 referrals per month, with 22% from BAME backgrounds, and meet NHS standards for waiting times. In 2023/24, Havering's performance exceeds NHS targets, with over 96% of referrals seen within six weeks and 99% within 18 weeks. Recovery rates also met NHS England's expectations (50%), with Havering achieving a recovery rate of 50.2%.
- Additionally, mental health service transformation is developing across Havering. For example, the Havering North Primary Care Network has successfully piloted the integration of psychological wellbeing practitioners within primary care. This approach has strengthened links between primary care and specialised mental health services, and supported the capacity and capability to manage patients with CMD. Patients whom PWPs engaged with who also completed therapy had an average recover rate of 65%, about 15% higher than the NHS performance target.

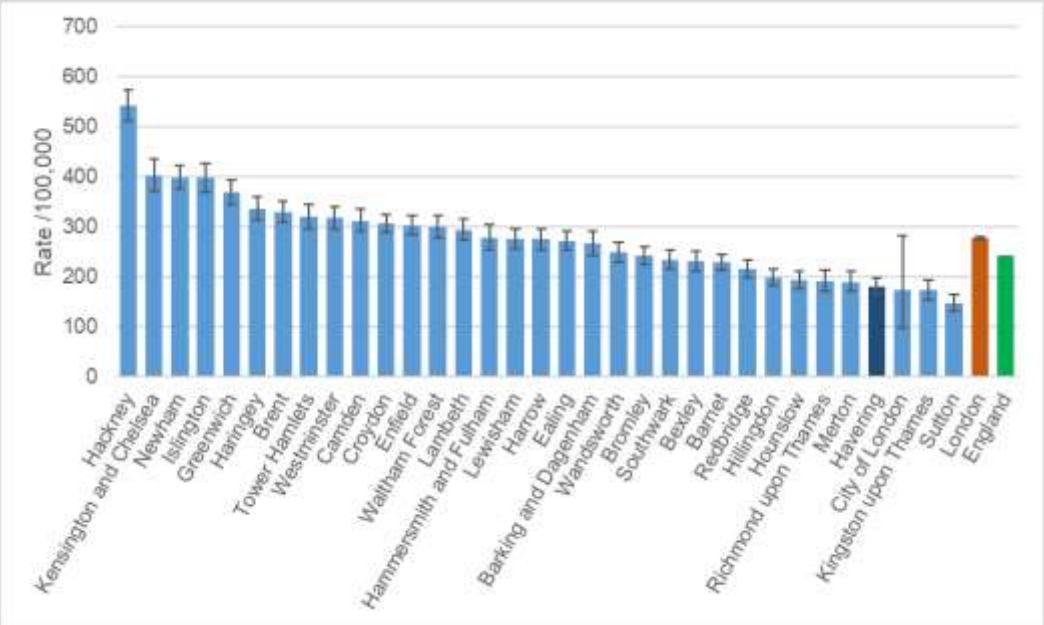
[181] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-lgbtiq-people
[182] https://www.nice.org.uk/guidance/ng54/chapter/context#:~:text=Population%2Dbased%20estimates%20suggest%20in,at%20any%20point%20in%20time.
[183] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Figure 34: Community and outpatient mental health service attendance per 100,000 population, Havering, London and England, 2017/18 – 2019/20



Source: OHID, Produced by LBH PHI

Figure 35: Inpatient stays in secondary care mental health services, 2019/20, London local authorities, London region and England.



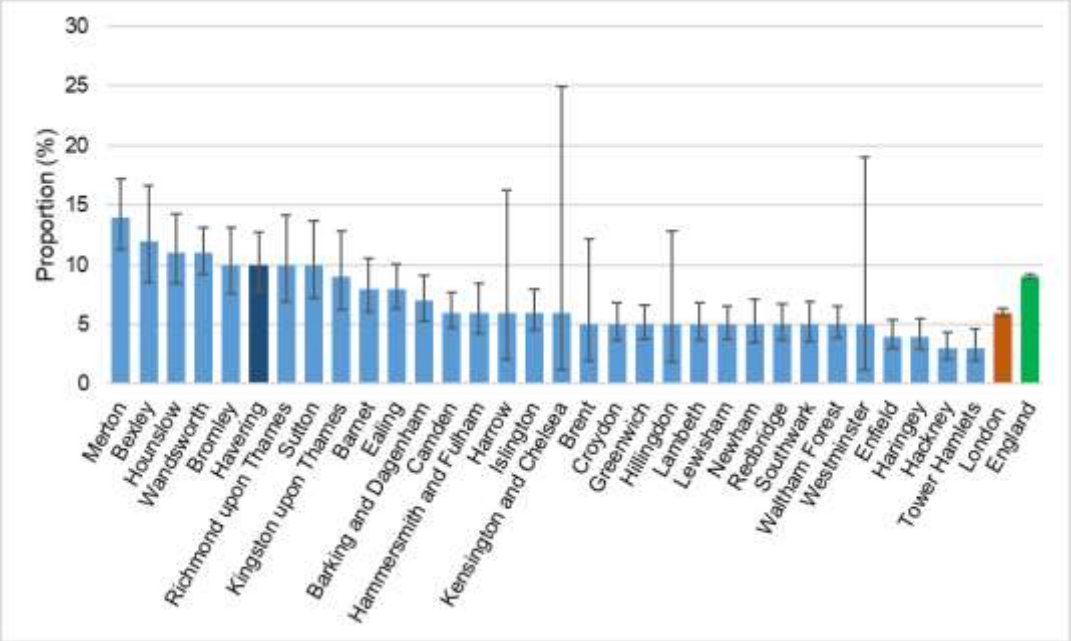
Source: OHID, Produced by LBH PHI

Findings

The proportion of adults in contact with secondary mental health services in paid employment or living independently in Havering (10%) was higher than the London (6%) and England (9%) averages in 2019/20[184] (Figure 36).

Havering managed to provide stable and appropriate accommodation to 83% of those adults who required secondary care mental health services. Although the rate has been a drop from 92% in 2013/14, it remains one of the highest in London (Figure 37).

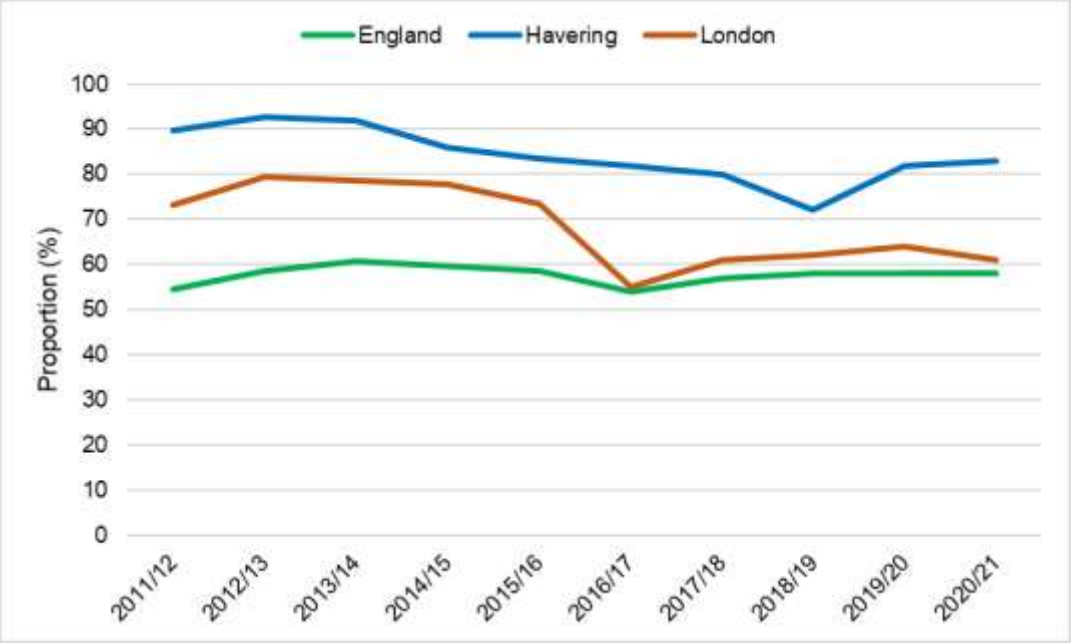
Figure 36: The percentage of the population who are in contact with secondary mental health services and on the Care Plan Approach that are in paid employment (aged 18 to 69), London local authorities, London region and England, 2020/21



Source: OHID, Produced by LBH PHI

[184] https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2020-21

Figure 37. Adults in contact with secondary mental health services who live in stable and appropriate accommodation, Havering, London and England, 2020/21



Source: OHID, Produced by LBH PHI

Service Gaps / Unmet Needs

While acute hospitals can provide crisis support, they are not always the most suitable setting for mental health emergencies. Crisis cafés serve as an alternative, offering non-clinical, therapeutic, and social support to reduce patient distress, emergency department visits and the length of inpatient stays.

SMI reduces life expectancy by 10-20 years,[185] largely driven by higher rates of cardiovascular disease, respiratory illness and cancer. Smoking rates are disproportionally higher among individuals with SMI, with rates between 50-80%. Despite NHS mandates and commissioning to deliver annual physical health checks for adults with SMI, gaps remain in annual physical health checks for individuals with SMI.

Recommendations

- Havering Council, NEL ICB, NHS, Social Care, voluntary organisations, employers, emergency services and other partners should sign the UK Government's *Prevention Concordat for Better Mental Health*.
- Havering Council, NELFT, NEL ICB and voluntary organisations should work together to ensure individuals with mental health conditions have timely access to equitable care, preventing deterioration into crisis.
- NELFT should assess expanding psychological wellbeing practitioners across all primary care networks in Havering.

[185] https://www.england.nhs.uk/long-read/improving-the-physical-health-of-people-living-with-severe-mental-illness/#:~:text=People%20living%20with%20SMI%20face,due%20to%20preventable%20physical%20illnesses.

- All key partners (Havering Council, NELFT, NEL ICB and voluntary organisations) should ensure public-facing staff have Making Every Contact Count (MECC) training to increase awareness, reduce stigma and promote early intervention.
- NELFT should evaluate whether groups at higher risk of mental ill health are proportionally represented in service access, treatment and outcomes.
- NELFT should pilot a Havering Crisis Café to provide non-clinical, therapeutic and social support to support those experiencing mental distress.
- Havering Council, NELFT, NEL ICB and voluntary organisations should collaborate with the *NEL SMI Physical Health Improvement Network* to ensure that individuals with SMI receive annual physical health checks.
- Public Health should commission a tailored stop smoking service for individuals with SMI.

4.7.4 Suicide Prevention

Introduction

Every suicide results from a complex interplay of risk factors and distressing life events, having devastating consequences for individuals, families, communities and frontline responders. Each death by suicide affects an average of 135 people, meaning nearly 900,000 people a year are affected by suicide across the UK per year[186].

The loss extends beyond personal grief, affecting healthcare professionals who experience emotional and professional strain, influencing recruitment, retention, quality of professional life and patient care[187]. Bereavement by suicide further increases the risk of additional suicides within affected circles, with socioeconomic deprivation playing a key role in disparities[188]. Beyond loss of life, there is economic burden, as every suicide costs at average £1.46 million to society. In 2022, productivity losses accounted for one third of all suicide-related costs in England, reaching £2.48 billion[186].

Suicide can affect anyone, but certain groups are at higher risk due to multiple vulnerabilities:

- **Age**: Suicide affects all age groups, but middle-aged individuals (40-59 years) are most at risk in Havering, reflecting national trends.
- **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[189]. Autistic people are seven times more likely to die by suicide than allistic (non-autistic) individuals[190].

[186] https://www.samaritans.org
[187] https://www.rcpsych.ac.uk
[188] https://www.samaritans.org/about-samaritans/research-policy/inequality-suicide/socioeconomic-disadvantage-and-suicidal-behaviour
[189] https://www.disabilityrightsuk.org/news/disabled-people-far-more-likely-die-suicide-non-disabled-people
[190] 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.

- **Gender identity and sexual orientation**: Men are three times more likely to die by suicide than women[191]. Additionally, individuals within the LGBTQ+ community face a higher risk of death by suicide compared to those who do not identify as LGBTQ+[192].
- **Ethnicity**: Although statistical evidence on differences in suicide rates among ethnic groups is limited, experiences of racism and discrimination contribute to poorer mental health outcomes and increased suicide risk[193].
- **Maternity**: Maternal suicide remains the leading cause of pregnancy-related deaths in the year after childbirth in the UK[194].
- **Deprivation**: People living in the most disadvantaged areas are 10 times more likely to die by suicide than those in the most affluent areas[195].
- **Stigma of mental ill health**: Communities with high levels of stigma surrounding mental illness and suicide often experience increased suicide risk due to lower engagement with preventative measures and support services[196].

The Havering All-age Suicide Prevention Strategy 2025-2030 aims to improve suicide prevention efforts across the borough, with the ultimate goals of reducing suicide rates in Havering. The Strategy is supported by a multi-agency steering group and a proposed Lived Experience Advisory Group, where individuals with personal experience of suicide contribute to shaping services and policies. Havering Public Health also maintains a dedicated suicide prevention webpage and training directory. There are also a variety of community-based services provide support to Havering residents:

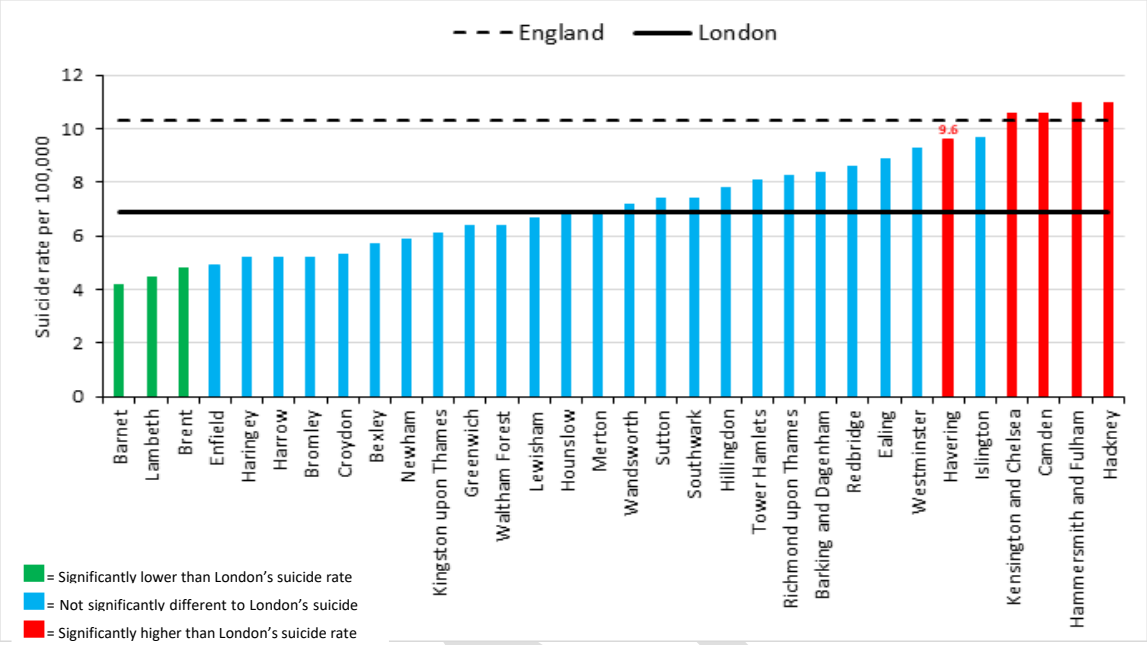
- Samaritans (Romford branch) – Offers free, 24/7 emotional support for anyone in distress.
- PAPYRUS – Provides specialist advice and resources for young people at risk of suicide and those supporting them.
- Grief in Pieces (Part of the Safe Connections: Local Support for People Facing Suicide) – Operated by MIND in North East London, this service offers tailored bereavement support for people and families who have experienced the loss of a loved one, friend or colleague to suicide.

Findings

Between 2015 and 2022, 139 lives were lost to suicide, with an additional 230 attempted suicides registered among Havering residents[197,198]. The average rate of suicide between 2020 and 2022 was 9.6 per 100,000 population, which is significantly higher than the London rate of 6.9 per 100,0000 and similar to the England rate of 10.3 per 100,000[15]. Havering is now one of the few London boroughs with a notably higher age-adjusted suicide rate, highlighting the need for targeted prevention strategies to address this growing concern.

[191] https://www.statista.com/statistics/282203/suicide-rate-in-the-united-kingdom-uk-since-2000-by-gender/
[192] https://www.tandfonline.com/doi/full/10.1080/09540261.2022.2053070
[193] https://www.samaritans.org/about-samaritans/research-policy/ethnicity-and-suicide/
[194] https://maternalmentalhealthalliance.org/news/suicide-remains-the-leading-cause-of-direct-maternal-death-in-first-postnatal-year/
[195] https://www.samaritans.org/about-samaritans/research-policy/inequality-suicide/
[196] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6998948/
[197] NEL Suicide Prevention Data Dashboard
[198] 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.

Figure 38 Three-year aggregate age-standardised suicide rates in London boroughs, London region and England, 2020-2022.



Source: Office for Health Improvement and Disparities (OHID) fingertips data, 2020-2022.[199]

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)[200]. In Havering, males accounted for 75% of attempted suicides and females accounted for 25% of attempted suicides from 2015 to 2023[201].

Figure 39: 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

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

Source: Havering All-age Suicide Prevention Strategy 2025-2030

Havering recently carried out a public consultation on Citizen Space and gathered feedback on suicide prevention from residents and other stakeholders. Key themes included the need

[199] Suicides in England and Wales - Office for National Statistics
[200] Primary Care Discovery Data Service from the Suicide Prevention NEL Data Dashboard
[201] Primary Care Discovery Data Service from the Suicide Prevention NEL Data Dashboard

for more discussions, safe spaces, stigma reduction and easier access to mental health care. Many also stressed the importance of preventive and proactive support, alongside tackling social, economic and environmental risk factors that contribute to suicide risk. Focus groups provided further insights into local needs:

- Primary Care Networks identified a gap in suicide prevention training, resources and crisis pathways, underscoring the need for better support for frontline health workers.
- Young people voiced the need for more empathetic support and accessible mental health resources, as well as more conversations about self-harm and suicide prevention.
- School networks highlighted the need for training for both parents and teachers. Educators also stressed the need to normalise stress and build resilience among students, equipping students with coping strategies.

Service gaps / identified needs

- Residents with lived experience report that bereavement services in Havering can be difficult to find, creating challenges for those coping with loss.
- Long waiting times and limited accessibility for marginalised groups prevent many from receiving timely, effective support.
- Insufficient early intervention and prevention that leads to more crises and long-term distress.
- Suicide and mental illness remain highly stigmatised, deterring individuals from seeking help, showing the need for more suicide prevention training for professionals, community members and frontline staff.

Recommendations

- Havering Council to adopt and implement a local all-age suicide prevention strategy to ensure best use of local data, intelligence and partnership working.
- Public Health to work to strengthen stakeholder collaboration (healthcare providers, voluntary and community sector organisations, council services) to address the complex and intersecting factors that lead to suicide.
- Havering Suicide Review Panel to review each death by suspected suicide amongst Havering residents to understand Havering-specific factors contributing to suicide with different demographic groups, such as socioeconomic status.
- Key partners and groups to continue to work across the North East London Region and more widely, London and National, including NEL Suicide Prevention Group, Havering Suicide Prevention Stakeholder Group, Havering Suicide Prevention Reference Group, Havering Suicide Prevention Steering Group, Havering Mental Health and Wellness Teams and Havering Talking Therapies.

4.7.5 Maternal Health

Introduction

Maternal health[202] refers to the health of women during pregnancy, childbirth and the postnatal period[203]. Being in good health and receiving good health and care support in the antenatal period is important to optimise outcomes for the pregnant woman or person, and their baby in the short and longer term. As such, supporting pregnant women to stay well has implications for both Starting Well and Living Well elements of the life course. Further information about maternal, neonatal and early years outcomes for Havering can be found in the Start Well JSNA chapter.

Antenatal care in Havering is provided by BHRUT, with core maternity services located at Queen's Hospital. While a significant proportion of Havering residents choose BHRUT as their maternity provider, patients are also able to access maternity services in other areas, including across NEL or further afield. Other elements of the maternity care pathway are also provided in primary care, and by NELFT (including perinatal mental health and health visiting services).

The North East London ICB 2024 Best Start in Life: A case for change report[204] and North East London Local Maternity and Neonatal System Equity and equality strategy and action plan 2022[205] both explore the challenges and inequalities that exist in across the local maternity and neonatal system (LMNS) and highlight opportunities for improvement. These, and other work, are contributing to the development of a NEL 10-year maternity and neonatal strategy.

Births

Provisional data for 2023/24 indicates that 3,019 live babies were born to Havering residents, the majority of births taking place at BHRUT maternity services. There has been a gradual decline in the number of births in Havering since 2016, with birth rates declining accordingly.

Ethnic inequalities in maternal outcomes

There has been marked growth in the proportion of births in Havering delivered to people from black, Asian, or other ethnic backgrounds, increasing from 22% in 2013/14 to 38.6% in 2022/23[206]. This reflects the increasing ethnic diversity of the borough, and is important given the national and local evidence about poorer maternal and neonatal outcomes amongst black and Asian women, and the higher prevalence of pre-existing conditions which are associated

[202]The phrases maternal, and mother are used to represent those who give birth to babies, while acknowledging that some of those who give birth are not cis-gender women.
[203]https://www.who.int/health-topics/maternal-health#tab=tab_1
[204]https://northeastlondon.icb.nhs.uk/wp-content/uploads/2024/07/Best-Start-in-Life-A-case-for-change_July-2024.pdf
[205]https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fnortheastlondon.icb.nhs.uk%2Fwp-content%2Fuploads%2F2024%2F10%2FNEL-LMNS-equity-and-equality-strategy_FINAL_v3.pptx&wdOrigin=BROWSELINK
[206]https://fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health/data#page/4/gid/1938132960/pat/6/par/E12000007/ati/502/are/E09000016/iid/92973/age/1/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

with poorer maternal outcomes. A previous equality analysis for North East London (NEL)[207] found that:

- Havering had the highest unplanned caesarean section rate across NEL, but rates are higher for black (32%) and Asian (28%) women than for white women (22%)
- Black women were found to be twice as likely to attend A&E during the course of their pregnancy as compared to white women (23% vs 11%).
- Black pregnant women were found to be more than twice as likely to have hypertension as compared to white women (11% vs 5%).
- Asian pregnant women were more than twice as likely to have diabetes (type 1, type 2 or gestational) as compared to white women (25% vs 10%).
- Black women were also found to have the highest rates of obesity across every NEL borough.

Addressing health inequalities for population groups that experience poorer maternal and neonatal outcomes is a key area of opportunity reflected in the NEL maternal and neonatal strategy 2024 case for change.[208]

Early access to antenatal care

Early access to maternity care is a vital part of ensuring that pregnant women or persons receive the necessary care and support, to optimise birth outcomes. A woman's first midwife appointment (booking appointment) should happen before the 10th week of pregnancy[209].

In 2023/24 only 60.2% of pregnant women in Havering received their booking appointment within this timeframe. This rate was similar to the rate across London (59.2%), but worse than the England average (63.5%). In the same period, 10% of all women booking at BHRUT did not do so until more than 20 weeks of pregnancy (+141 days gestational age)[210]. Equality analysis across NEL identified disparities in early booking rates, with black women in Havering tending to access antenatal care an average of 4 weeks later than white women[211].

Maternal body mass index (BMI)

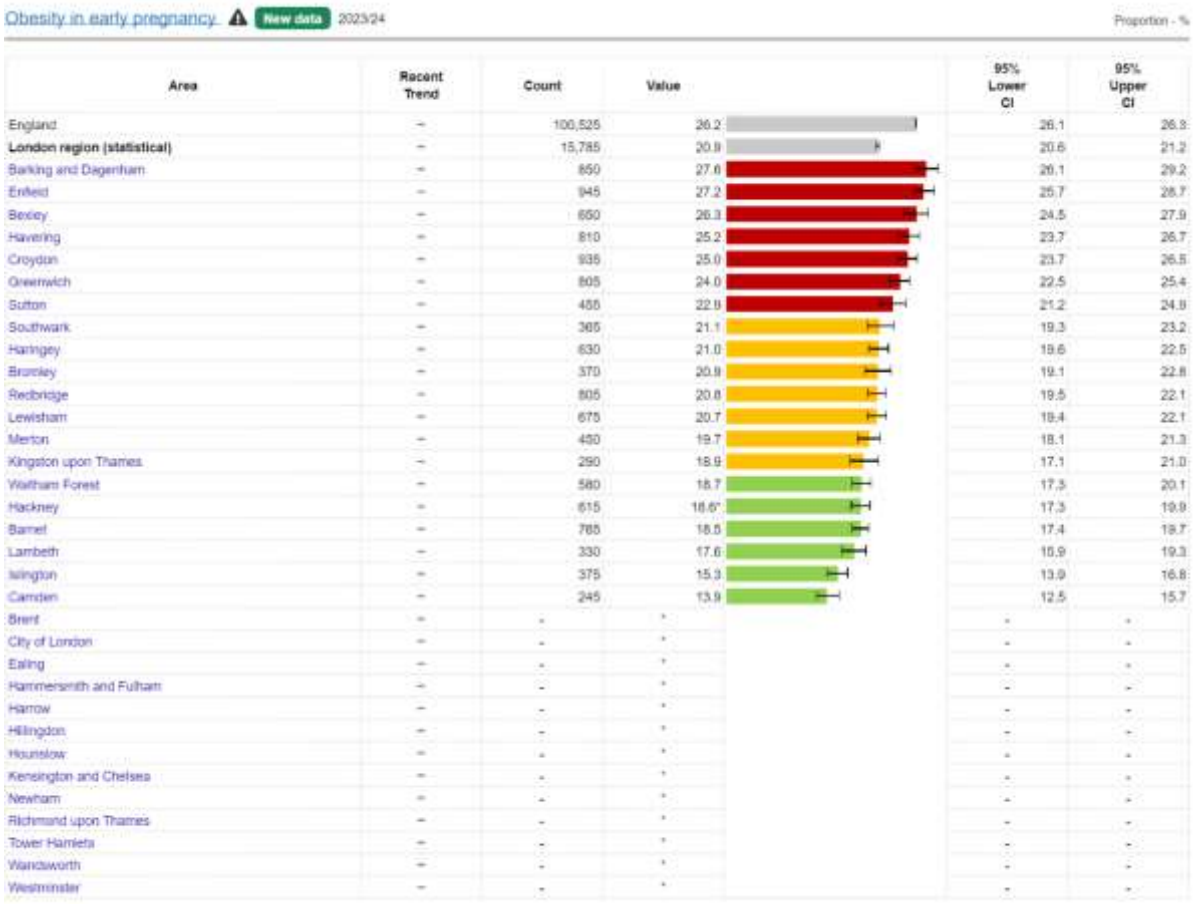
Obesity has become one of the most commonly occurring risk factors in obstetric practice. Pregnant women who are obese are at greater risk of a variety of pregnancy-related complications compared with women of normal BMI, including pre-eclampsia and gestational

[207] https://www.healthwatchhavering.co.uk/sites/healthwatchhavering.co.uk/files/NHSNEL%20-%20Maternity%20report.pdf
[208] https://northeastlondon.icb.nhs.uk/wp-content/uploads/2024/07/Best-Start-in-Life-A-case-for-change_July-2024.pdf
[209] https://www.nice.org.uk/guidance/ng201/evidence/h-timing-of-first-antenatal-appointment-pdf-9202942629
[210] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard
[211] North East London Local Maternity and Neonatal System Equity and equality strategy and action plan (2022)

diabetes. Pregnant women who are obese are also at increased risk of caesarean birth and can complicate other aspects of maternal care[212].

Between April 2023 and March 2024, around a quarter of women booking with BHRUT at 15 weeks gestation were found to be obese or severely obese, while around a further third were recorded as overweight[213]. Comparative data for London boroughs suggest that Havering has one of the highest rates of maternal obesity in early pregnancy in North East London and London (amongst those boroughs for which this data has been published[214]).

Figure 40: Proportion of mothers identified as obese within the first 14 weeks of pregnancy, 2023/24



Obesity in early pregnancy ⚠ New data 2023/24

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	100,525	26.2	26.1	26.3
London region (statistical)	-	15,785	20.9	20.6	21.2
Barking and Dagenham	-	850	27.6	26.1	29.2
Enfield	-	945	27.2	25.7	28.7
Bexley	-	650	26.3	24.5	27.9
Havering	-	810	25.2	23.7	26.7
Croydon	-	935	25.0	23.7	26.5
Greenwich	-	805	24.0	22.5	25.4
Sutton	-	455	22.9	21.2	24.9
Southwark	-	365	21.1	19.3	23.2
Haringey	-	630	21.0	19.6	22.5
Bromley	-	370	20.9	19.1	22.8
Redbridge	-	805	20.8	19.5	22.1
Lewisham	-	675	20.7	19.4	22.1
Merton	-	450	19.7	18.1	21.3
Kingston upon Thames	-	290	18.9	17.1	21.0
Waltham Forest	-	580	18.7	17.3	20.1
Hackney	-	615	18.6*	17.3	19.9
Barnet	-	765	18.5	17.4	19.7
Lambeth	-	330	17.6	15.9	19.3
Islington	-	375	15.3	13.9	16.8
Camden	-	245	13.9	12.5	15.7
Brent	-	-	*	-	-
City of London	-	-	*	-	-
Ealing	-	-	*	-	-
Hammersmith and Fulham	-	-	*	-	-
Harrow	-	-	*	-	-
Hillingdon	-	-	*	-	-
Hounslow	-	-	*	-	-
Kensington and Chelsea	-	-	*	-	-
Newham	-	-	*	-	-
Richmond upon Thames	-	-	*	-	-
Tower Hamlets	-	-	*	-	-
Wandsworth	-	-	*	-	-
Westminster	-	-	*	-	-

Source: OHID

[212] https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/care-of-women-with-obesity-in-pregnancy-green-top-guideline-no-72/

[213] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

[214] For data quality reasons, data for City of London, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, Newham, Richmond upon Thames, Tower Hamlets, Wandsworth and Westminster has not been published

Maternal mental health (perinatal mental health)

Nationally, it is reported that as many as one in five women develop a mental health problem during pregnancy or in the first year after the birth of their baby (the perinatal period)[215]. Recently published model-based estimates of perinatal mental health prevalence from 2019 suggest the figure could be closer to one in four[216]. These problems can frequently go unrecognised and untreated, with some women not seeking help because of fear of stigma or intervention by social services. If left untreated, perinatal mental health problems can have significant and long-lasting effects on the woman, her family, [217]

Locally reported data suggests that 12.2% of pregnant women in Havering accessed specialist community perinatal mental health services in 2023-24. This proportion was higher than for residents of Barking and Dagenham and Redbridge (averaging 7% of pregnancies)[218]. This may reflect a difference in population need but may be likely to be impacted by local differences in identification and referral rates and access to other support services available within the borough.

Newly published data indicates that pregnant women in Havering had a higher rate of access to specialist perinatal mental health services between 2020/21 - 2022/23 (101.1 per 1,000 pregnant women) than the London (74.4 per 1,000) and England (77.8 per 1,000) averages[219].

- Maternal smoking is considered in section 4.4.3 Smoking.
- Maternal vaccination is considered in section 4.4.7 Vaccination

Service gaps / unmet needs

The North East London ICB 2024 Best Start in Life: A case for change report identifies the following opportunities for improvement in relation to maternal health:

- Matching maternity demand and capacity in the system - ensuring that maternity capacity can respond to both the expected increase in demand and changing profile and complexity of pregnancies.
- Strengthening antenatal and postnatal care pathways - working to ensure that antenatal care pathways are clearly accessible and understood by all pregnant women or people and other professionals, and extensively signposted to, to support early access to care.
- Addressing variation in quality, access and experience – taking action to address quantitative and qualitative evidence that demonstrates variation in experiences and outcomes experienced by those accessing different antenatal care provision across NEL.
- Reducing health inequalities – understanding and acting on persistent inequalities which drive differences in maternal experiences and outcomes.
- Making the most effective use of staff resource and improving staff wellbeing - optimising the future workforce model to make best use of staff resources and skillsets in response

[215] https://www.rcog.org.uk/media/3ijbpfvi/maternal-mental-health-womens-voices.pdf
[216] https://fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health/data#page/3/gid/1938132957/pat/6/par/E12000007/ati/502/are/E09000016/iid/94103/age/332/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0
217 Maternity and mental health | NICE
[218] NELFT Perinatal Mental Health Service Data, provided by NEL ICB
[219] https://fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health/data#page/4/gid/1938132975/pat/6/par/E12000007/ati/502/are/E09000016/iid/94089/age/316/sex/2/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

to population needs, while ensuring that staff are effectively supported to avoid low morale, poor mental and physical wellbeing and risk of burnout.

Locally, there are concerns about the growing numbers of women being identified with diabetes (gestational, or not-previously diagnosed type II) during pregnancy, and the higher rates of access to perinatal mental health support services amongst Havering residents compared to Barking and Dagenham and Redbridge. Work is underway to develop a place-based maternal and neonatal action plan, which will further articulate the specific issues and challenges faced in Havering and identify partnership actions to address them.

Recommendations

- As part of a life-course approach to addressing excess weight, partnership to actively promote local weight management opportunities to support women wishing to conceive to lose excess weight prior to conception.
- Health and Wellbeing board to support efforts to maximise the proportion of eligible women taking up Healthy Start vouchers during pregnancy to support access to healthy foods, ensuring that a broad range of partners are actively promoting the scheme.
- NEL ICB and health partners to explore any reasons for differential referral rates for perinatal mental health support amongst Havering residents and any disproportionately affected groups, and whether there is need for additional prevention or early intervention to support existing provision.
- All partners to support efforts to promote access to early antenatal care, particularly amongst communities or groups that tend to access maternity services later in pregnancy.
- NEL ICB and maternity providers to improve access to preconception advice for women with existing, or at higher risk of long-term conditions, including diabetes.
- Partnership to commit to delivering against a place-based maternal and neonatal action plan, seeking to maximise impact through collaborative action.

4.7.6 Sensory Impairment, Disability & Learning Disability

Introduction

People with poor health and / or disability are at particular risk of disadvantage in all its forms and their outcomes are worse than those of general population. In 2023, 6% of the population in England was reported to have hearing loss and two million people are estimated to be living with sight loss in the UK.

More than one in 44 people in England[220] have a learning disability. A learning disability is not the same as a learning difficulty, which is a reduced ability for a specific form of learning. Learning difficulties encompass a broader range of conditions than learning disabilities, including dyslexia and attention deficit hyperactivity disorder (ADHD).

A person with a learning disability may also have one or more learning difficulties. Some people who fit the definition of having a learning disability prefer to talk about themselves as a person who has learning difficulties. There are also a number of impairments and genetic differences that may involve some type of learning disability, such as Down's syndrome,

[220] www.mencap.org.uk/ learning-disability-explained/research-and-statistics/how-common-learningdisability

autism and cerebral palsy. Having a learning disability affects the way a person learns new things, throughout their life, and the type of learning disability they have will determine how much care and support they will need. People with a learning disability have higher levels of premature death compared with the rest of the population. Unhealthy diet and smoking could be more common than in the general population and adherence to health advice could be challenging. People with learning disability also have poor physical and mental health, and as a result they live shorter lives.[221]

In England, regular Health checks have resulted in the identification of previously undetected health conditions in 51% to 94% of patients.[222] The number of previously undetected or unmanaged health needs (cancer, oral health, dementia, ear wax etc.) identified per patient range from 2 to 5. Health checks are also effective in promoting actions to address identified health needs such as vaccinations, blood tests, breast and testicular screening, dental review and vision and hearing assessment.

Findings

- In Havering, an estimated 38,449 residents reported having a disability in 2021. The neighbourhoods in Havering that have the highest number of households where at least one member is disabled were Hornchurch Marshes, Rush Green and Harold Hill East[223].
- The estimated number of people in Havering aged 18-64 with impaired mobility in 2023 is 8,653, equivalent to a rate of 5,463 per 100,000 population. This rate is significantly higher than the London average (4,945)[224].
- In 2023, 103 Havering residents aged 18-64 were estimated to have a serious visual impairment, 957 severe hearing loss and 15,443 some hearing loss[225].
- The prevalence of people with a learning disability was recorded to be 0.4% in Havering compared to 0.4% in London and 0.6% in England[229].
- Among those who have a diagnosis of autism, the prevalence of learning disability could be around 40%[226].
- Health messages do not reach people with learning disability effectively[227]. People with learning disabilities are less likely to do regular exercise and eat a balanced diet with enough fruit and vegetables[228]. For example, during the pandemic the LD community experienced 4.1 to 6.3 times higher rate of death from COVID-19 than the general population due to insufficient prevention measures[229].

[221] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/health-inequalities
[222] https://www.gov.uk/government/publications/annual-health-checks-and-people-with-learning-disabilities/annual-health-checks-and-people-with-learning-disabilities#:~:text=Studies%20have%20consistently%20demonstrated%20that,51%25%20to%2094%25%20of%20patients
[223] https://www.haveringdata.net/wp-content/uploads/2024/04/Havering-JSNA-Demography-Chapter-2024.pdf
[224] https://democracy.havering.gov.uk/documents/s72056/JSNA%20Demography%20Chapter%202023%20v0.3A.pdf
[225] https://fingertips.phe.org.uk/profiles
[226] https://www.sciencedirect.com/science/article/pii/S2666776223000455?via%3Dihub
[227] https://www.tandfonline.com/doi/full/10.1080/09687599.2024.2333017
[228] https://assets.publishing.service.gov.uk/media/5a82eb88e5274a2e87dc3a49/Social_care_staff_supporting_diet_and_exercise_in_learning_disabilities.pdf
[229] https://www.gov.uk/government/news/people-with-learning-disabilities-had-higher-death-rate-from-covid-19#:~:text=It%20found%20451%20per%20100%2C000,such%20as%20age%20and%20sex.

- There are higher proportions of those with severe obesity (37%) among people with learning disabilities than among people without learning disabilities (30.1%) in England.
- Chronic constipation is common among those with learning disabilities due to the unbalanced diet[230].
- Proportion of eligible adults with a learning disability having had a health check (73.7%, 674) in Havering was higher than London average (58.2%) and England average (52.3%) in 2018/19 (Note: these are latest available data from NHS England as data at legacy CCG level is no more made publicly available).
- Medical evaluation of 1,135 people with learning disabilities referred to a clinic for challenging behaviour found that 75% of the sample had one or more undiagnosed or undertreated health problems[231].
- Proportion of working age adults with learning disability in paid employment (2.8%) in Havering is lower than both London (5.3%) and England (4.8%) averages in 2022/23[232].

Service Gaps /Unmet Needs

Awareness and adjustment in care could be improved to meet the needs of people with learning disability and those who communicate differently due to their disability.

Recommendations

- Formation of a working group under Place based Partnership to increase accessibility of services and awareness within staff around how to support people who are deaf or communicate differently, to co-design with local people and to implement the actions such as awareness training and accessible information standards.
- Partners should ensure health messages and health programmes are culturally sensitive and services should be designed to enable equal access to those with learning disabilities, working with carers and families.
- Healthy weight and weight management programmes need to consider tailored approach co-designed with service users with learning disabilities and carers
- Reasonable adjustments should be made to health services to improve access for people with a disability including learning disability
- ICS and HWB to work with NHS England and OHID to ensure publication of data at Place level related to learning disability in parity with other ICBs in England as sub-ICB level data are not available in London
- ICB and Primary care should work together to continue high levels of annual health checks and to ensure a pathway for positive behaviour support.
- Council and NHS providers should collaboratively work with the DWP to offer residents excluded from employment due to disability and / or ill health including mental illness the opportunity to gain confidence, skills, work experience and ultimately secure employment. (applying social values in contracts)

[230] https://bjgp.org/content/72/720/348

[231] https://www.gov.uk/government/publications/annual-health-checks-and-people-with-learning-disabilities/annual-health-checks-and-people-with-learning-disabilities#:~:text=Medical%20evaluation%20of%201%2C135%20people,hypothyroidism%20(13%25)

[232] https://fingertips.phe.org.uk/profiles

4.7.7 Planned Care, Unplanned Care and Dental Services

Introduction

A variety of health care is provided on a planned basis, including diagnostic investigations, specialist assessment and then treatment, including surgery. In England, it's a requirement that 92% of patients should not wait longer than 18 weeks from referral to treatment (RTT).[233] The benefit of planned care includes the ability to avoid acute events and ability to offer more treatment options than in an emergency situation. Nonetheless, when capacity is limited, often emergency care is prioritised and waiting time for planned care becomes longer. This could become a vicious cycle in a few situations and result in poor health outcomes including the need for an A&E attendance or emergency procedure.

Unplanned care is care that is delivered when the person seeking care, and their health-care providers, did not anticipate that care would be required. Reducing unplanned care in hospitals (accident and emergency department visits and hospital admission) is a priority for the NHS.[234]

Urgent and Emergency Care (UEC) services perform a critical role in responding to the acute illnesses and emergencies. Very large numbers of people attend UEC service as it offers one-stop shop for healthcare needs. This has created a huge demand on the services and resulted in many people waiting to be seen at the A&E department. Alternative services offering a faster, more convenient response, at lower cost to the NHS, are available via other urgent care options and /or primary care.

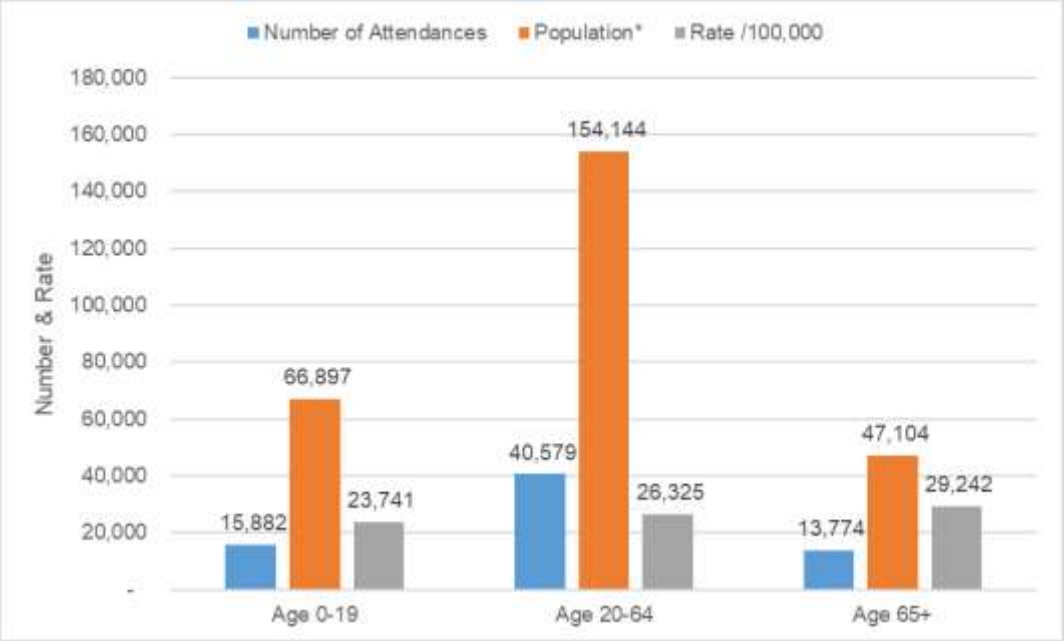
A number of the opportunities identified in other chapters of the JSNA could reduce pressure on urgent and emergency care e.g. improved management of LTCs, better identification and care of frail older people, better end of life care, easier access / perceived access to primary care etc.

Findings

Demand on unplanned care takes resources away from planned care, and vice versa. A&E attendance and emergency hospital admissions continue to increase. In 2023/24, there were over 26,000 A&E attendance per 100,000 persons in Havering. A&E use by Havering residents at BHRUT was the highest among persons aged 65 years and over (29,242 per 100,000) followed by age 20-64 (26,325/ 100,000) and 0-19 (23,741/100,000) (Figure 41).

[233] https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks/referral-to-treatment-consultant-led-waiting-times-rules-suite-october-2022
[234] https://www.england.nhs.uk/wp-content/uploads/2014/08/avoid-unplanned-admissions.pdf

Figure 41: Havering residents A&E attendance by age group, BHR UT hospitals, 2023/24.



Source: NHS BHRUT Hospitals

In terms of ethnicity among those who attended BHRUT A&E in 2023/24, the highest rate was among “Other” ethnic group (70,269 per 100,000) followed by “Asian” (68,742 per 100,000) (Table 7).

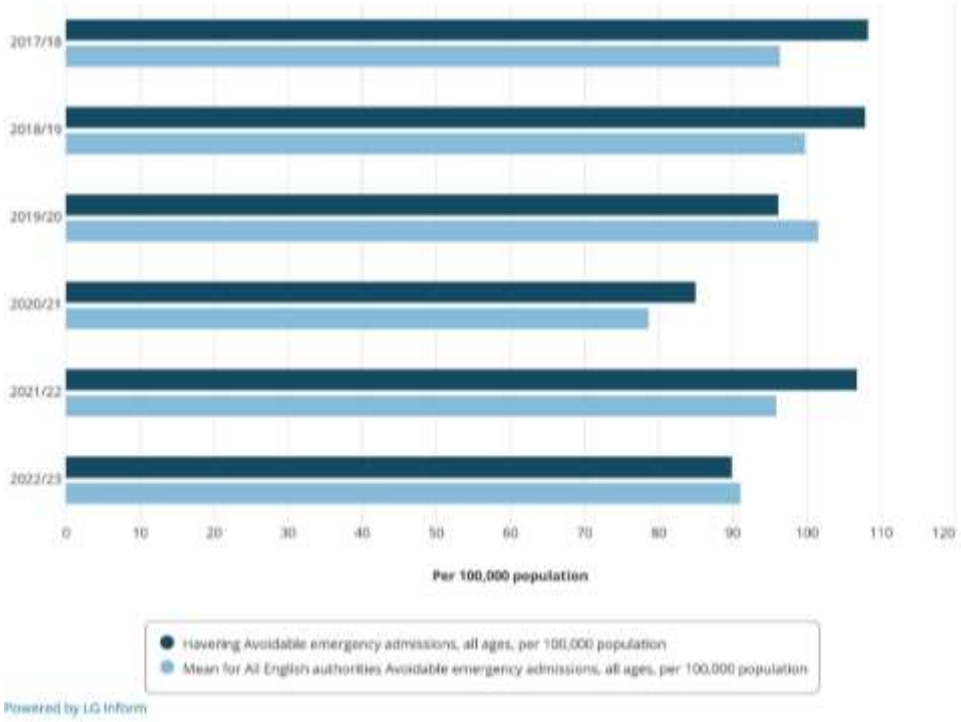
Table 7: Havering residents A&E attendance by ethnicity, BHR UT hospitals, 2023/24.

Ethnic Group	Number of Attendances	Population *	Rate /100,000	95%CI - L	95%CI - U
Asian	19,351	28150	68,742	67,777	69,718
Black	10,331	21567	47,902	46,983	48,835
Mixed	3,480	9747	35,703	34,527	36,910
Other	3,706	5274	70,269	68,025	72,569
White British	18,882	174232	10,837	10,683	10,993
White Other	10,520	23082	45,577	44,710	46,456
Unknown	3,968				
Total	**70,238**	262052	26,803	26,605	27,002
* Census 2021					

Source: NHS BHRUT Hospitals

Havering's Hospital admissions from Ambulatory Care Sensitive Conditions (ACSCs) 2022/23 (89.9/100,000) was similar to the England average (91.9/100,000). Havering rates have been higher than those of England average during the pandemic (Figure 42).

Figure 42: Unplanned Admissions from Ambulatory Care Sensitive Conditions, all ages, rate per 100,000, Havering, 2017 - 2023



Source: NHS England, Produced by LG INFORM

There are 24 dental practices providing care for Havering residents and 16 are accepting new NHS patients at this time (Tables 8 and 9, September 2024). Some GPs expressed that seeking NHS dental care for bedbound and housebound patients and new residents is often challenging.

Table 8: Dental practices providing care for Havering residents, 2024

As of September 2024, the following Havering dental practices are accepting new NHS patients.

Church View Dental Clinic	34A Station Road	RM14 2TR
Elm Park Dental Surgery	28 Rosewood Avenue	RM12 5LH
Raydens Dental Surgery	Upminster Road South	RM13 9AB
Rush Green Dental Practice	193 Rush Green Road	RM7 0PX
Dental Fitness Clinic	17 Chase Cross Road	RM5 3PJ
10 Hall Lane Dental Practice Ltd	10 Hall Lane	RM14 1AE
All Smiles Dental Care	261 Hornchurch Road	RM12 4TG
St Johns Dental Practice Limited	56 Western Road	RM1 3LP
Romford Smile Dental Practice Ltd	167 North Street	RM1 1DT
Sunny Smiles Dental Innovations	7 St Mary's Lane	RM14 2QU
Parkview Dental Practice	300 Upper Rainham Road	RM12 4EQ
Essex Family Dental Care	109 Mawney Road	RM7 7JA
Corbets Tey Dental Practice	36A Corbets Tey Road	RM14 2AD
St Marys Dental Care	163 St Mary's Lane	RM14 3BL
The Harrow Dental Practice	23 - 27 High Street	RM11 1TP
Southend Road Dental Surgery	166 South End Road	RM13 7XR

Source: NHS England

Table 9: Dental practices in Havering not accepting NHS patients, 2024

As of September 2024, the following Havering dental practices are not accepting new NHS patients.

Oasis Dental Care Hornchurch	Slewins Lane	RM11 2BS
Essence Dental Clinic	219 - 221 Straight Road	RM3 7JP
Cranham Dental Centre Ltd	141 Ingrebourne Gardens	RM14 1BJ
Newham Family Dental Care Ltd	Collier Row	RM5 3NR
Naidu & Naidu Dental Surgeons	132 Gubbins Lane	RM3 0DP
Retford Dental Centre	79 Retford Road	RM3 9ND
Hornchurch Dental Care	98 North Street	RM11 1SU
Ardleigh Green Dental	102 Ardleigh Green Road	RM11 2LG

Source: NHS England

Service Gaps /Unmet Needs

Waiting time for A&E and elective surgeries is an area identified by the commissioners and providers for improvement.

Recommendations

- HWB members to support implementation of plans developed by the BHR Planned Care Transformation Board to reduce waiting times for planned care.
- NHS England and OHID should work together to make data publicly available.
- Services to support residents to stay well longer and ensure they receive effective preventative and / or primary treatment to minimise the need for urgent and emergency care
- Health and care partners to promote immunisation to prevent infection which usually trigger exacerbation of chronic conditions.
- LTC Group members to facilitate proactive management of long-term conditions. Integrated Neighbourhood Teams (INT) using PHM approach should identif cohorts who would benefit most by proactive mgt.
- Commissioners to engage and empower primary care clinicians, LAS and patient communities to understand their needs and make appropriate use of alternatives to ED referral and attendance, including self-care and peer support. (tools and sharing of care plans)
- NHS England to improve access to NHS dental care for bedbound patients and new residents; to inform and support general practices around NHS dental care.

4.7.8 Social care

Introduction

Demand for social care is estimated to be rising in both the older and under-65 population.[235] For adults aged 20 to 64, limiting illness or disability could be around 19%. The proportion of adults under 65 with a disability has risen in recent years. One reason for the increased demand for care in the under-65 population is the increased proportion of people with a learning disability, following improvements in diagnosis and reporting of a disability, and increased longevity and improved survival of premature babies.

A learning disability is different for everyone. Lots of people who have a learning disability can work, have relationships, live alone and get qualifications. Other people might need more support throughout their life. A profound and multiple learning disability (PMLD) is when a person has a severe learning disability and other disabilities that significantly affect their ability to communicate and be independent. Someone with a profound and multiple learning disability might have difficulties seeing, hearing, speaking and moving. They may have complicated health and social care needs due to these or other conditions.[236]

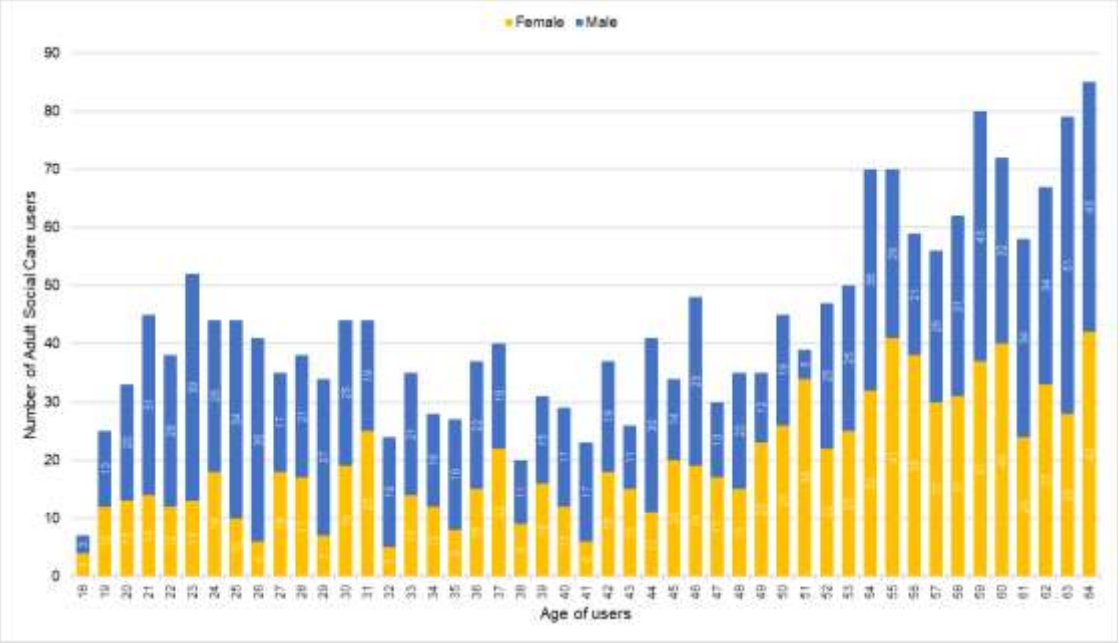
[235] https://www.gov.uk/government/publications/evidence-review-for-adult-social-care-reform/evidence-review-for-adult-social-care-reform-summary-report
[236] https://northeastlondon.icb.nhs.uk/health-advice/learning-disabilities/

Some working age residents with severe mental illness also require social care and their needs could overlap. People in more deprived areas become ill earlier[237] and are more likely to experience mental health disorders.[238]

Findings

In 2023/24 financial year, 1,368 Havering residents aged 18-64 were receiving support from the Havering Adult Social Care service. Unlike older adults, there were more male (733) than female (635) among the services users aged 18-64 (Figure 43). Altogether they were receiving 2,043 care packages. Both the demand and complexity are rising.

Figure 43. Age and sex distribution of ASC users aged 18-64, Havering, 2023/24.



Source: Havering Adult Social Care

- In 2023/24, 35 residents with mental health or learning disability were receiving care in nursing placements and 120 residents in residential placements (Table 10). More than 460 clients with LD or MH were in direct payment and 230 were receiving supported living accommodation and 241 received Homecare placement.[239]
- Average residential home placement cost has risen by +£167 per week as compared to 2022-23, and supported living by +£200 per week (due to the higher complexity of need and other factors)[244]

[237] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-are-health-inequalities?gad_source=1&gclid=CjwKCAiAtsa9BhAKEiwAUZAszfqqH7ftjnS5tRvg24xHtfo2zu3jOrjeddaNZ2iGVNEeO9bOOXWCnBoC9ugQAvD_BwE

[238] https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/2-understanding-place

[239] NHS England, NELCA and Havering GPs continue to improve cancer screening coverage, reduce health inequalities by improving access to those with Severe Mental Illness (SMI) and Learning Disability.

- In 2022/23, the percentage of adult social care users who had as much social contact as they would like (43.0%) was higher than the London average (39.7%) but similar to the England average (44.4%)[240]
- In Havering, the percentage of adult social carers who had as much social contact as they would like - (25.3%) was lower than both London (27.5%) and England (28.0%) averages.[245]
- According to 2021 census, 9.2% of Havering residents aged 5 years and over were unpaid carers which was higher than the London average (7.7%) and similar to England average (9.6%).[241]

Table 10: ASC Support Packages 18-64, 23/24.

Service Type	Count	Service Type	Count
Assistive tech	243	Home care	241
Re-ablement	131	Direct Payment	464
Transport	118	Nursing Care	35
Equipment	240	Residential care	120
Shared lives	15	Supported living	233
Shared lives respite	10	Extracare	20
Nursing Respite	2	Residential respite	11
Others	3	Day care	155

Source: ASC demographics

Service Gaps /Unmet Needs

Demand and intensity of need is known to be increasing year on year hence challenging for services to be sustainable within available funding.

Recommendations

- Some of the learning disability are preventable through early and better pregnancy care, better maternity services, mental health care, tackling poverty and improving lifestyle.
- Population health management (PHM) approach should be used to identify the preventable and avoidable risk factors for the requirement of care packages; and to

[240] https://fingertips.phe.org.uk/profiles
[241] https://www.nomisweb.co.uk/

recommend most effective mental health and physical support interventions, including the use of technology for better and efficient care.

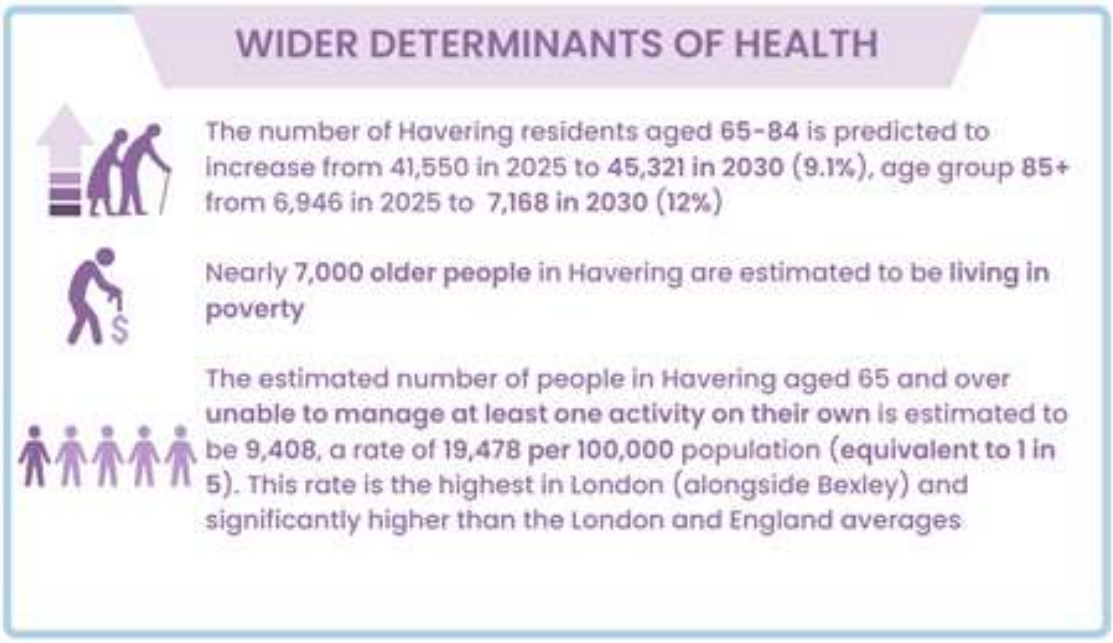
- Partners should embrace the role of technology for better and efficient care.
- Service users and carers should be offered JoyApp and other support to reduce social isolation.
- System partners should implement carers strategy to support informal and unpaid carers.

Ageing Well

5. Ageing Well

5.1 Infographic Summary

Wider Determinants of Health



Places & Communities

Lifestyle & Behaviours / Healthy Ageing

LIFESTYLE & BEHAVIOURS

In 2023/24, all Havering PCNs achieved the **bowel screening coverage** target of 60%. Nonetheless, latest available data on cancer staging (2019-21, NDRS) found that nearly **70% of rectal cancers** and over **50% of colon cancers** in Havering were diagnosed in later stages

Havering has around **8,061 residents** who are recorded to be **frail.** Havering South PCN (3,758), Liberty PCN (1,587) and Havering North PCN (1,530) have the highest number of patients of age 65+ who have a frailty diagnosis

In 2023/24, the Havering coverage of both **pneumococcal and shingles vaccines** was above the London and England averages. Flu vaccine coverage of those aged 65 and over was 72.7% (**below England average 77.8%**)

Integrated Health & Social Care

INTEGRATED HEALTH AND SOCIAL CARE

The percentage of Havering residents **aged 75 years** and over having **emergency admissions** within 30 days of discharge (20.8%) in 2023/24 was slightly higher than London (19.1%) and England (17.2%) averages. However, **87.3%** of those **age 65 and over remained at home 91 days** after discharge from hospital.

In 2023/24, the percentage of patients with **delayed discharge** from BHRUT hospitals (53%) was similar to the London average

There are an estimated **3,121** people with **Dementia** in Havering. In 2024, the number of people diagnosed was 1,757. A further **335** people need to be diagnosed to meet the national diagnosis target of 67%

In 2023/24, **4,483** Havering residents aged 65 years and over received support in form of 6,655 **care packages** from Havering Adult Social Care

In 2021/22, **282** Havering residents aged 65 years and over were admitted permanently to **residential or nursing care homes.** This was the third highest number in London

60% of the **Havering adult social care service users** aged 65 years and over are overall extremely or very satisfied compared to **54.9%** for service users in London and **61.8%** for service users in England

5.2 Key Findings and Recommendations

Key findings

Wider Determinants of Health

- 1 in 8 people aged 66 and above in Havering live in **one-person households** which is half of all one-person households.[242] This is the highest proportion among London boroughs (London average 9.1%) alongside Bexley (12.8%).
- Nearly 7,000 older people are estimated to be living in **poverty** in Havering.[243]
- The estimated number of people in Havering aged 65 and over unable to **manage at least one activity on their own** is estimated to be 9,408, a rate of 19,478 per 100,000 population (equivalent to 1 in 5). This rate is the highest in London (alongside Bexley) and significantly higher than the London and England averages

Places & Communities

- 9.2% of our population are unpaid carers and 51% of them were providing **unpaid care** 20 hours or more hours a week.
- The prevalence of **osteoporosis** among those 50 years and over in Havering in 2022/23 (0.9%) was higher than London average (0.6%).
- Havering's rate of **hip fractures** in people aged 65 and over was higher among women (618 per 100,000) than men (330 per 100,000).

Lifestyle & Behaviours / Healthy Ageing

- All Havering PCNs achieved the **bowel screening** coverage target of 60%. Nonetheless, latest available data on cancer staging (2019-21, NDRS) found that nearly 70% of rectal cancers and over 50% of colon cancers in Havering were diagnosed in later stages.
- Havering has around 8,061 residents recorded as **frail**. Havering South PCN (3,758), Liberty PCN (1,587) and Havering North PCN (1,530) have the highest number of patients of age 65+ who have a frailty diagnosis.
- In 2023/24, Havering's coverage of both pneumococcal and shingles vaccines was above the London and England averages. Flu **vaccine coverage for residents aged 65 years and over** was 72.7%, below England average (77.8%).

Integrated Health & Social Care

- The percentage of Havering's 75+ year olds having **emergency admissions within 30 days of discharge** (20.8%, indirectly standardised) is slightly higher than London average (19.1%) and higher than England average (17.2%). However, 87.3% of those age 65 and over **remain at home 91 days after discharge from hospital** to re-ablement or rehabilitation services.
- The percentage of patients with **delayed discharge** from BHR UT (53%) in 2023/24 was similar to the London average. The percentage of delayed discharges (74.6%) was highest in February of the same year.

- There are an estimated 3,121 people with **Dementia** in Havering. In 2024, the number of people diagnosed was 1,757. A further 335 people need to be diagnosed to meet the

[242] https://democracy.havering.gov.uk/documents/s72056/JSNA%20Demography%20Chapter%202023%20v0.3A.pdf
[243] https://democracy.havering.gov.uk/documents/s72056/JSNA%20Demography%20Chapter%202023%20v0.3A.pdf

national diagnosis target of 67% whereas Havering's rate is currently 56.3%, which is below both London and England average rates.

- In 2023/34, 4,483 residents aged 65 years and over were receiving support from Havering **Adult Social Care (ASC)**. 1,504 were male and 2,979 were female. Altogether they received 6,655 care packages.
- In 2023/24, around 900 clients entered into the Havering ASC service and 550 died in the service. The increase in numbers, intensity and average cost resulted in overall increase in adult social care cost by London Borough of Havering.
- In 2021/22, 282 Havering residents of aged 65 years and over were admitted permanently to **residential or nursing care homes**. This was the third highest number in London and equivalent to a rate of 606 per 100,000 which is significantly above the London (401/100,000) and England (539/100,000) average.
- The percentage of adult social care users aged 65 years and over who have as much social contact as they would like in Havering in 2022/23 was 36.7% which was similar to London average (35.7%) but lower than England average (41.5%).
- In 2023/24, among Havering residents aged 65 years and over who needed a placement (3,160), most were under homecare placements (1,697), which has the lowest **cost per placement** (£20,171 per annum) but the highest percentage increase in per unit cost.
- In Havering, supported living has the highest average annual placement cost (£65,410 per annum) closely followed by nursing placement (£61,352) and residential care (£53,409). The increase in the number of users is highest with supported living and residential care. The intensity of need has become higher as the cost of 1:1 services more than tripled in 3 years (£2.52M in 2021 to £8.23M in 2023/24).
- 60% of the services users of adult social care aged 65 years and over in Havering are overall **extremely or very satisfied** compared to 54.9% for service users in London and 61.8% for service users in England.

Recommendations

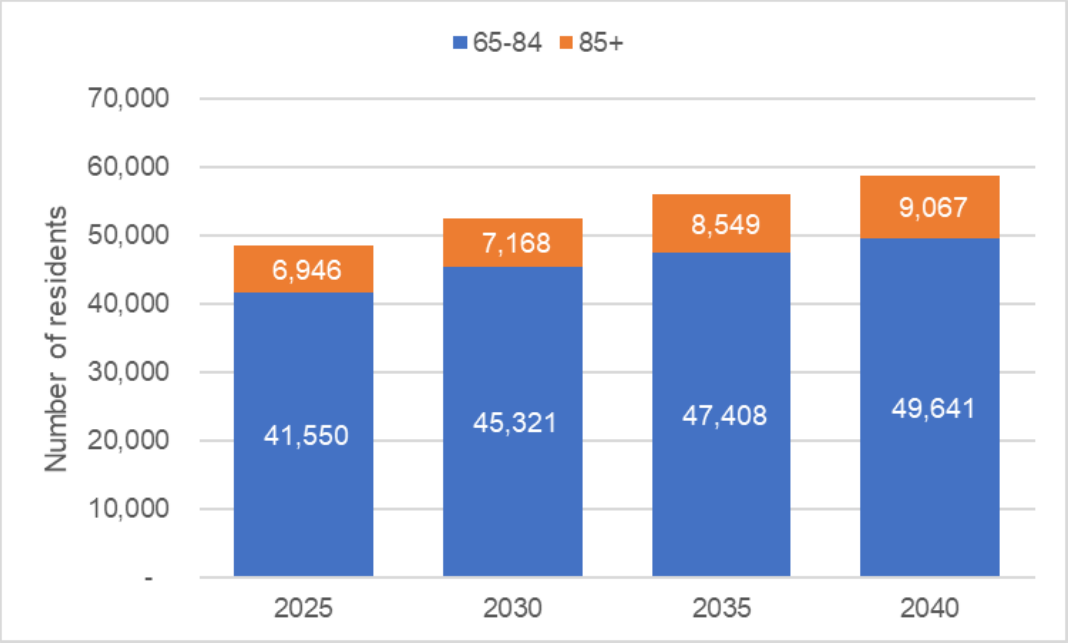
- Working with voluntary care sector, the members of the HWB to support the implementation of poverty reduction strategy and reduce health inequalities among older people.
- Havering Dementia Operational Working Group working with NELFT and
- Admiral nurses to maintain efforts to further increase the completeness of dementia diagnosis, and improve access to the information and support for patients and their families
- Ageing Well Group members to support efforts to tackle social isolation in general, but particularly amongst older residents, as part of wider efforts to improve the mental health and independence of older people. Mental health services must be made more accessible for older people who needs them.
- Adequate nutrition for older people, falls risk assessment and physical activity to improve bone strength and balance should be promoted by Ageing Well Group members through relevant channels and voluntary care sector.
- Ageing Well group to ensure that patients at risk of falls, deconditioning and moderate to severe frailty are systematically identified, using population health management approach; effectively supported by the local partners to stay well; or receive urgent additional help in times of crisis.
- NHS England, ICB and PCNs to build on the effective partnerships established during the pandemic to maintain and further improve uptake of flu, covid, pneumococcal and zoster vaccines.
- Older people with bowel cancer symptoms should be investigated by GPs appropriately.
- Effective frailty pathway is supported by HWB partners to avoid A&E presentation and hospital admissions, and further deterioration of independence and wellbeing.

- Services tailored to the patients' needs such as community re-ablement services should be used to facilitate and sustain hospital discharge.
- Residents in care homes should have their needs assessed and addressed by good practice such as the **Enhanced Health in Care Homes (EHCH)** model avoid unnecessary unplanned and admissions to hospital.
- Population Health Management approach and evidence around effective and cost-effective social care should be used to limit the rise in the intensity of need in social care, and to inform strategies to empower older residents to live independently for longer.
- Hospital Discharge and LAS pathway to be managed differently with new models and good practice to limit demand on both health and social care. (e.g., ward-based re-ablement, social worker in hospitals, falls prevention, enhanced re-ablement)
- Current high level of care quality of the ASC must be maintained to achieve lower level of deterioration of health and dignity.
- HWB partners to support the implementation of carers strategy.

5.3 Introduction

The latest GLA projections (2024) indicate that the largest increases in population will occur among older people (age groups 65 years and above). Age group 65-84 is predicted to increase from 41,550 in 2025 to 47,408 in 2035 (14%), age group 85+ from 6,946 in 2025 to 8,549 in 2035 (23%). The 65+ population will increase by over 3,993 in the next 5 years (Figure 44).

Figure 44: Havering residents aged 65 years and over population projections, 2025-2040



Source: GLA 2022-based housing-led population projections, Produced by LBH PHI

As is the case for the population as a whole, cancers and CVD are the big killers in old age, together with dementia.

The conditions that cause the bulk of ill health for the population as a whole, mental conditions, long-term conditions (LTCs), and musculoskeletal condition (MSK), also contribute most to the frailty together with dementia.

Infections, falls, social isolation and cognitive impairment are a few of the potentially preventable or modifiable risk factors that contribute to the development of frailty**;** others include alcohol excess; visual and hearing impairment, mood problems, nutritional compromise, physical inactivity, polypharmacy[244] and smoking. Learning disability and physical disability continue to contribute towards needing care packages.

Someone with moderate frailty has three times the annual risk of urgent care utilisation, death and care home admission than an older person of the same age who is not frail.[245] [246]

There is strong evidence that an early diagnosis helps someone with dementia to continue to live independently in his or her own home for longer. Havering's dementia diagnosis rate is one of the lowest in London.

Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care settings.[247]

Falls, social isolation and cognitive impairment are a few of the potentially preventable or modifiable risk factors that contribute to the development of frailty**;** others include alcohol excess; functional impairment, hearing problems, mood problems, nutritional compromise, physical inactivity, polypharmacy, smoking, and vision problems.

5.4 Wider Determinants of Health

Key Findings

- Havering's population of persons aged 65-84 years is predicted to increase from 39,226 in 2021 to 47,894 in 2031 (22%), age group 85+ from 7,051 in 2021 to 7,864 in 2031 (12%).
- Nearly 7,000 older people are estimated to be living in poverty in Havering.
- The estimated number of people in Havering aged 65 and over unable to manage at least one activity on their own is estimated to be 9,408, a rate of 19,478 per 100,000 population (equivalent to 1 in 5). This rate is the highest in London (alongside Bexley) and significantly higher than the London and England averages.
- The prevalence of osteoporosis among Havering residents aged 50 years and over in 2022/23 (0.9%) was higher than the London average (0.6%).
- In 2022/23, there were 255 hip fractures among Havering residents aged 65 and over. This is equivalent to a rate of 508 per 100,000 which is similar to the London average (502per 100,000). The rate of hip fractures in people aged 65 and over was higher among women (618 per 100,000) than men (330 per 100,000).

[244] Polypharmacy refers to the use of multiple medications. WHO defines polypharmacy as 'the routine use of five or more medications. This includes over-the-counter, prescription and/or traditional and complementary medicines used by a patient'.

[245] https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf

[246]

[247] https://yougov.co.uk/topics/politics/trackers/most-popular-forms-of-elderly-care

Recommendations

- Working with voluntary care sector, the members of the HWB should support the implementation of poverty reduction strategy and reduce health inequalities among older people.
- Adequate nutrition for older people, falls risk assessment and physical activity to improve bone strength and balance should be promoted through relevant channels and voluntary care sector.

5.4.1 Life Expectancy

In 2020-22, the life expectancy at age 65 years in Havering was 18.2 years for males, which was similar to the London (18.3) and England (18.4) averages. Among females it was 20.6 years which was lower than the London average (21.3) but similar to England's average (20.9).[248]

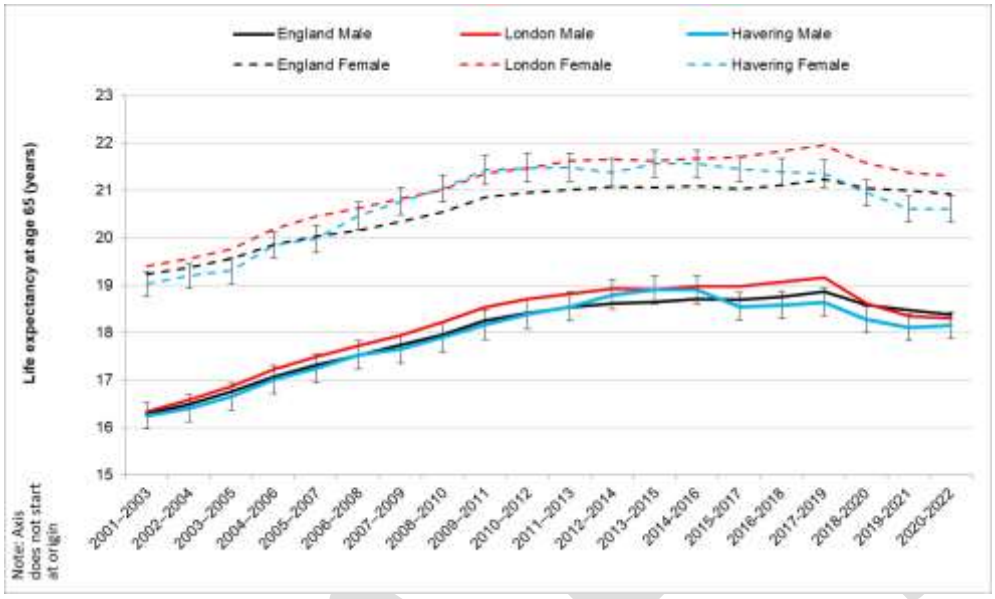
But nearly half of these years are often affected by disability. The latest data shows that in 2018-2020 period, disability-free life-expectancy for Havering residents at age 65 was 10.8 years for females and 9.8 years for males.[254]

The conditions that cause the bulk of ill health for the population as a whole – mental illness, long-term conditions (LTCs), and musculoskeletal (MSK) conditions also contribute most to the burden of disease in old age alongside dementia.[249]

All things being equal, older people experience more ill health and have greater need for health and social care than other age groups, with the oldest residents having the greatest need. It follows that population ageing will significantly increase the need for health and care services unless we do better in preventing ill-health.[250] This conclusion is very clearly illustrated by comparisons between life expectancy and healthy life expectancy at age 65, and a research paper that showed the significance of older age on hospital admissions[251].

[248] https://fingertips.phe.org.uk/profiles
[249] https://pubmed.ncbi.nlm.nih.gov/25468153/
[250] https://democracy.havering.gov.uk/documents/s72056/JSNA%20Demography%20Chapter%202023%20v0.3A.pdf
[251] https://pmc.ncbi.nlm.nih.gov/articles/PMC5318571/pdf/bmjopen-2016-014045.pdf

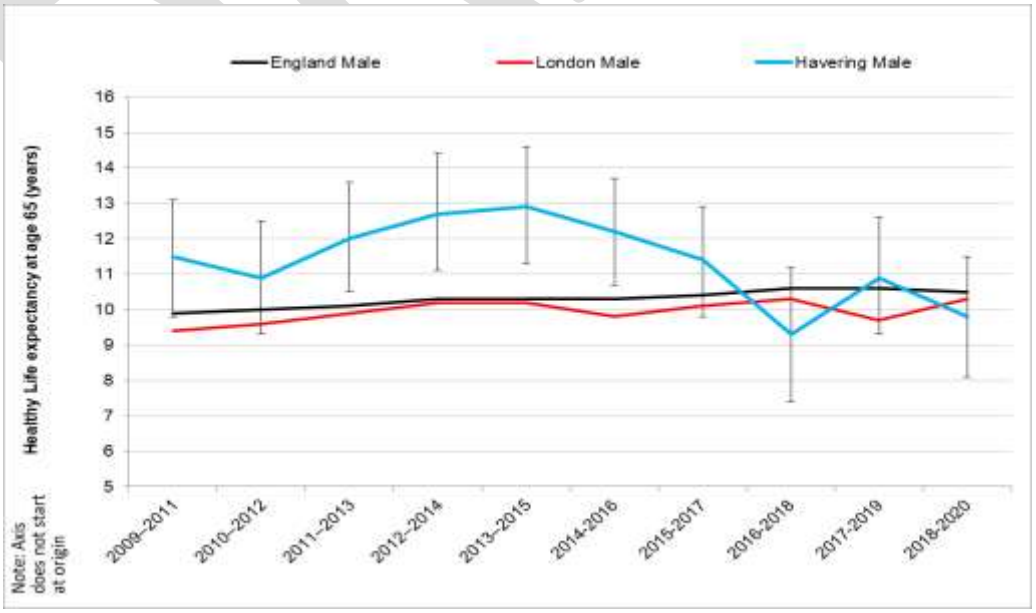
Figure 44: Life expectancy at age 65 years, by gender, Havering compared to London and England, 3 year rolling periods 2001-2022



Source: OHID, Produced by LBH PHI

In addition, Havering is expected see an increase in persons aged 65 and over with limiting long term illness whose day-to-day activities are limited a lot from 12,081 in 2023 to 14,201 in 2035 (8.6%), a lower increase than London (13.2%) but higher than England (-10.4%).[252]

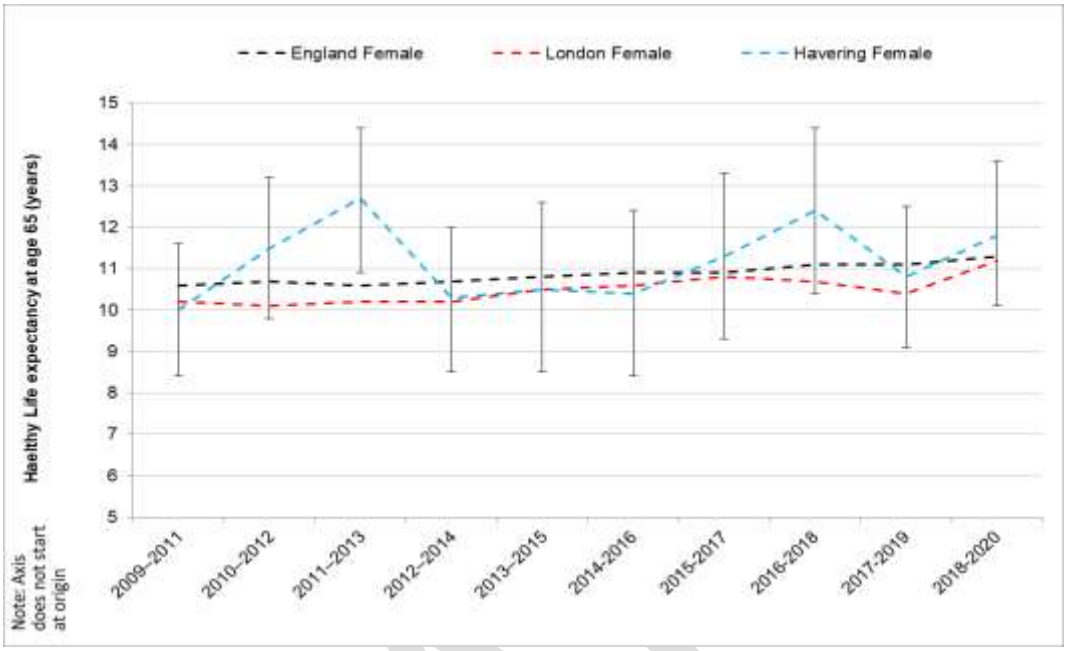
Figure 45: Healthy life expectancy at age 65 years, males, Havering compared to London and England, 3 year rolling periods 2009/11 – 2018/20



Source: OHID, Produced by LBH PHI

[252] https://www.haveringdata.net/joint-strategic-needs-assessment/

Figure 46: Healthy life expectancy at age 65 years, females, Havering compared to London and England, 3 year rolling periods 2009/11 – 2018/20



Source: OHID, Produced by LBH PHI

A greater focus on the prevention of ill health throughout life is crucial if we are to improve healthy life expectancy and quality of life in later life and maintain the sustainability of health and care services as the population becomes progressively older.

5.4.2 Deprivation

The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation. 11.7% of those aged 60 and over in Havering (6,895 in number) experienced income deprivation in 2019, compared to 14.2% in England. Havering is among the London boroughs with the lowest proportion of older people living in poverty (11.7%). However, nearly 7,000 older people are estimated to be living in poverty in Havering.[253]

5.4.3 Fuel Poverty

PHE estimated that 1 in 10 excess winter deaths are directly attributable to fuel poverty[254]. In Havering 9.3% of households are affected by fuel poverty, a lower percentage than London (11.9 %) and England (13.1 %).

5.4.4 Excess Winter Deaths

Death rates among Havering residents aged 85 and above was about 5.2% higher during the winter months of 2021/22. Havering's winter mortality index was lower than the London (10.3%) and England (8.1%) averages during the same winter period. The bulk of excess

[253] https://www.poppi.org.uk/

[254] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/355790/Briefing7_Fuel_poverty_health_inequalities.pdf

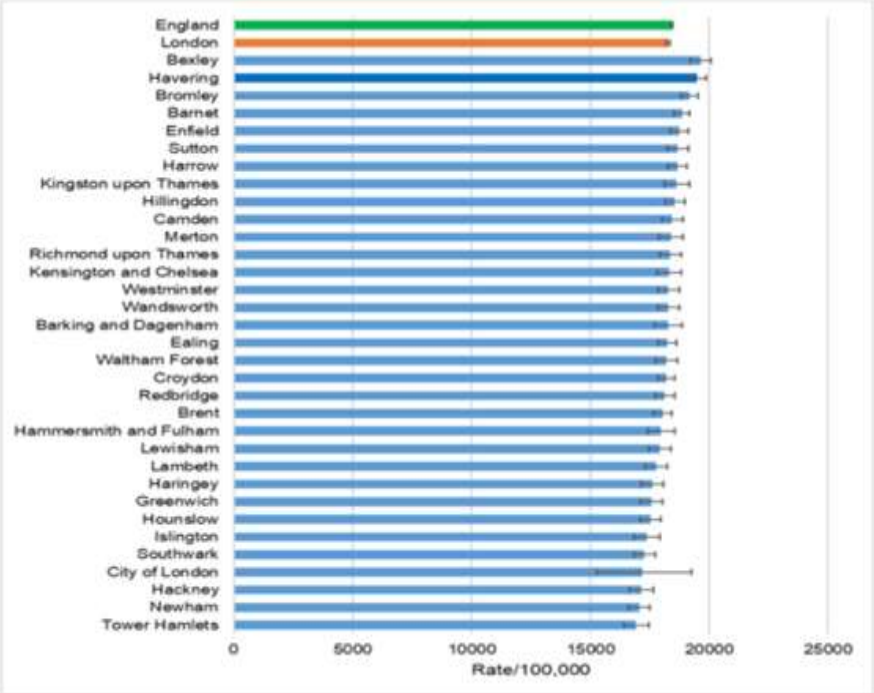
winter deaths result from respiratory conditions, some linked to flu infection; dementia and CVD (heart disease and stroke).[255]

5.4.5 Independent living

The estimated number of people in Havering aged 65 and over unable to manage at least one activity on their own is estimated to be 9,408, a rate of 19,478 per 100,000 population (equivalent to 1 in 5). This rate is the highest in London (alongside Bexley) and significantly higher than the London and England averages (See Figure 47). This number is predicted to increase to 10,192 by 2030 if no additional interventions are implemented.

Two-thirds of people who survive a stroke find themselves living with a disability.[256] In 2023/24, 4,484 Havering residents were living with stroke. Stroke is a leading cause of adult disability in the UK. Visual and hearing impairment could make an older person lose balance and confidence to live and be mobile independently. In 2023, 4,040 Havering residents of age 65+ were estimated to have severe hearing loss and 4,398 to have moderate to severe visual impairment.

Figure 47: Estimated Population aged 65+ unable to manage at least one activity on their own, 2023



Source: POPPI, Produced by LBH PHI

Service Gaps / Unmet Needs

[255] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/excesswintermortalityinenglandandwales/2019to2020provisionaland2018to2019final

[256] https://www.stroke.org.uk/stroke/support/materials/rebuilding-lives/stroke-research-means-everything#:~:text=Stroke%20is%20a%20leading%20cause,themselves%20living%20with%20a%20disability.

Increasing older people population requires services to be planned for future demand and prevention strategies to limit the rise in demand.

Recommendations

- Working with voluntary care sector, the members of the HWB should support the implementation of poverty reduction strategy and reduce health inequalities among older people.
- Adequate nutrition for older people, falls risk assessment and physical activity to improve bone strength and balance should be promoted by the ICB and Ageing Well Group members through relevant channels and voluntary care sector.

5.5 Places & Communities

Key Findings

- About 12.7% (12,838) of the Havering population aged 66 years and above were living in one-person households, occupying almost half (48%) of all one-person households in Havering (2021). This is the highest proportion among London boroughs (London average 9.1%) alongside Bexley (12.8%).
- 7.9% of Havering's population are unpaid carers and 51% of them provide unpaid care for 20 hours or more hours a week.
- The percentage of adult carers (65+ years) who have as much social contact as they would like (22.7%) is lower than both London (27.7%) and England (28.8%) averages.

Recommendations

- Residents in care homes should have their needs assessed and addressed by good practice such as the Enhanced Health in Care Homes (EHCH) model to avoid unnecessary unplanned admissions to hospital.
- HWB partners should support the implementation of the Havering's carers strategy.
- HWB partners should support efforts to tackle social isolation in general, but particularly amongst older residents, as part of wider efforts to improve the mental health and independence of older people. Mental health services should be made more accessible for older people who need them.

5.5.1 Social Connectivity

Social isolation among older people

Isolation can become a real issue if older people feel that they cannot access shops and services, or simply connect with other people. UK based surveys show that people can feel lonely at any stage of life, but that the experience is most severe among older people. Social networks shrink with retirement and the associated reduction in income may limit social activities. Additional contributory factors for loneliness in old age include: the loss of a loved one; health conditions that precipitate disability and loss of mobility; and caring responsibilities. According to census 2021, about 12.7% (12,838) of the Havering population aged 66 years and above were living in one-person households, occupying almost half (48%) of all one-

person households in Havering. This is the highest proportion among London boroughs (London average 9.1%) alongside Bexley (12.8%).[257]

Projecting Older People Population Information (POPPI) estimate a higher number of persons aged 65 and over in Havering currently living alone (16,432) and predict that the number will increase to 17,451 by 2030 (Table 11).

Table 11: Population aged 65 and over in Havering predicted to live alone, 2025 – 2040

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

Source: POPPI

Successful interventions to tackle social isolation reduce the burden on health and social care services; as such, they are typically cost-effective.[258]

5.5.2 Carers Support

Evidence shows that 30% of older carers experience depression at some point.[259] The percentage of adult carers (65+ years) in Havering who have as much social contact as they would like (22.7%) is lower than both London average (27.7%) and England average (28.8%).

5.5.3 Falls, osteoporosis and hip fracture

Falls are the most common cause of death from injury in the over 65s. A third of people over 65, and half of people over 80, fall at least once a year.[260] Falls are the number one factor precipitating a person losing independence and going into long-term care.

Havering's age standardised rate of emergency hospital admissions due to falls for persons aged 65 and over in 2022/23 (1,655 per 100,000) was lower than both London (2,071 per 100,000) and England (3,130 per 100,000) averages. Nonetheless, close to 830 emergency admissions due to falls were recorded in 2022/23 of which 550 were for persons aged 80 years and over.

Hip fracture is a particularly serious consequence of falls especially among those with osteoporosis, malnutrition, weak muscle strength, sensory impairment and frailty. One in three people with a hip fracture dies within a year. Osteoporosis among older people especially women increases the risk of hip fractures. The prevalence of osteoporosis among Havering residents aged 50 years and over in 2022/23 (0.9%) was higher than the London average (0.6%). In the same year, there were 255 hip fractures among people aged 65 and over. This was a rate of 508 per 100,000 which was similar to London average (502 per 100,000) but better than the England average (558 per 100,000). The rate of hip fractures in people aged

[257] https://www.poppi.org.uk/
[258] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf
[259] https://www.ageuk.org.uk/siteassets/documents/policy-positions/health-and-wellbeing/ppp_mental_health_england.pdf
[260] https://publichealthmatters.blog.gov.uk/2014/07/17/the-human-cost-of-falls/

65 and over was higher among women (618 per 100,000) as compared to men (330 per 100,000)[261].

Falls are not an inevitable consequence of ageing; the risk of falling and the harm caused can be reduced. One-third of people over 65 will fall at least once a year. Most falls occur on flat surfaces; falls on the stairs or in the bathroom are relatively rare. Older women tend to fall in the house and older men in the garden. In `care homes', many falls occur on the way to or from the toilet. Only one in a hundred falls results in a hip fracture, but one-fifth cause serious injury.[262] The Falls and Fragility Fractures Pathway[263] defines the core components of an optimal service for people who have suffered a fall or are at risk of falls and fragility fractures. The pathway involves residents, carers, voluntary care sectors; and focuses on the three priorities for optimisation:

- Falls prevention
- Detecting and Managing Osteoporosis
- Optimal support after a fragility fracture

Adequate nutrition for older people, falls risk assessment and physical activity to improve bone strength, muscle strength and balance reduces the risk of falls significantly and can be facilitated through accessible communication channels and voluntary care sector.

Havering Falls Group aims to embed a preventative approach to reduce the number of older people who have falls, so more people are supported to remain independent at home, with fewer avoidable attendances and admissions to Emergency Departments due to falls. They do this by:

- Early identification of those at risk of first time falls and taking steps to reduce this risk
- Increasing uptake of men attending falls exercise classes by developing tailored classes, in suitable community locations
- Improving communication flow between care homes/ home care providers and hospital to ensure all organisations have the most up to date information on the individual on admission and discharge from hospital
- Providing tailored training and support to care homes and home care providers to manage risk of falls and respond appropriately when someone falls.
- Exploring cost effective use of telecare, equipment and AI to prevent falls in care homes and in individual's own home.

Recommendation

Residents in care homes have their needs assessed and addressed by good practice such as the Enhanced Health in Care Homes (EHCH) model avoid unnecessary unplanned and admissions to hospital.

[261] https://fingertips.phe.org.uk/profiles
[262] https://pmc.ncbi.nlm.nih.gov/articles/PMC1281399/
[263] https://www.england.nhs.uk/rightcare/products/pathways/falls-and-fragility-fractures-pathway/

5.6 Life Style & Behaviours / Healthy Ageing

Key Findings

- All Havering PCNs achieved the bowel screening coverage target of 60% (in 2023/24. Nonetheless, latest available data on cancer staging (2019-21, NDRS) found that nearly 70% of rectal cancers and over 50% of colon cancers in Havering were diagnosed in later stages.
- Havering has around 8,061 residents who are currently recorded as frail. Havering South PCN (3,758), Liberty PCN (1,587) and Havering North PCN (1,530) have the highest number of patients aged 65 years and over who have a frailty diagnosis.
- In 2023/24, Havering's coverage of both pneumococcal and shingles vaccines was above the London and England averages. Flu vaccine coverage among persons aged 65 years and over was below the England average.

Recommendations

- The ICS partners should build on the effective partnerships established during the pandemic to maintain and further improve uptake of flu, covid, pneumococcal and zoster vaccines.
- Adequate nutrition for older people, falls risk assessment and physical activity to improve bone strength and balance should be promoted through relevant ICS channels and voluntary care sector.
- Ensure that patients at risk of falls, deconditioning and moderate to severe frailty are systematically identified, using population health management approach; effectively supported by the local partners to stay well; or receive urgent additional help in times of crisis.

5.6.1 Health Screening

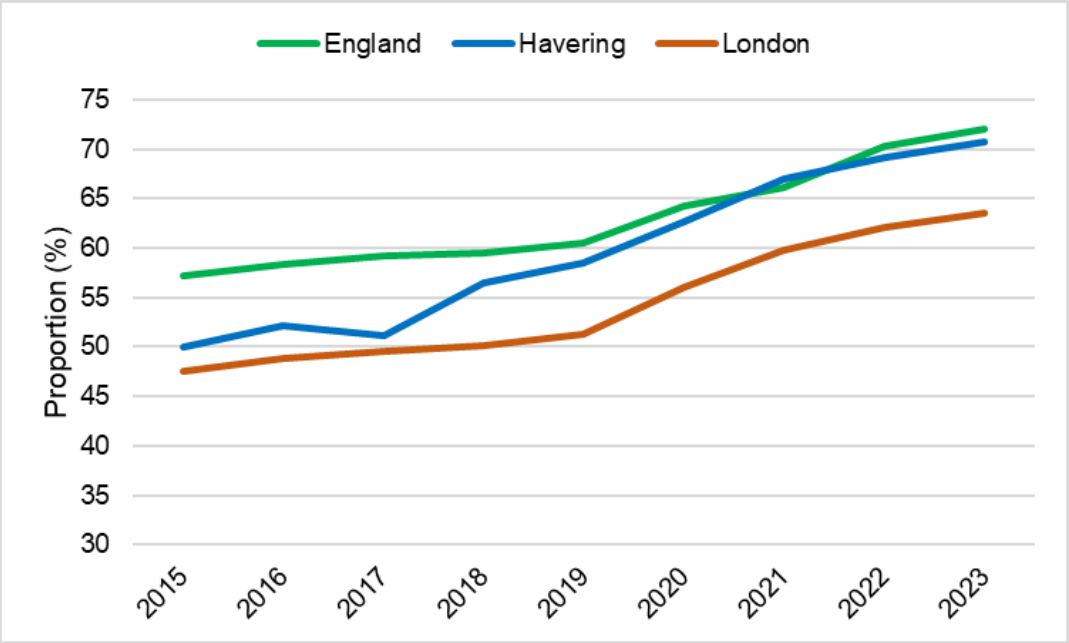
Bowel Cancer Screening

Havering residents who are of age 54-74 (formerly 60-74) receive home testing kits every 2 years. Those aged over 75 can request a home testing kit every 2 years; target coverage is set at 60%.Bowel screening detects approximately 10% of bowel cancer.

Latest data (2023) shows that Havering had a coverage of 70.7% which was above London (63.5%) and NEL ICB (61.3%) averages. All Havering PCNs achieved the coverage target of 60%. Nonetheless, latest available data on cancer staging (2019-21) found that nearly 70% of rectal cancers and over 50% of colon cancers in Havering were diagnosed in later stages, highlighting a requirement to achieve above the screening programme's target (60%) and to have better awareness for early recognition so that home test kits can be requested.

The PCNs are working to increase FIT (Faecal Immunochemical Test) testing outside the bowel screening programme because GP referrals were the main source of bowel cancer diagnosis and bowel cancers occurred more outside the screening eligible age group than in the screening eligible age group.

Figure 48: Bowel Cancer screening coverage, Havering, London & England, 2015-2023

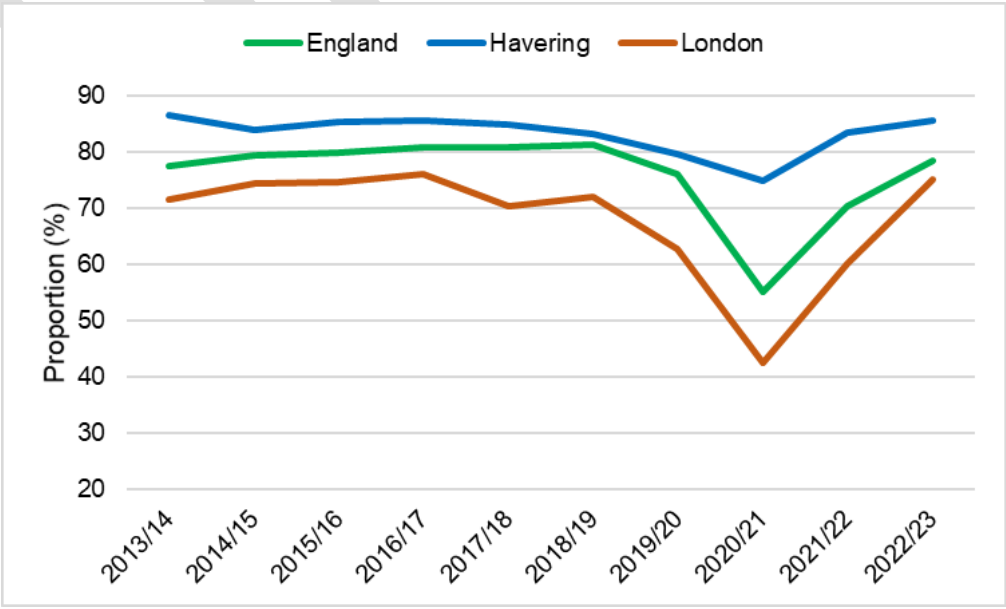


Source: OHID, Produced by LBH PHI

Abdominal aortic aneurysm (AAA) Screening coverage

Abdominal aortic aneurysm (AAA) screening is offered to men in the year they turn 65. Havering's AAA screening coverage in 2022/23 was 85.6%, the highest among London boroughs and significantly higher than the England average (78.3%).

Figure 49: AAA Screening Coverage, Havering, London & England, 2013/14 – 2022/23



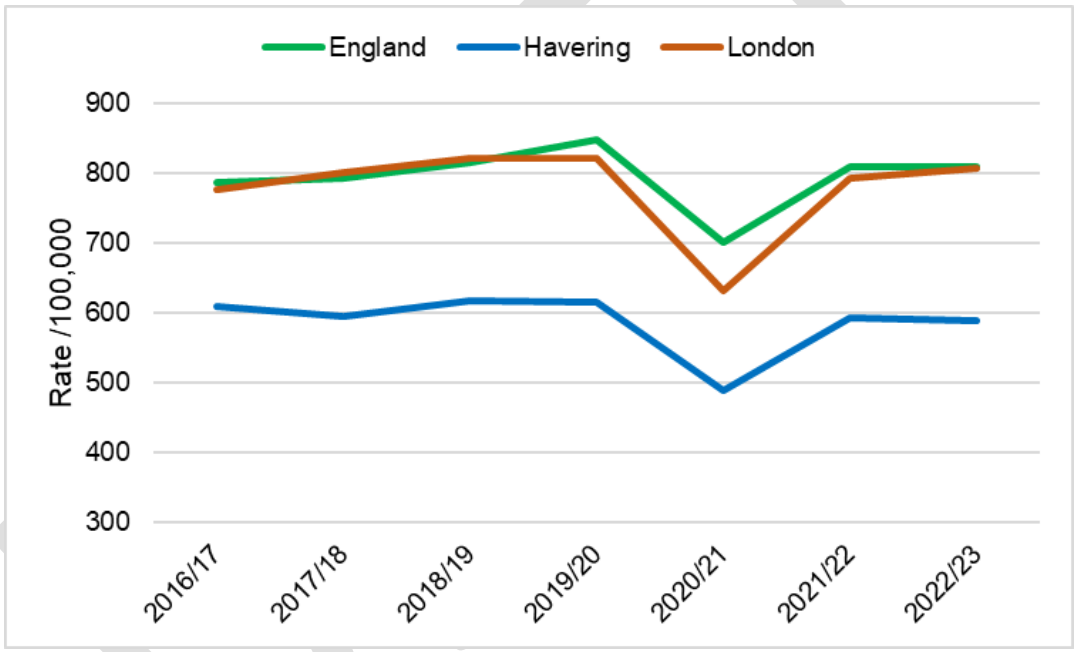
Source: OHID, Produced by LBH PHI

5.6.2 Alcohol related hospital admissions

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. As people age, changes in their bodies, as well as in their physical and mental health, may cause alcohol to affect them differently than when they were younger and put them at greater risk for negative consequences. Understanding how alcohol affects the health of older adults can help them and their health care providers make informed decisions about their health and well-being.

In 2022/23, the rate of admissions due to alcohol related conditions for persons aged 65 and over in Havering (590/100,000) was lower than the London (808/ 100,000) and England (810/100,000) averages.[264]

Figure 50: Rate of Admissions due to alcohol related conditions for persons aged 65 and over in Havering, 2015 – 2023



Source: OHID, Produced by LBH PHI

5.6.3 Frailty

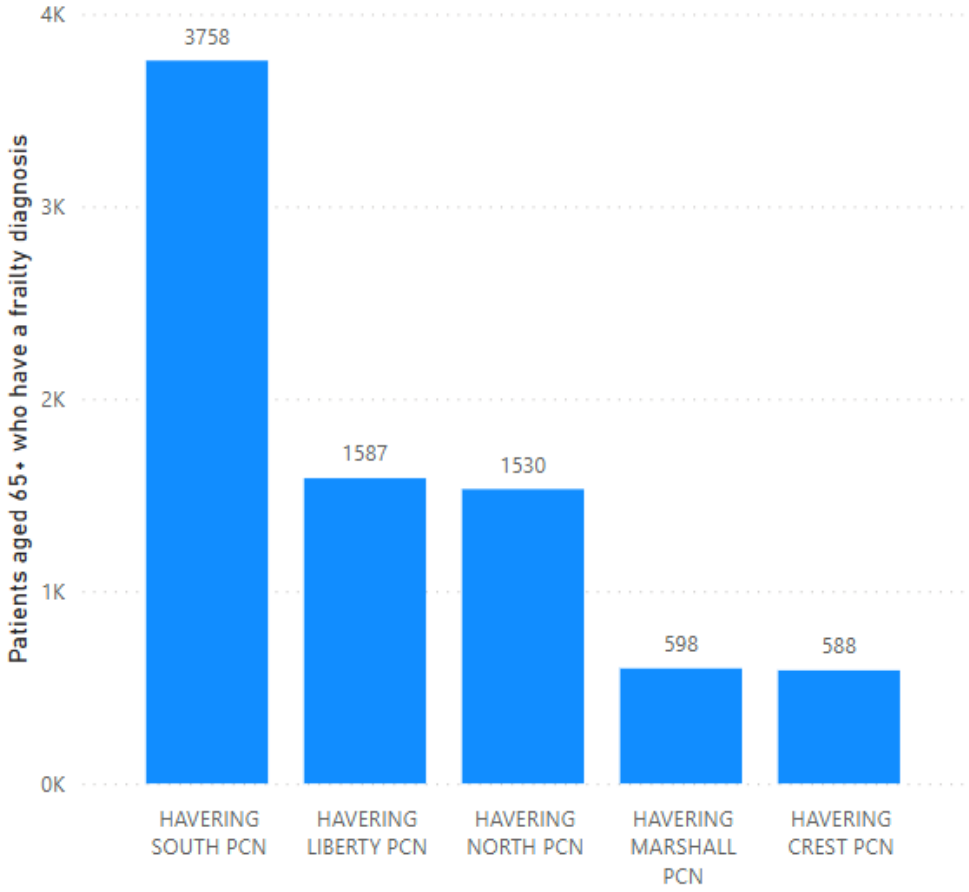
Frailty is a particular state of health experienced by a significant minority of older people. Being frail can mean that a relatively minor problem results in disproportionate and prolonged harm to health and wellbeing. For example, someone with moderate frailty has three times the annual risk of urgent care utilisation, death and care home admission than an older person of the same age who is not frail.[265]

As of June 2024, Havering has around 8,061 residents who were recorded as frail. Havering South PCN (3,758), Liberty PCN (1,587) and Havering North PCN (1,530) have the highest number of patients aged 65 years and over who have a frailty diagnosis (Figure 52). In

[264] https://fingertips.phe.org.uk/profiles
[265] https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf

Havering, 4,418 patients were also recorded to have had a stroke and living with the consequences.

Figure 51: Havering patients aged 65+ who have a frailty diagnosis by PCN, as at June 2024



Source: NHS Digital

A comprehensive approach to minimise the harm caused by frailty[266] includes:

- comprehensive prevention as described above
- population-based stratification to systematically identify people who are living with moderate and severe frailty by using tools such as eFrailty index
- coupled with targeted support to help older people living with frailty to stay well and live independently for as long as possible including:
- Community multidisciplinary teams – focused on the moderate frailty population who are most amenable to targeted proactive interventions to reduce frailty progression and unwarranted secondary care utilisation.
- Urgent Community Response – crisis response and community recovery for older people who are at risk of unwarranted stay in hospital admission and whose needs can be met more effectively in a community setting.

Havering Liberty PCN provides proactive care for housebound older adults living with frailty. A team of Advanced Clinical Practitioners from different professions are visiting older adults

[266] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

living with frailty in their own homes. Reflecting the multifactorial nature of frailty, they complete a full and holistic assessment of health, social and psychological needs. They build and work in a multi-disciplinary team (MDT) of professionals from across NHS, social care and voluntary sector agencies around the patient to maximise their ability to age well in their own homes. The initiative will be evaluated and is anticipated to reduce falls and unplanned admissions and improve long-term condition stability. Carers gave early feedback as below:

'This has allowed my partner and I to live independently now.'

'I now have more free time for myself, as I am in full-time employment as well as being a carer.'

5.6.4 Multimorbidity and polypharmacy

Over our lifetime we accumulate diagnoses, such that many people experience old age as a state of multimorbidity.[267] According to the 2019 NHS data, 27.1% of female population and 21% of male population in Havering were recorded to have two or more chronic conditions and these percentages were higher than England averages of 22.9% (female) and 17.5 % (male).

Efforts to manage multimorbidity can lead to polypharmacy. In some instance, polypharmacy generates yet more prescribing for example when medication is required to manage the side effects of existing drugs or when side effects are wrongly interpreted as new conditions.

Sometimes the complexity is such that the balance between the risks inherent in treatment and the benefits arising can be misplaced so that patients are exposed to harm. Deprescribing, the discontinuation of medications in a systematic and considered manner, can serve to restore the desired balance between benefits and harm. Multidisciplinary teams, including pharmacists and nurse specialists can help. Deprescribing requires a thoughtful explanation to patients and carers. Deprescribing is not about restricting the access of some people to healthcare, but instead an acceptance of the limitations of medicines in some situations. Prescribing fewer drugs is not the same as offering less care.

5.6.5 Immunisation

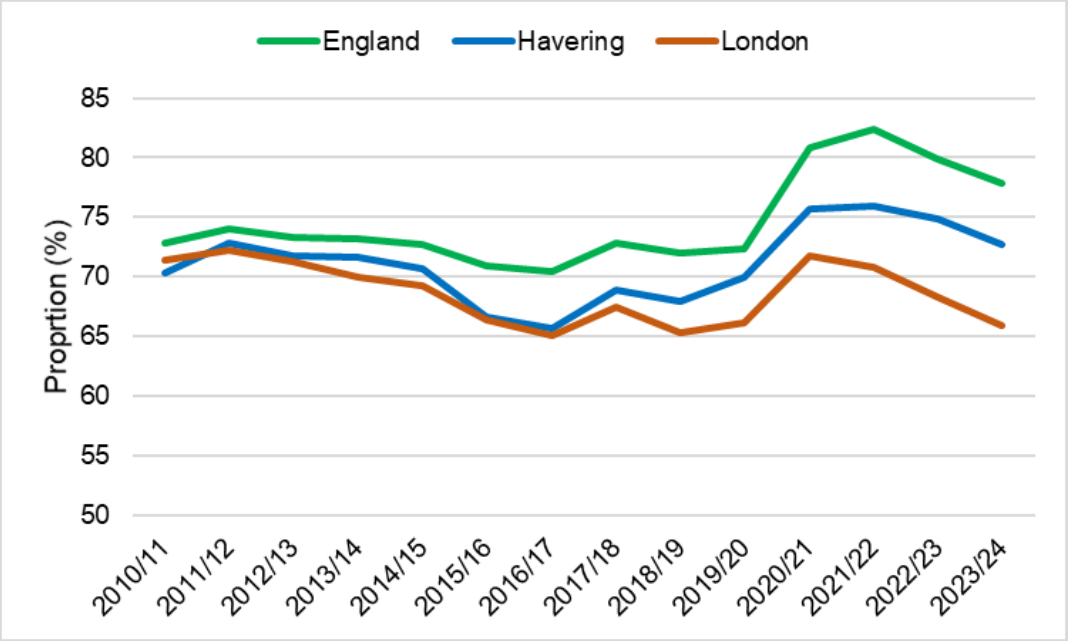
Pre-pandemic, there was strong evidence that flu vaccination reduced excess winter deaths among the elderly. The benefit of flu vaccination is likely to be greater still while coronavirus is circulating, as patients with SARS-CoV-2 and influenza virus co-infection are around twice as likely to die[268] as people with SARS-CoV-2 alone.[269]

The flu vaccine is recommended for adults aged 65 and above, and people with certain long-term conditions including diabetes and chronic respiratory conditions, who are at increased risk of severe complications and death from flu.

Havering's flu vaccination coverage for adults aged 65 and over (72.7%) was better than in the London average (65.9%), but worse than the England average. Coverage is again below the 75% target, having achieved the target during the pandemic period (2020-2022), perhaps related to wider awareness raising in the context of the Covid vaccination programme.

[267] https://www.bgs.org.uk/blog/more-is-less-and-less-is-more-breaking-the-cycle-of-polypharmacy-with-deprescribing
[268] Odds ratio 2.27 (95% Confidence Interval 1.23 to 4.19)
[269] https://pubmed.ncbi.nlm.nih.gov/33942104/

Figure 52: Influenza vaccination coverage for aged 65 and over, Havering, London & England, 2010/11 – 2023/24



Source: OHID, Produced by LBH PHI

To prevent severe complications and excess winter deaths from respiratory illness, adults aged 65 and above are recommended to have a single dose of pneumococcal vaccine, and an annual seasonal flu vaccine. Since September 2023 shingles vaccination is also offered to people aged 65 years, having previously been recommended for adults aged 70-79.

Coverage of both pneumococcal and shingles vaccines was above the London and England averages in 2022/23:

- Pneumococcal vaccination coverage: Havering 74.4%; London 67.2%; England 71.8%
- Shingles vaccination coverage: Havering 57.4%; London 40.8%; England 48.3%

Service Gaps / Unmet Needs

Bedbound and housebound patients require additional resources to receive vaccination.

Recommendation

Havering PCNs should build on the effective partnerships established during the pandemic to maintain and further improve uptake of flu, covid, pneumococcal and zoster vaccines.

5.7 Integrated Health & Social Care

Key Findings

- There are an estimated 3,121 people with Dementia in Havering. In 2024, the number of people diagnosed was 1,757. Havering's diagnosis rate is currently 56.3%, which is below both London and England average rates.
- A further 335 people need to be diagnosed with dementia to meet the national diagnosis target of 67%.
- In 2021/22, 282 Havering residents aged 65years and over were admitted permanently in residential or nursing care homes. This was the third highest number in London, equivalent to a rate of 606 per 100,000 which is significantly above the London (401/100,000) and England (539/ 100,000) averages.

Recommendations

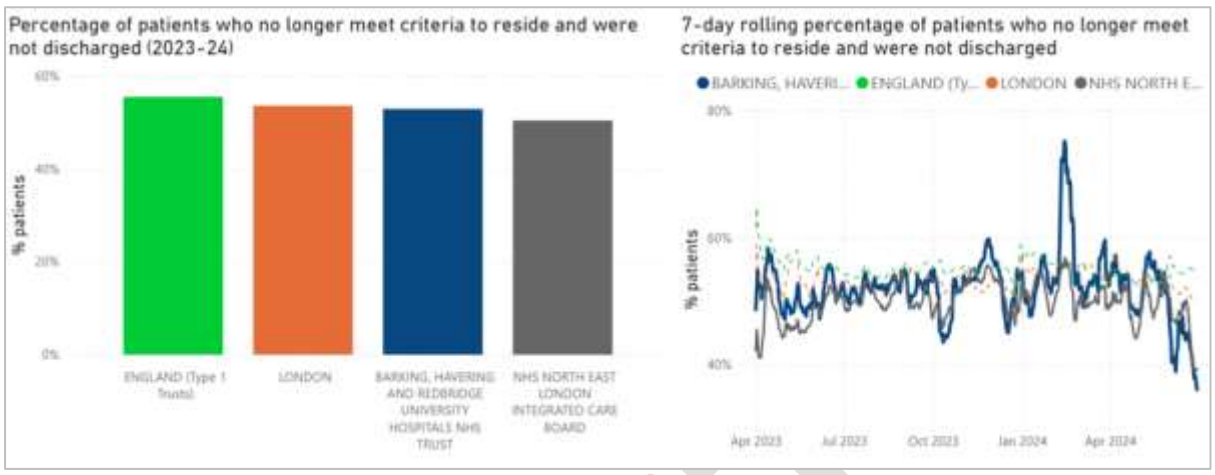
- NEL ICB and partners should ensure older people with bowel cancer symptoms are investigated appropriately.
- Ageing Well subgroup members and partners should facilitate the empowerment of older people so that they can live independently in their own homes with appropriate care, support and social connectivity by:
- Developing a multidisciplinary approach around PCNs
- Raising the importance of social connectivity, nutrition, physical activity, polypharmacy, and falls prevention
- Frailty prevention and intervention including St George's hub
- Prevention of first time falls and better use of technology for prevention
- Re-ablement pathways and innovation around early intervention
- Havering PCNs should build on the effective partnerships established during the pandemic to maintain and further improve uptake of flu, covid, pneumococcal and zoster vaccines.
- Havering Dementia Working Group should continue with efforts to further increase the completeness of dementia diagnosis, and improve access to information and support for patients and their families.
- Hospital Discharge and LAS pathway to be managed differently with new models and good practice to limit demand on both health and social care. (e.g., community-based re-ablement, social worker in hospitals, falls prevention, enhanced re-ablement)
- The current high care quality provided by Havering ASC should be maintained to achieve lower level of deterioration of patient's health and dignity.

5.7.1 Unplanned care

Although essential in some circumstances**,** hospital admission entails significant risks to the continuing independence of older people, as a short period of inactivity can result in a disproportionately large decline in physical ability. There is strong evidence that provision of re-ablement services after admission improves function and hence independence.[270]

[270] https://www.scie.org.uk/integrated-care/intermediate-care-reablement/reablement-guide/#:~:text=The%20benefits%20of%20reablement&text=It%20has%20also%20been%20found,of%20traditional%20care%20subsequently%20required.

Figure 53: Delayed transfer of care from hospital to the community, BHRUT, London & England, 2023/24



Source: NHS England

The percentage of patients with delayed discharge from BHRUT (53%) in 2023/24 was similar to London average, lower than England average (55%) but higher than NEL ICS (50%). The rate of delay in discharges (75%) was highest in February.

The percentage of 75+ year olds having emergency admissions within 30 days of discharge (20.8%, indirectly standardised) is slightly higher than London average (19.1%) and higher than England average (17.2%). However, 87.3% of those aged 65 and over remained at home 91 days after discharge from hospital to re-ablement or rehabilitation services. This highlights the success of continuing care upon discharge and a need for pre-discharge assessment and ward re-ablement.

There were 1,620 Havering residents who used re-ablement services in 2023/24. 77.8% were White and 87.3% were of age 70 and over reflecting Havering's older people population (Table 12). Nonetheless 62.8% were female and 37.2% were male as female service users were over presented in every age group (Table 13).

Table 12: Ethnicity of Havering residents who use re-ablement services, 2023/24

Ethnicity	Number	%
Asian	45	2.8%
Black	25	1.5%
Mix/other	6	0.4%
No data	284	17.5%
White	1,260	77.8%
TOTAL:	**1,620**	

Source: ASC, LBH.

Table 13: Age and gender of Havering residents who use re-ablement services, 2023/24

Gender	20-29	30-39	40-49	50-59	60-69	70-79	80-89	>90	**Total**
Female	75% (*)	78% (*)	57% (12)	52% (24)	60% (67)	62% (217)	62% (421)	67% (266)	63% (1017)
Male	25% (*)	22% (*)	43% (*)	48% (22)	40% (44)	38% (134)	38% (257)	34% (134)	37% (603)
Total	100% (*)	100% (*)	100% (21)	100% (46)	100% (111)	100% (351)	100% (678)	100% (400)	100% (1620)

*numbers less than 5 were suppressed

Source: ASC, LBH.

5.7.2 Dementia, delirium and mental health among older people

An early diagnosis of dementia can help people take control of their condition; plan for the future; potentially benefit from available treatments and make the best of their abilities. There is strong evidence that an early diagnosis helps someone with dementia to continue to live independently in his or her own home for longer.[271] 3,121 people are estimated to be living with dementia in Havering. In 2024, the number of people diagnosed is 1,757. A further 335 people need to be diagnosed to meet the national diagnosis target of 67% from Havering's current diagnosis (56.3%) (Table 14), which is below both London and England rates.

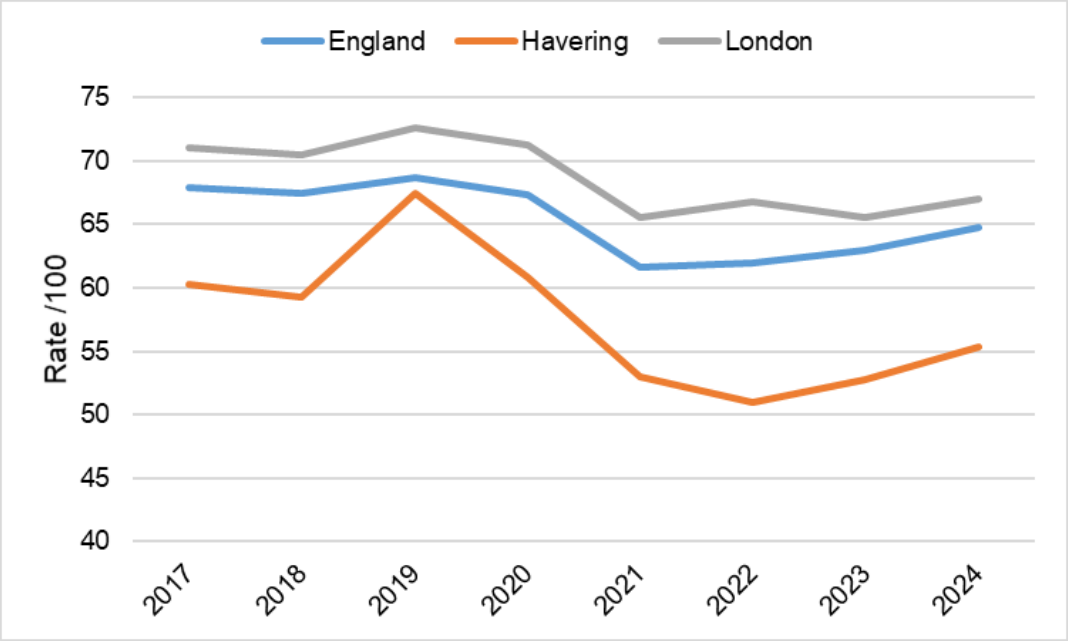
Table 14: Dementia diagnosis, GP recorded and estimated figures, 2024

Area	Estimated*	Recorded	Gap to 67% target	Dx Rate (%)	UL Dx Rate	LL Dx Rate
England	726,391	472,198	14,484	65	70.5	58.6
London	75,736	50,972	-229	67.3	73	60.4
B&D	1,385	859	69	62	68.7	54.4
Hackney	1,376	923	-1	67.1	74.3	58.6
Havering	3,121	1,757	334	56.3	61.6	50.2
Newham	1,662	963	150	58	64.3	50.5
Redbridge	2,779	1,788	74	64.3	70.5	57.2
Tower Hamlets	1,233	912	-86	74	82	64.7
Waltham Forest	2,009	1,139	207	56.7	62.5	50

Source: NHS England, June 2024. *NHSE estimates are different from POPPI estimates.

[271] https://www.scie.org.uk/dementia/symptoms/diagnosis/early-diagnosis.asp

Figure 54: Estimated Dementia diagnosis rate for persons aged 65 and over, Havering, London and England, 2017 - 2024.



Source: OHID, Produced by LBH PHI.

POPPI estimates a much larger local prevalence and they also include projected numbers up to 2040 (Table15).

Table 15: People aged 65 and over predicted to have dementia, by age, projected to 2040, LB Havering.

	2023	2025	2030	2035	2040
People aged 65-69 predicted to have dementia	209	220	244	249	237
People aged 70-74 predicted to have dementia	326	326	369	408	421
People aged 75-79 predicted to have dementia	620	631	565	647	721
People aged 80-84 predicted to have dementia	756	789	965	875	1,006
People aged 85-89 predicted to have dementia	878	878	893	1,105	1,049
People aged 90 and over predicted to have dementia	967	967	1,026	1,120	1,368
Total population 65 and over predicted to have dementia	3,756	3,810	4,060	4,404	4,800

Source: www.poppi.org.uk version 14.2.

Sudden confusion (delirium) can have many causes. Infection e.g. a urinary tract infection is a common cause of confusion in elderly people and people with dementia. Confusion can also result from a variety of medical conditions, drug side effects and head injury. The cause of many cases of delirium can be treated and recurrence prevented. New onset confusion

requires urgent investigation and the responsible clinician should talk to someone who knows the person well and knows what has happened to them recently.[272]

Research shows 75% of people aged 65+ have experienced significant anxiety or low mood at least once since turning 65, with 10% feeling this frequently or all the time.[273] Within this cohort, particular groups are at higher risk of mental health difficulties including those in nursing homes, with long-term physical conditions and disabilities.

There is a high prevalence of mental health issues in older people so Comprehensive Geriatric Assessment is not complete without addressing both mood and cognition. Care that looks at a 'whole person' and that is undertaken by a geriatric MDT is the gold standard approach so as not to miss either physical or mental health conditions. Depression often co-exists with physical illness or dementia. In addition, the health of an older person can also be adversely impacted by hazardous drinking of alcohol.

The most common mental health condition in older people is depression, affecting 22% of men and 28% of women aged 65 or over, followed by anxiety.[274] 40% of older people who are living in care homes have depression; 30% of older carers experience depression at some point; and older people going through a bereavement are up to four times more likely to experience depression than older people who haven't been bereaved.[275]

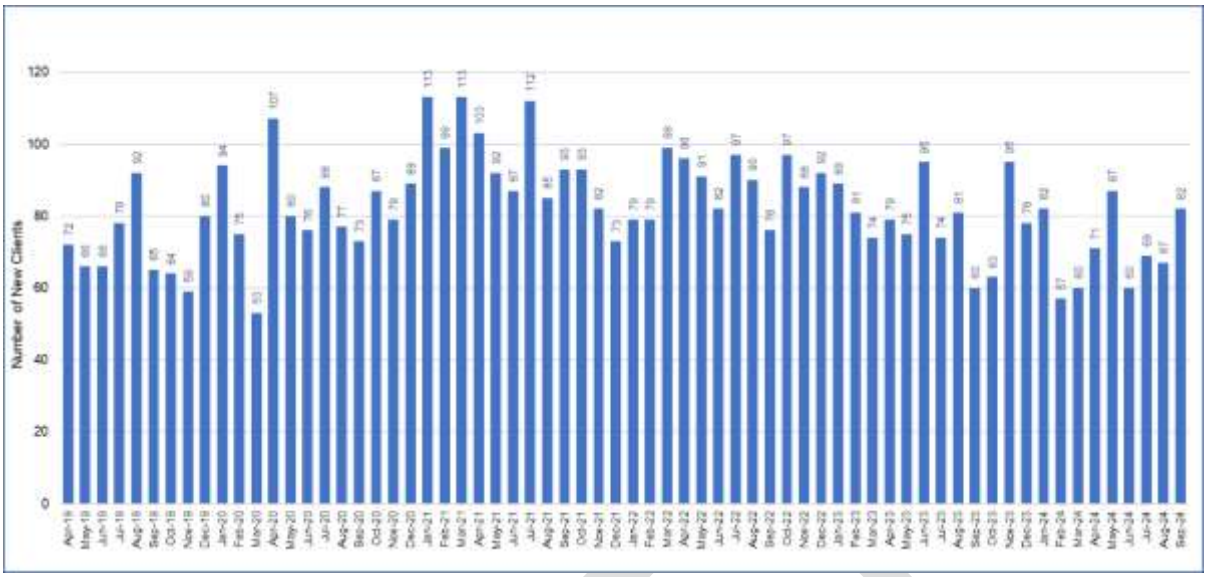
Older people living with dementia may struggle to express how they are feeling which also increases the difficulty of diagnosis.[276] Dementia can also trigger mental health problems, with estimates suggesting that 20-40% of people living with dementia are depressed.[277] It is important that older people are able to access services which are appropriate for their needs.[278] A target was set in 2011 to increase the proportion of older people referred to IAPT (Improving Access to Psychological Therapies) services to 12%. However, the proportion of IAPT service users who are over 65 has remained stable at or below 7%, despite this age group making up 18% of the population.[279]

5.7.3 Social Care

In 2024, 4,483 residents aged 65 years and over were receiving support from Havering Adult Social Care. 1,504 were male and 2,979 female. Overall they received 6,655 care packages. In 2023/24, around 900 clients entered into the Havering ASC service. 550 clients unfortunately died in the service. Not only has the number of service users increased, there has also been an increase in the intensity of need as evident by the rise in one-to-one care costs. Some clients also need more than two people to support them.

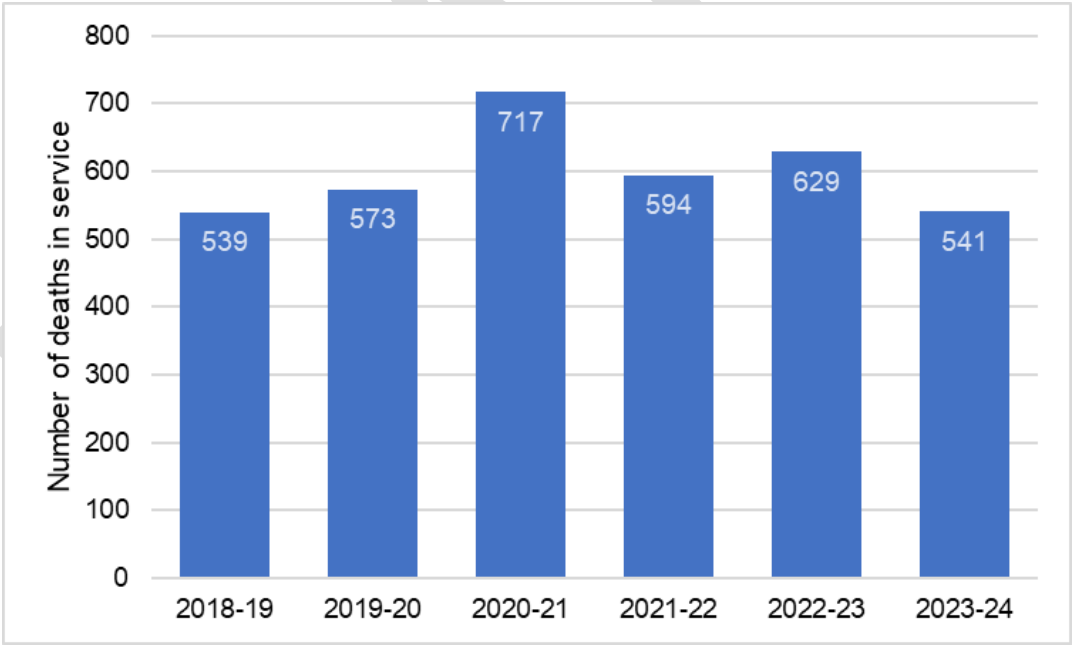
[272] https://cks.nice.org.uk/topics/delirium/
[273] https://academic.oup.com/ageing/article/42/5/598/18032?login=true
[274] http://www.hscic.gov.uk/pubs/hse05olderpeople
[275] https://independent-age-assets.s3.eu-west-1.amazonaws.com/s3fs-public/2018-04/Good Grief report.pdf
[276] https://www.bgs.org.uk/sites/default/files/content/attachment/2018-09-12/Depression%20among%20older%20people%20living%20in%20care%20homes%20report%202018.pdf
[277] https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/depression
[278] https://www.cambridge.org/core/journals/bjpsych-advances/article/interface-between-general-adult-and-old-age-psychiatry/CE00434266EF2CE393903E705EFB5192
[279] https://pubmed.ncbi.nlm.nih.gov/29704904/

Figure 55: Number of Havering Adult Social Care clients. 2023/24



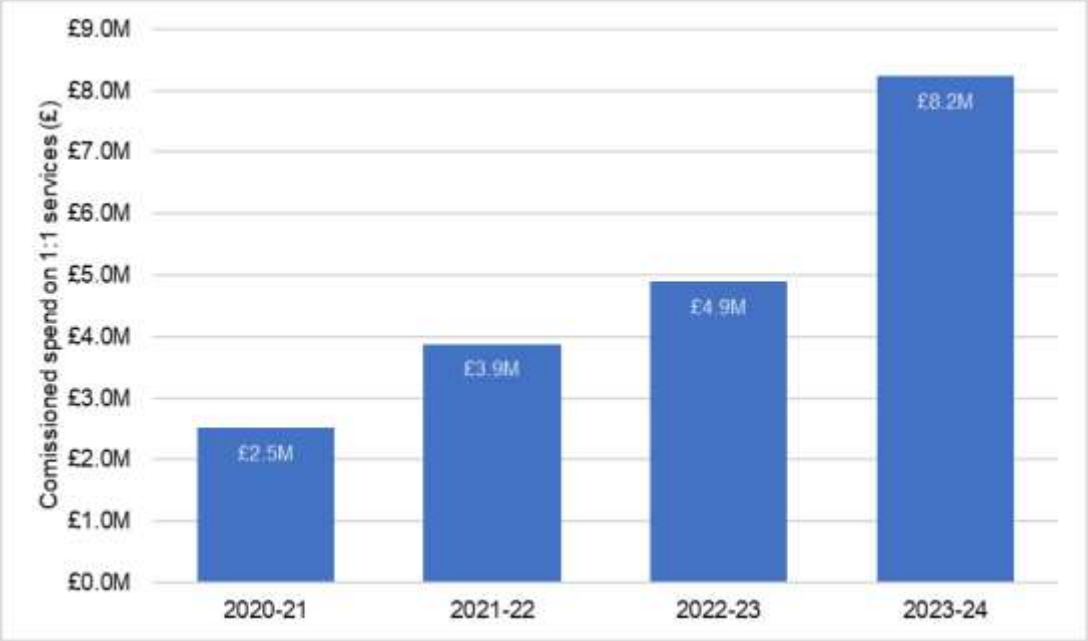
Source: LBH, ASC

Figure 56: Number of deaths in service, Havering Adult Social Care, 2018/19 - 2023/24



Source: LB Havering ASC

Figure 57: Commissioned spend on 1:1 services, Havering Adult Social Care, 2020/21 - 2023/24



Source: LB Havering ASC

Adult Social Care Placements and average cost of each placement type

3,160 Havering residents aged 65 years and over needed a placement in 2023/24. Most were under homecare placements (1,697), which has the lowest cost per placement (£20,171 per annum) (Table 16) but also the highest percentage increase in per unit cost. Supported living had the highest average annual placement cost (£65,410 per annum) closely followed by nursing placement (£61,352) and residential care (£53,409). The increase in the number of users was highest with supported living and residential care. The intensity of need has become higher as the cost of 1:1 services more than tripled in 3 years (£2.52M in 2021 to £8.23M in 2023/24).

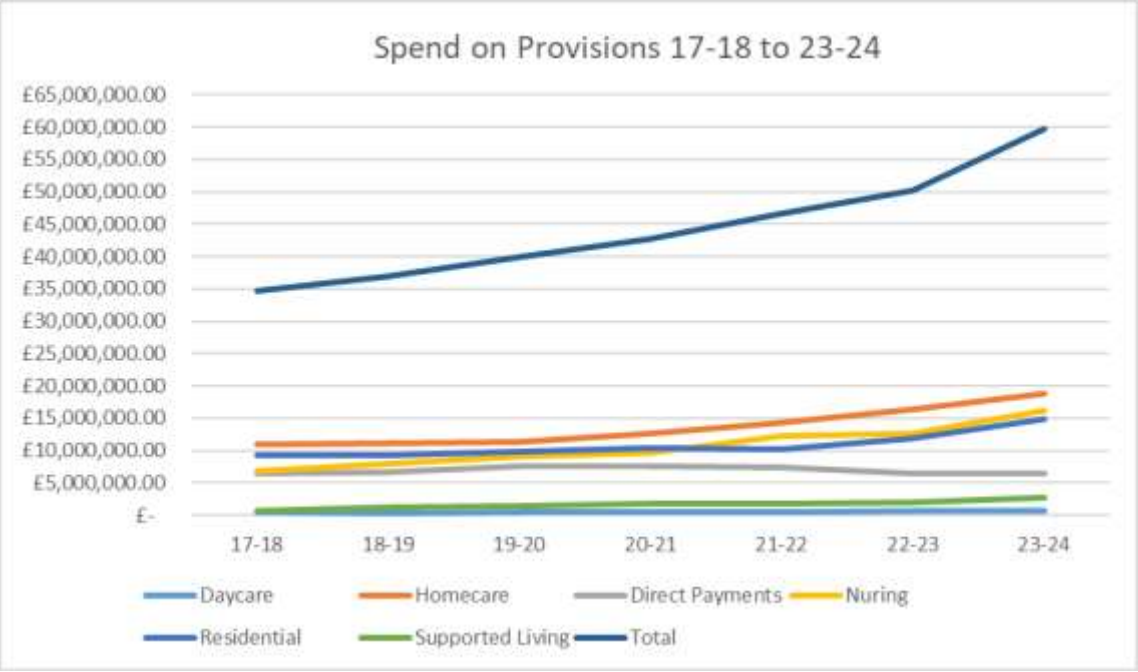
Table 16: Number of clients and average cost per placement, 2023/24

Key Metrics and Assumptions	No. of clients	Cost per placement (average annual)
Nursing Placements	410	£61,352
Residential Placements	484	£53,409
Homecare Placements	1,697	£20,171
Direct Payments	406	£23,265
Supported Living	52	£65,410
Day Care	110	£10,894

Source: LBH, ASC

Average weekly cost of every provision has increased year on year except supported living. The increase in numbers, intensity and average cost has resulted in overall increase in adult social care cost by London Borough of Havering.

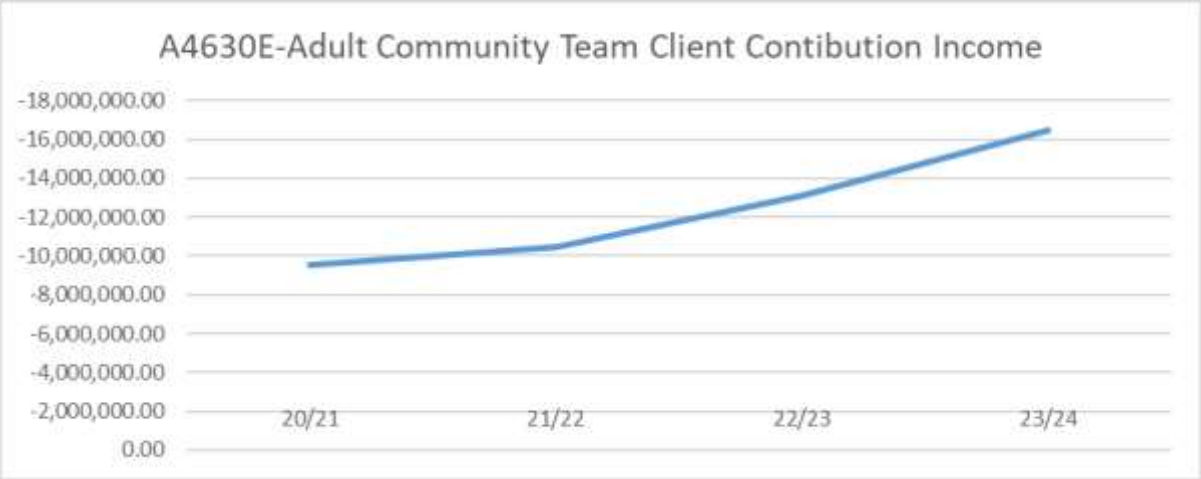
Figure 58: Spend on provisions, Havering Adult Social Care, 2017/18 - 2023/24



Source: LB Havering ASC

Clients' contributions are also rising due to increase in expenditure in most care needs.

Figure 59: Adult community team client contribution income, Havering Adult Social Care, 2020/21 - 2023/24



Havering hosts the highest number of care home beds in the BHR system.

Table 20: Care home beds, number and rate (per 100,000 people aged 75+), 2021

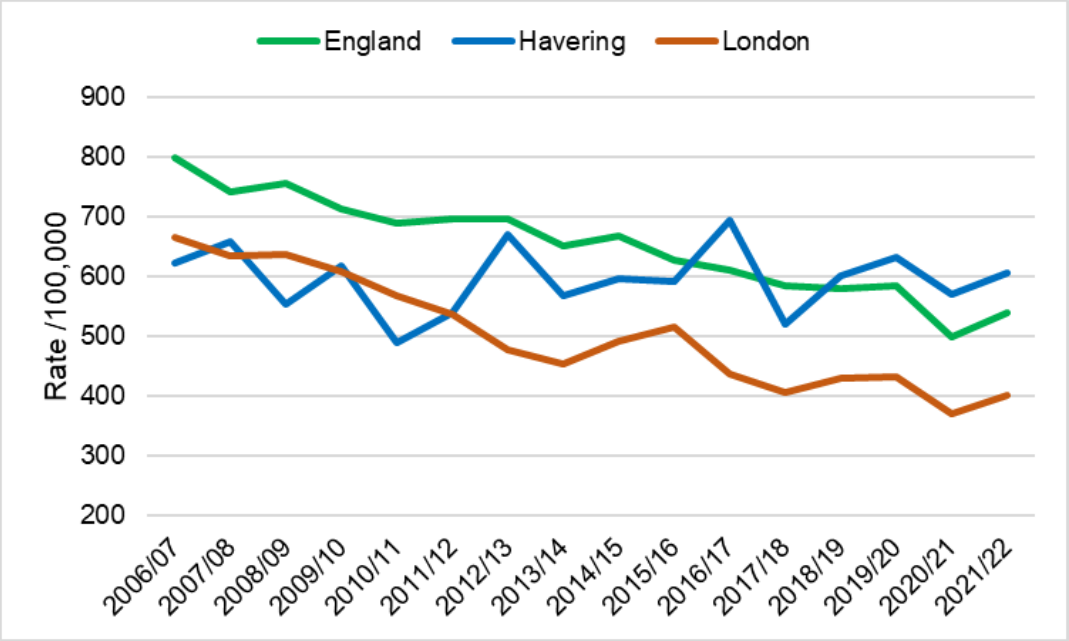
Area	Number	Rate
LBBD	718	8.0
LB Havering	1,834	8.0
LBR	1,379	7.7
London	35,435	7.1
England	458,955	9.4

Source: Care Quality Commission (CQC) and Office for National Statistics (ONS)

Evidence shows that, where possible, older people prefer to stay in their own home rather than move into residential care.[280] In 2021/22, 282 Havering residents aged 65 years and over were admitted permanently to residential or nursing care homes. This was the third highest number in London and equivalent to a rate of 606 per 100,000 population. This rate is significantly above the London (401/100,000) and England (539/100,000) averages where the rate has been slowly dropping unlike among Havering residents.

[280] https://personalalarms.org/cost-of-living-crisis-impact-on-elderly-care-based-decisions

Figure 60: Permanent admissions to care homes per 100,000 aged 65+, Havering, London and England, 2006/7 – 2021/22.



Source: OHID, Produced LBH PHI

Nonetheless, the proportion of people using social care who received self-directed support, and those receiving direct payments (98.2%) was higher than London average (96.3%) and England average (93.2%). Studies have shown that direct payments increase satisfaction with services and are the purest form of personalisation. The Care Act places personal budgets on a statutory footing as part of the care and support plan. Nationally, one in seven people aged 85 and above live in a care home.

It is crucial that residents in care homes are having their needs assessed and addressed as well as they could be, this may avoid unnecessary unplanned and admissions to hospital. The Enhanced Health in Care Homes (EHCH) model is designed to put this right.

Social contact of service users

The percentage of Havering adult social care users aged 65 years and over who had as much social contact as they would like in 2022/23 was 36.7% which was similar to London average (35.7%) but lower than England average (41.5%).

Service user satisfaction - adult social care (age 65+)

60% of Havering adult social care service users aged 65 years and over are overall extremely or very satisfied compared to an average rate of 54.9% in London and 61.8% in England.

Service Gaps / Unmet Needs

Increasing demand, complexity and costs meant current provision at the current quality of care may not be sustainable without additional funding.

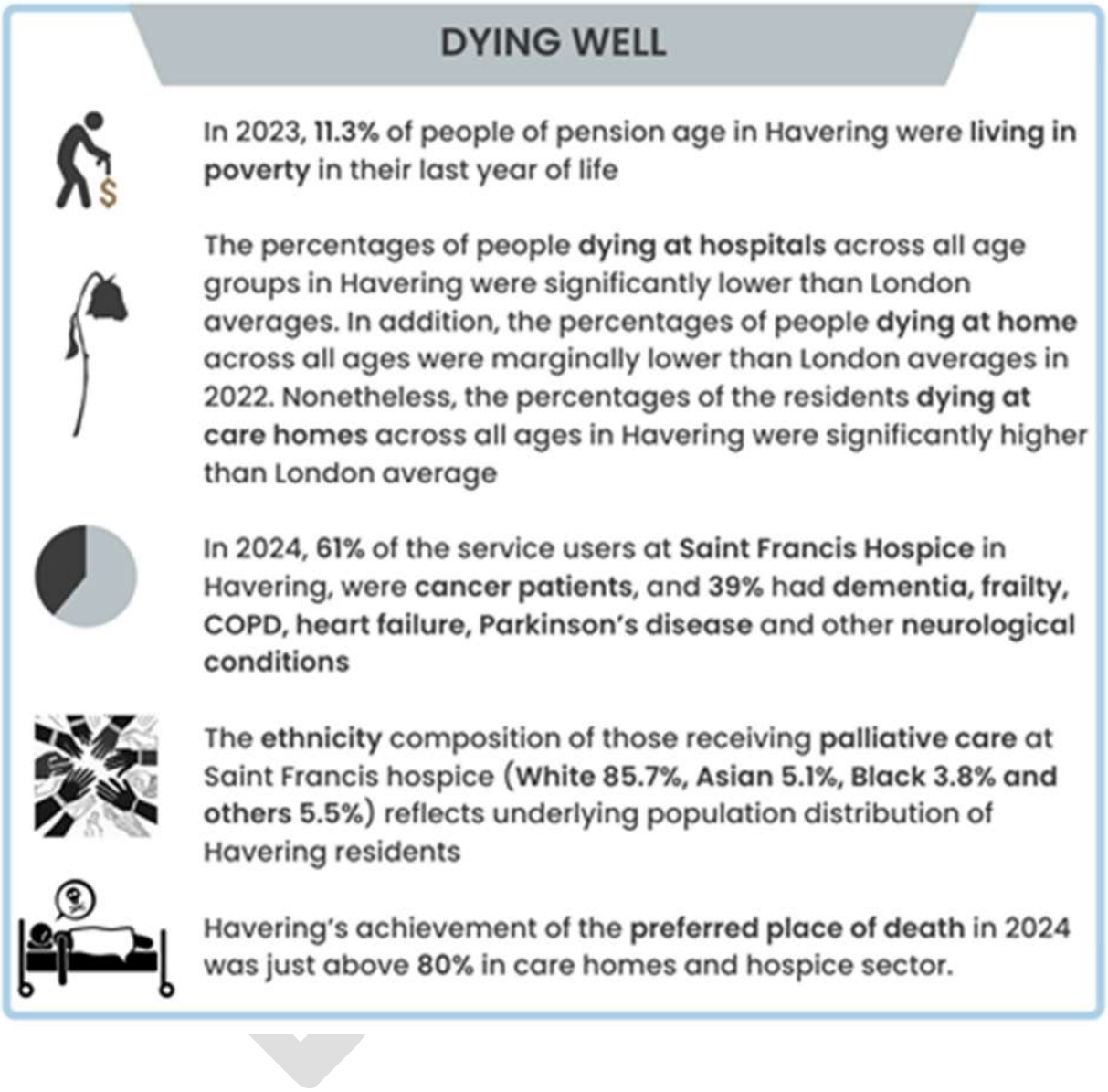
Recommendation

Population health management (PHM) approach should be used by social care and public health to identify the avoidable risk factors for learning disability and other care packages; and to recommend most effective mental health and physical support interventions, including the use of technology for better and efficient care.

Dying Well

6. Dying Well

6.1 Infographic Summary



6.2 Key Findings & Recommendations

Key findings

- In 2022, 11.3% of Havering residents of pension age were in poverty in their last year of life.
- Havering's 75+ population is 93.5% White but this proportion is changing with continued inward migration from other London boroughs.
- Havering's proportion of adults aged 66 years and over **living alone** (12.7%) is similar to England average but higher than London average (9.1%).
- In 2021, the percentage of people providing **unpaid care** in Havering (9.2%) was higher than the London average (7.7%)
- The percentages of people **dying at hospitals** across most age groups in Havering were lower than London averages in 2023. Nonetheless, the percentages of the residents **dying at care homes** across most ages in Havering were significantly higher than London average. A significantly higher proportion of care home deaths compared to London averages may indicate good availability of care home placements, the availability of specialist palliative care advice and end-of-life care support in care home settings.
- The percentage of Havering patients who died at **hospices** for age groups **under 75 years was higher** than London and England averages.
- In 2024, 61% of the Havering service users at Saint Francis Hospice were cancer patients, and 39% had dementia, frailty, COPD, heart failure, Parkinson's disease and other neurological conditions.
- The **ethnicity composition** of Havering patients receiving palliative care at Saint Francis hospice (White 85.7%, Asian 5.1%, Black 3.8 and others 5.5%) reflects underlying population distribution of Havering residents aged 70-74 years (White 99.2%, Asian 4.5%, Black 1.7% and other 1.7%).
- Havering's achievement of the **preferred place of death** was just above 80% in care homes and hospice sector in 2024.

Recommendations:

- The council, ICB and partners should adequately support residents to ensure the last stages of their lifes happen in the best possible circumstances, receiving the right help at the right time from the right people, and place.
- The council, ICB and partners should enhance home based end of life care by increasing training for care givers and community services on managing end of life symptoms effectively
- NEL ICB should increase the use of urgent care plan (UCP) and ensure that UCPs are well integrated with primary care, secondary care and ambulance records.
- Local commissioners and providers of palliative and end of life care should apply NICE guidance NG142 in the context of local and national priorities for funding and in light of their duties to have due regard to the need to eliminate unlawful discrimination and to reduce health inequalities.
- The council, ICB and partners should strengthen end-of-life care to increase the proportion of people who are supported to die with dignity in their usual place of residence or a preferred place of death.
- The council, ICB and partners should ensure timely access to end-of-life medications by working with community pharmacies.
- The council, ICB and partners should work towards increasing capacity and resources for hospice care to meet the demand for hospice care among those under 75 years of age

6.3 Introduction

Wellbeing matters for everyone at all stages of life, and the end of life is no exception. Adequately addressing the needs of patients at the end of life and their relatives is pivotal in preventing unnecessary suffering and optimising their quality of life. The borough's need for palliative care will continue to grow as a result of the ageing of populations and the rising burden of diseases.

If someone has an illness that cannot be cured, palliative care makes them as comfortable as possible by managing their pain and other distressing symptoms. It also involves psychological, social and spiritual support for them and their family or carers. This is called a holistic approach, because it deals with them as a "whole" person, not just their illness or symptoms. Early delivery of palliative care reduces unnecessary hospital admissions and the use of health services.

People are considered to be approaching the end of life when they are likely to die within the next 12 months, although this is not always possible to predict. This includes people whose death is imminent, as well as people who:

- have an advanced incurable illness, such as cancer, dementia or motor neurone disease
- are generally very frail and have co-existing conditions that mean they are expected to die within 12 months
- have existing conditions if they are at risk of dying from a sudden crisis in their condition
- have a life-threatening acute condition caused by a sudden catastrophic event, such as an accident or stroke

End of life care should help them to live as well as possible and to die with dignity. The people providing their care should ask them about their wishes and preferences and take these into account as they work with them to plan their care. They should also support their family, carers or other people who are important to you. They have the right to express their wishes about where they would like to receive care and where they want to die. They can receive end of life care at home, in a care home, hospice or be cared for in hospital, depending on their needs and preference.

In 2021, NHS England published a national framework for local action (2021-2026)[281] with 6 ambitions for Palliative and End of Life Care:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

[281] https://www.england.nhs.uk/wp-content/uploads/2022/02/ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf

6.4 Wider Determinants of Health

In 2022, 11.3% of Havering residents of pension age were in poverty in their last year of life. Poverty makes dying well harder. Havering's 75+ population is currently 93.5% White but this proportion is changing with continued inward migration from other London boroughs (Table 18). In a study carried out by Marie Curie, they found that, overall, palliative and end of life care provision for ethnic minority groups was often inadequate.[282] Therefore, raising awareness across communities and provision of culturally sensitive care will be crucial in meeting the diverse needs of the Havering population.

Robust knowledge of these services, and the range of other supports available, is therefore key to ensuring households and families impacted by terminal illnesses are able to access care and support when and where they need it. In death literate communities, people can talk openly about death and dying. This helps to increase engagement with palliative care services and also leads people to feel more capable of sharing their end of life wishes.[283]

Table 18: Havering population 65 years and above by age and ethnicity, 2021

Ethnicity	Age 65 to 69 years	Age 70 to 74 years	Age 75 to 79 years	Age 80 to 84 years	Age 85 and over
Asian	6.20%	4.51%	3.46%	3.21%	2.01%
Black	3.24%	1.70%	1.89%	1.90%	1.38%
Mixed	0.56%	0.54%	0.48%	0.39%	0.36%
Other ethnic group	1.63%	1.11%	0.69%	0.70%	0.49%
White	88.4%	92.2%	93.5%	93.8%	95.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: ONS Census, 2021

Service Gaps / Unmet Needs

Occasionally, residents with complex need e.g., drugs and alcohol use, rough sleeping or mental health condition have died without end of life care and referred to safeguarding for review. It is also important that end of life care services adequately cater for those with learning disability or autistic spectrum disorder.

Recommendation

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people, and place.

[282] https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/june-2013/palliative-and-end-of-life-care-for-black-asian-and-minority-ethnic-groups-in-the-uk.pdf
[283] https://www.mariecurie.org.uk/document/creating-a-death-literate-society-ni-2022

6.5 Places & Communities

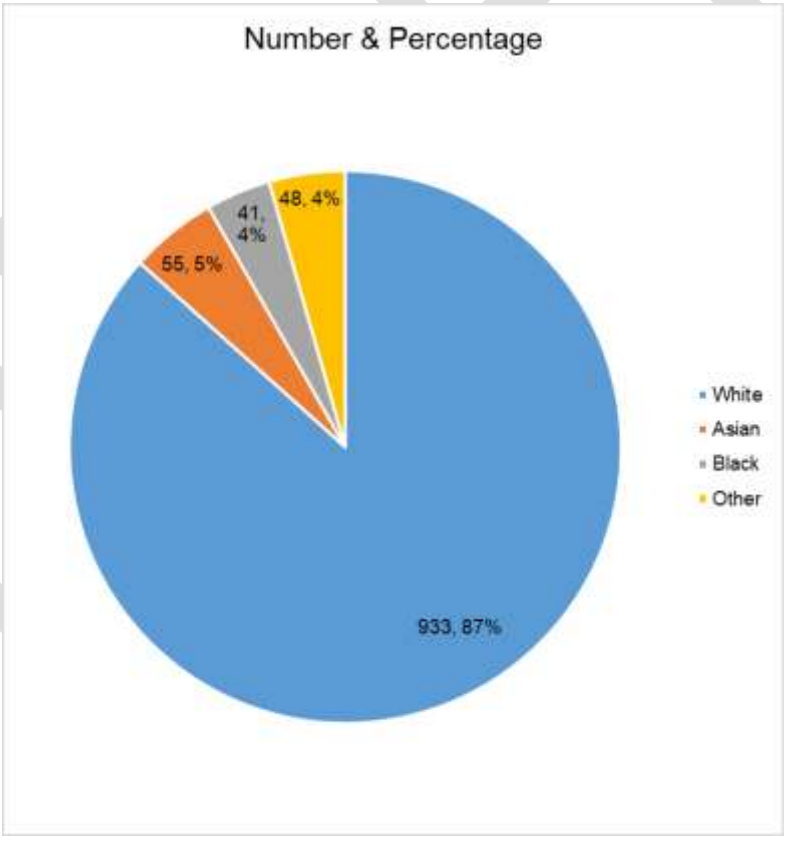
We need to build communities which are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways, where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss.

According to the census 2021, the percentage of people providing unpaid care in Havering (9.2%) was higher than London average of 7.7%.

The proportion of adults aged 66 and over living alone (12.7%) was similar to England average but higher than London average (9.1%).

In 2024, 85% of the service users at Saint Francis Hospice were White reflecting the Havering's older people population characteristics (Figure 61). The hospice is for anyone struggling with an advanced progressive condition, irrespective of faith or ethnic background.

Figure 61: Ethnicity distribution of service users at Saint Francis Hospice in Havering, 2024



Source: Saint Francis Hospice.

The community awareness of services or options for End-of-life-care (EoLC) should be strengthened as well as ensuring consistency of sharing EoLC plans across all care settings. With adequate planning and support people can die with dignity in familiar surroundings; for some people this will mean a care home. The BHR EoLC work stream aim is to acknowledge

a person's wishes and support their end-of-life needs in their preferred place of care and is addressing this challenge across three boroughs. Care Home Support, a rapid response team and 24-hour support line are being implemented and the palliative care capacity is increasing to improve the quality of the end-of-life care.

Place of death (for home, care homes, hospice and hospitals)

The percentages of people dying at hospitals across all age groups were significantly lower than London averages. In addition, the percentages of people dying at home across all ages were marginally lower than London averages in 2022. Nonetheless, the percentages of the residents dying at care homes across all ages were significantly higher than London average. A significantly higher proportion of care home deaths compared to London averages may reflect more availability of care home placements in Havering but could also suggest a need for more robust home care or hospice care alternatives.

The percentages of those who died at hospices for age groups under 75 years in Havering were higher than London and England averages. It is positive that the hospice services are preferred place of death for many under 75s so we can build upon this confidence for broader age groups.

Bereavement support

OrangeLine is a telephone support line (01708 758649) for any local person of any age who may be bereaved, feeling isolated or lonely. OrangeLine helps by:[284]

- Regular telephone calls from specially trained OrangeLine staff and volunteers
- Information and signposting to local services and social groups
- Referrals to local specialist advice centres

Recommendations

- People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people, and place.
- Enhance Home based end of life care by increasing training for care givers and community services on managing end of life symptoms effectively
- To work with community partners to ensure there is no disparities in hospice usage amongst ethnic minorities e.g., outreach work targeting potentially under-represented groups to raise awareness of end of life care options.

6.6 Lifestyle & Behaviours

Awareness and preparation: It is important that people are supported to be able to make the end-of-life arrangements. When someone is approaching end of life, health and care services should ask them:

- Whether they have an advance care directive
- If they've named someone to make decisions about their medical care
- Whether someone knows where their important paperwork is and what their essential online passwords are

[284] https://www.sfh.org.uk/orangeline-helpline

- If they have a current will
- If they have funeral preferences and whether they want to be buried or cremated

Recommendation

Strengthen end-of-life care to increase the proportion of people who are supported to die with dignity in their usual place of residence or a preferred place.

6.7 Integrated Health & Social Care

Each person's journey to death is unique. Some people have a very gradual decline, while others fade away quickly. Different health and social care professionals may be involved in their end of life care, depending on their needs. For example, hospital doctors and nurses, their GP, community nurses, hospice staff and counsellors may all be involved, as well as social care staff, chaplains (of all faiths or none), physiotherapists, occupational therapists or complementary therapists.

Palliative and end of life care: If they have an illness that cannot be cured, palliative care makes them as comfortable as possible by managing their pain and other distressing symptoms. It also involves psychological, social and spiritual support for them and their family or carers. This is called a holistic approach, because it deals with them as a "whole" person, not just their illness or symptoms.

End of life care is a form of palliative care they receive when you're close to the end of life. People are considered to be approaching the end of life when they are likely to die within the next 12 months, although this is not always possible to predict.

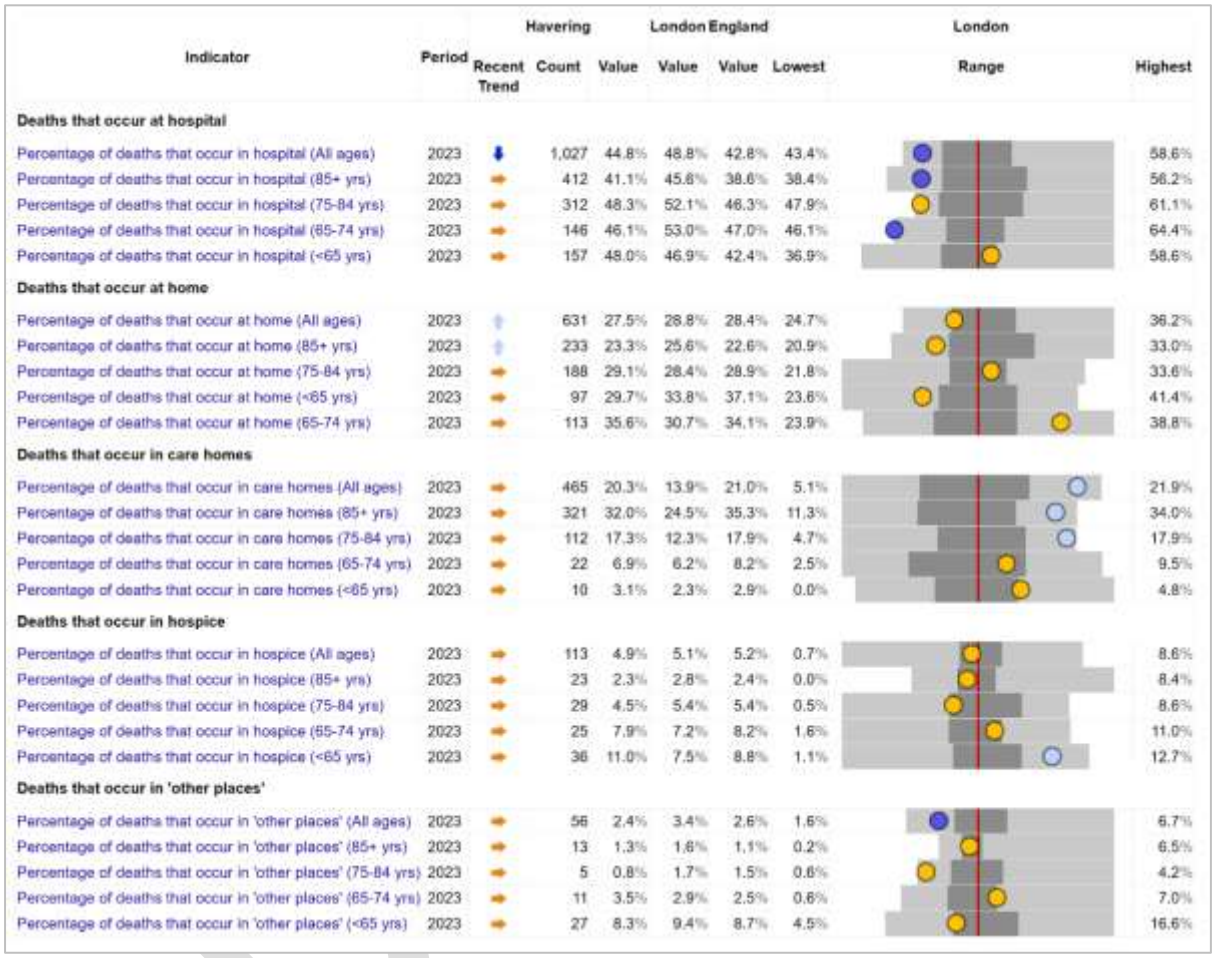
Both palliative care and end of life care could be given at home, care homes and specialist palliative care provider depending on the individual situation and choice. The providers work alongside GPs, community nurses, social care, voluntary care sector organisation and hospital specialists to help manage pain and other difficult symptoms, with an aim for comfort, as much independence as possible, and the best possible quality of life. Hospice services support those on the frontline and those in crisis with complex issues related to end of life care. We need to ensure timely access to services for people facing advanced illness.

NICE Guidance NG142 (https://www.nice.org.uk/guidance/ng142) covers organising and delivering end of life care services, which provide care and support in the final weeks and months of life (or for some conditions, years), and the planning and preparation for this. It includes recommendations on:

- Identifying adults who may be approaching the end of their life
- Holistic needs assessment
- Supporting carers and providing information
- Reviewing current treatment
- Advance care planning and reviewing people's needs
- Communication between services, providing multi-practitioner care and care coordination
- Transferring people between care settings and providing out-of-hours care.

The percentages of people dying at hospitals across most age groups in Havering were significantly lower than London averages. Nonetheless, the percentages of the residents dying at care homes across most ages in Havering were significantly higher than London average. A significantly higher proportion of care home deaths compared to London averages may indicate good availability of care home placements. (Fig. 62)

Figure 62: Place of death in Havering, 2023.



Indicator	Period	Havering			London	England	London		
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
Deaths that occur at hospital									
Percentage of deaths that occur in hospital (All ages)	2023	↓	1,027	44.8%	48.8%	42.8%	43.4%		58.6%
Percentage of deaths that occur in hospital (85+ yrs)	2023	→	412	41.1%	45.6%	38.6%	38.4%		56.2%
Percentage of deaths that occur in hospital (75-84 yrs)	2023	→	312	48.3%	52.1%	46.3%	47.9%		61.1%
Percentage of deaths that occur in hospital (65-74 yrs)	2023	→	146	46.1%	53.0%	47.0%	46.1%		64.4%
Percentage of deaths that occur in hospital (<65 yrs)	2023	→	157	48.0%	46.9%	42.4%	36.9%		58.6%
Deaths that occur at home									
Percentage of deaths that occur at home (All ages)	2023	↑	631	27.5%	28.8%	28.4%	24.7%		36.2%
Percentage of deaths that occur at home (85+ yrs)	2023	↑	233	23.3%	25.6%	22.6%	20.9%		33.0%
Percentage of deaths that occur at home (75-84 yrs)	2023	→	188	29.1%	28.4%	28.9%	21.8%		33.6%
Percentage of deaths that occur at home (<65 yrs)	2023	→	97	29.7%	33.8%	37.1%	23.6%		41.4%
Percentage of deaths that occur at home (65-74 yrs)	2023	→	113	35.6%	30.7%	34.1%	23.9%		38.8%
Deaths that occur in care homes									
Percentage of deaths that occur in care homes (All ages)	2023	→	465	20.3%	13.9%	21.0%	5.1%		21.9%
Percentage of deaths that occur in care homes (85+ yrs)	2023	→	321	32.0%	24.5%	35.3%	11.3%		34.0%
Percentage of deaths that occur in care homes (75-84 yrs)	2023	→	112	17.3%	12.3%	17.9%	4.7%		17.9%
Percentage of deaths that occur in care homes (65-74 yrs)	2023	→	22	6.9%	6.2%	8.2%	2.5%		9.5%
Percentage of deaths that occur in care homes (<65 yrs)	2023	→	10	3.1%	2.3%	2.9%	0.0%		4.8%
Deaths that occur in hospice									
Percentage of deaths that occur in hospice (All ages)	2023	→	113	4.9%	5.1%	5.2%	0.7%		8.6%
Percentage of deaths that occur in hospice (85+ yrs)	2023	→	23	2.3%	2.8%	2.4%	0.0%		8.4%
Percentage of deaths that occur in hospice (75-84 yrs)	2023	→	29	4.5%	5.4%	5.4%	0.5%		8.6%
Percentage of deaths that occur in hospice (65-74 yrs)	2023	→	25	7.9%	7.2%	8.2%	1.6%		11.0%
Percentage of deaths that occur in hospice (<65 yrs)	2023	→	36	11.0%	7.5%	8.8%	1.1%		12.7%
Deaths that occur in 'other places'									
Percentage of deaths that occur in 'other places' (All ages)	2023	→	56	2.4%	3.4%	2.6%	1.6%		6.7%
Percentage of deaths that occur in 'other places' (85+ yrs)	2023	→	13	1.3%	1.8%	1.1%	0.2%		6.5%
Percentage of deaths that occur in 'other places' (75-84 yrs)	2023	→	5	0.8%	1.7%	1.5%	0.6%		4.2%
Percentage of deaths that occur in 'other places' (65-74 yrs)	2023	→	11	3.5%	2.9%	2.5%	0.6%		7.0%
Percentage of deaths that occur in 'other places' (<65 yrs)	2023	→	27	8.3%	9.4%	8.7%	4.5%		16.6%

Source: OHID

To facilitate home based end of life care, it is crucial to provide effective training for care givers and community services on managing end of life symptoms, and to ensure that urgent care plans are well integrated with primary care and hospital records/LAS enabling seamless care transitions and timely access to services. Moreover, we must work with community pharmacies to ensure timely access to end of life medications particularly for those opting for home based care.

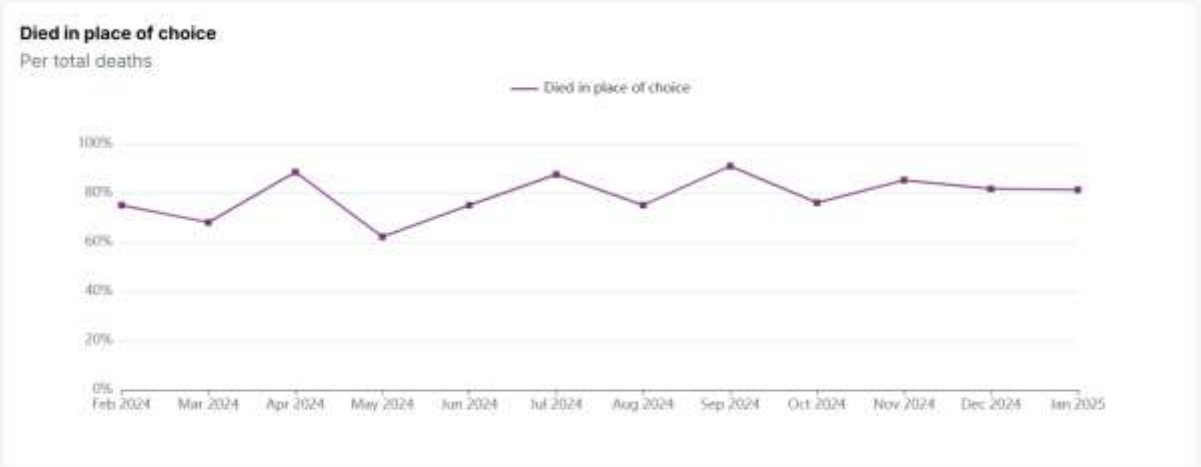
Place of death and preferred place of death

Helping someone to be cared for and die in their preferred place, avoiding intensive hospital treatment are all crucial palliative considerations.[285] To improve dying at the preferred place

[285] https://www.england.nhs.uk/blog/its-emotional-lets-talk-about-dying/

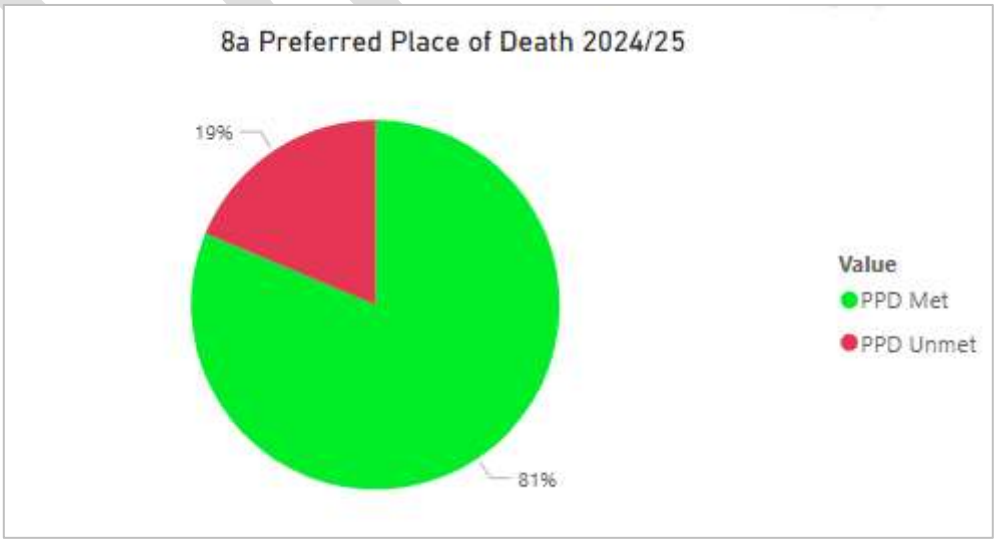
of death, we should regularly analyse place of death against preferred place and transform services to match patient preferences also ensuring this information is included in urgent care plans. There should be regularly reviewed including an update of patients' preferred place of death throughout their care journey. A key quality metric could be a report on the percentage of individuals achieving their preferred place of death. Although there is no publicly available data, data provided by Saint Francis Hospice shows that over 80% of those who died in care homes were recorded as "died in place of choice" in 2024 (Fig. 63). Similarly, 81% of those who died at Saint Francis Hospice were recorded to be deaths at preferred place of death up to Q3 2024/25.

Figure 63: Percentage of deaths documented as preferred place of death among those who passed in nursing homes in Havering Feb 2024 to Jan 2025.



Source: Carepulse

Figure 64: Percentage of deaths documented as preferred place of death among those who passed at Saint Francis Hospice.



Source: Saint Francis Hospice, Havering, 2025.

The percentages of those who died at hospices for age groups under 75 years were higher than London and England averages. Nonetheless, people had to make decision to be in the hospice for their place of choice for death.

To meet the demand for hospice care among under 75s, we should strengthen the capacity and awareness for hospice care. We need to partner collaboration to provide enhanced bereavement support for families and care givers.

Saint Francis Hospice is a major provider of both of these services. Higher referrals were seen in December, January, May and June. Referral sources were mainly from the hospitals, followed by GP, district nurses and self- referrals. They also provide support on hospital wards.

Although there is no central register for all adults who need palliative care or end of life care, and the reasons for requiring palliative care, the largest provider Saint Francis Hospice in Havering reported that in 2024, 61% of the service users were cancer patients, and 39% had dementia, frailty, COPD, heart failure, Parkinson's disease and other neurological conditions. Year-on-year, the hospice is helping with a broader range of advanced illnesses that need palliative care.

It is crucial that death does not come unexpected and after an emergency hospital admission. Proactive care planning can reduce emergency admission at end of life and by better identification of earlier palliative care needs. This could be achieved through GP and MDT training on identifying deterioration of those likely to die within 12 months and initiating EoL discussions early. Community pharmacies could be included in EoLC multi-disciplinary teams (MDTs) to improve medication management and symptoms control. The success could be measured by the reduction on the percentage of older people dying within 7-days of emergency hospital admissions.

Service Gaps / Unmet Needs

Residents with liver failure who have complex issues (rough sleeping, substance misuse, mental health condition, lack of family and social support) could die without a planned end of life care.

Recommendations

Local commissioners and providers of palliative and end of life care should:

- Apply NICE guidance NG142 in the context of local and national priorities for funding and in light of their duties to have due regard to the need to eliminate unlawful discrimination and to reduce health inequalities.
- Work towards improving early access to available community palliative care support services to prevent avoidable hospital admissions;
- Increase the use of urgent care plan (UCP) in EoLC, especially within the community setting, to improve multi-agency communication and prevent avoidable hospital admissions;
- Ensure that urgent care plans are well integrated with primary care and hospital records/LAS enabling seamless care transitions and timely access to services;
- Regularly update place of death against preferred place and information is included in urgent care plans;
- Develop mechanisms to regularly review and update patients preferred place of death to match the demand and supply;

- Include community pharmacies in MDT EoLC teams to improve medication management and symptoms control; and to ensure timely access to end-of-life medications by working with community pharmacies;
- Increase capacity and resources for hospice care to meet the demand for hospice care among those under 75 years of age; and to collaborate with the hospices to provide enhanced bereavement support for families and care givers.
- Facilitate care providers to report on the percentage of individuals achieving their preferred place of death and those dying within 7 days of an emergency admission.

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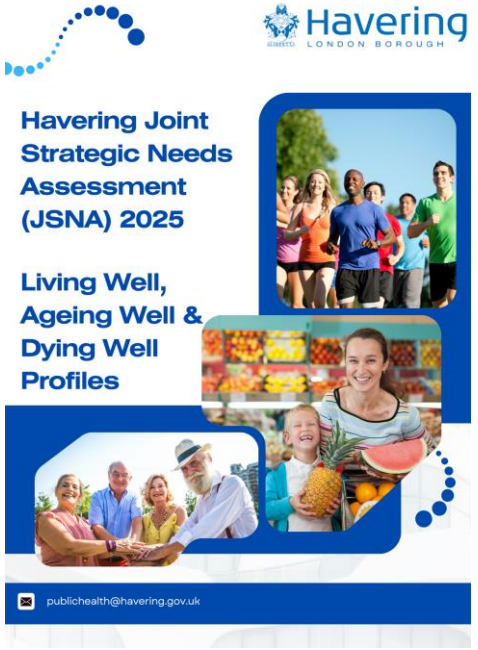
JSNA 2025:
Living Well, Ageing Well, Dying Well

Havering Health & Wellbeing Board

April 2025



Introduction

- This publication of JSNA covers the life courses of living well, ageing well, and dying well. Some areas overlap as no one situation is limited to one part of the life course.
- It includes all 4 pillars of health across the life course
  - Wider determinants of health
  - Places and communities
  - Lifestyle
  - Health and care
- It emphasises
  - The place shaping role of the council
  - The role of prevention in health and wellbeing outcomes
  - Health inequalities

Key findings: population

POPULATION & HEALTH OUTCOMES

According to the ONS 2023 mid-year population estimates, the Havering resident population is currently estimated to be **268,145**, an increase by **3.4**% in the last 5 years.

65+

The Havering over 65 population (**16.7%**) remains higher than the London average (**12.2%**) but slightly lower than the England average (**18.7%**).

In 2024 there were an estimated **34** people aged 65 and over for **every 100** Havering residents of "working age" (20-64 years).

Non-communicable diseases make up approximately **79%** of the burden of disease experienced by Havering residents; the largest contributors of non-communicable disease being neoplasms (**17%** of the burden of DALYs), cardiovascular disease (**12%** of the burden of DALYs) and musculoskeletal disorders (**9%** of the burden of DALYs)

Havering is ranked near to the National average regarding an Active and Engaged Community (**14,510/33,755**), however has a higher score than the National average in the Loneliness Index (**Havering, 1.22; England 0.07**)

Key findings: Living Well

WIDER DETERMINANTS

As of 2023, the **Gross Weekly Pay** for full-time workers in Havering (**£781.90**) was lower than London average (**£796.30**)

As of December 2024, **7,655 people** in Havering (4.7% of the population, compared to 5.9% in London) were **claiming Job Seekers Allowance (JSA) or Universal Credit** for unemployment.

According to 2021 census, **20%** of residents in Havering **aged 16 and over** have **no formal qualifications**, higher than the proportion across London (**18.1%**) and England (**16.2%**), and the 7th highest rate in London.

In Havering, **19.7 per 1,000** households are owed a duty under the **Homelessness Reduction Act**, higher than in both London (**15.8**) and England (**12.4**).

Key findings: Living Well

PLACES AND COMMUNITIES

Domestic abuse in Havering has seen a steady increase over the past 3 years (668 per quarter in 2021 to 746 per quarter in 2022) and now constitutes **14% of reported crime**. This is the only crime type in Havering reported to reach a rate (34.5/1,000) similar to London average (34.5/1,000).

In 2024, Havering earned a combined score of **1.97** out of **10** in the overall **Healthy Street Score Card Assessment**- the **fifth lowest** in London.

In 2022, it was estimated that the equivalent of **6.4% of all-cause deaths** amongst adults aged 30 and over in Havering could have been attributable to exposure to **PM2.5 air pollution**.

In 2021/22, the number of premises licensed to sell **alcohol per square km in Havering** (**5.2**) was higher than England average (**1.3 per square km**), but significantly below the London average (**13.7 per square km**)

Havering's resident **digital exclusion risk index (2.8)** is slightly higher than the London average (**2.7**).

In 2021, Havering had the highest age standardised proportion (ASP) of residents providing **unpaid care** (**8.7%, 20,637 residents**) among all local authorities in London (**London average, 7.8%**).

In Havering, 2% of the population identify with one of the **LGBTQ+** orientations.

3,645 residents in Havering previously served in UK regular **armed forces** and **1,243** in UK reserve armed forces.

Key findings: Living Well

LIFESTYLE & BEHAVIOURS

In 2022/23, based on the latest Sport England Survey data from OHID, **65.8% of adults in Havering (18+)** were classified as **overweight or obese** using self-reported height and weight. This is in line with the **England average (64%)**

Havering had one of the highest proportions of respondents reporting being **physically inactive, at 27.9%**, higher than both London (**22.9%**) and England (**22.3%**) averages

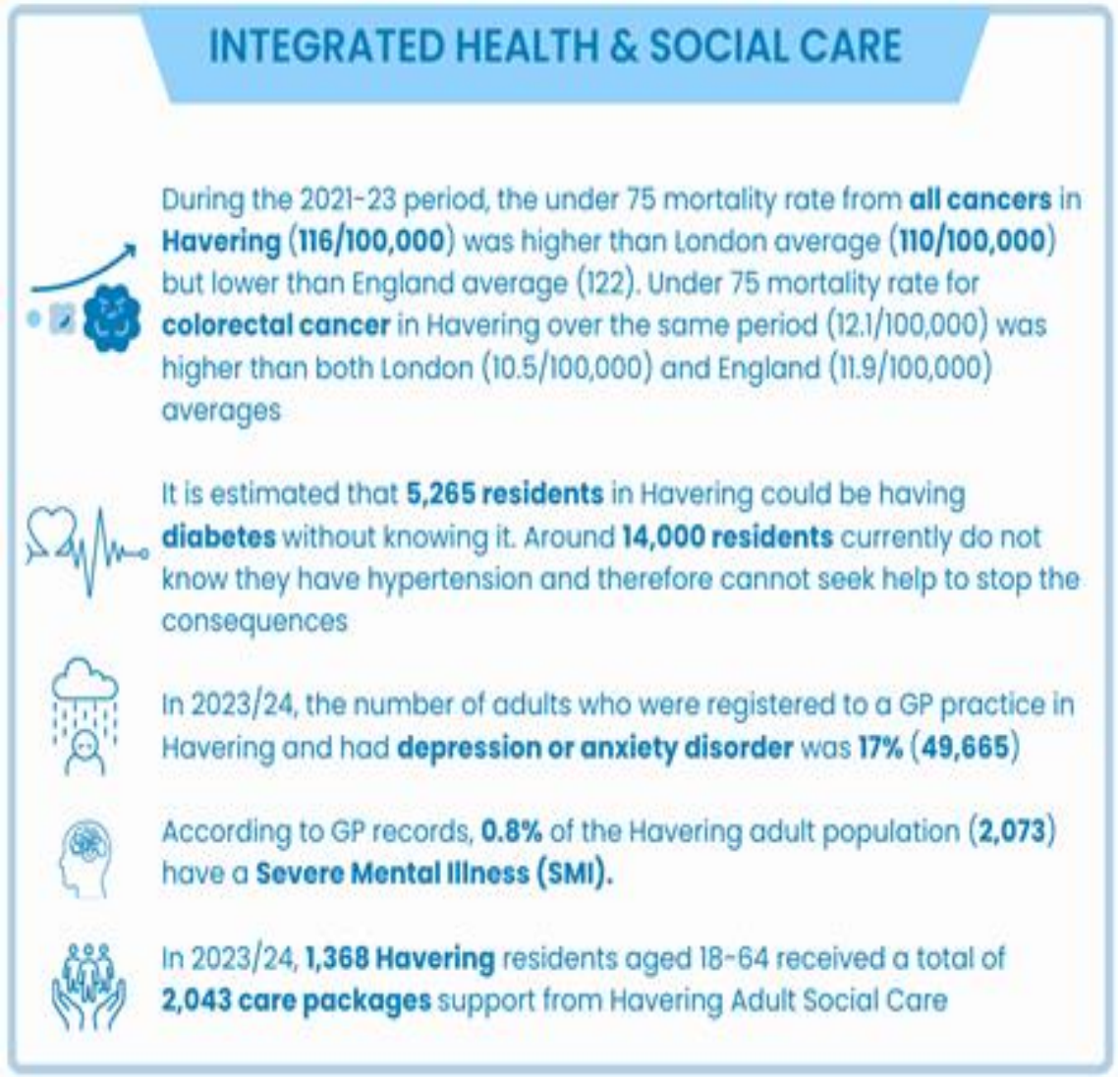
Havering's adult **smoking prevalence** over the latest 3-year period (2021 to 2023) was **12.4%**, similar to London (**11.6%**) and England (**12.4%**) averages.

In 2023/24, the percentage of **pregnant women smoking** at time of delivery in Havering was **3.7%**, similar to London average (**3.9%**), but lower than the England average (**7.4%**)

The latest data (2023) shows that for every 100,000 deaths in Havering, **36 are related to alcohol**. This death rate is similar to the London (**34/100,000**) and England (**41/100,000**) averages

Number of Havering residents in treatment for **substance misuse** has increased from **528 in 2020/2021** to **1,093 in Q2 2024**. This was facilitated by offering additional capacity using a supplementary grant which will end in April 2025

Key findings: Living Well



Key findings: Ageing Well

WIDER DETERMINANTS OF HEALTH

The number of Havering residents aged 65-84 is predicted to increase from 41,550 in 2025 to 45,321 in 2030 (9.1%), age group 85+ from 6,946 in 2025 to 7,168 in 2030 (12%)

Nearly 7,000 older people in Havering are estimated to be living in poverty

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

Key findings: Ageing Well

PLACES & COMMUNITIES

About 12.7% (12,838) of the Havering population aged 66 years and above were living in **one-person households**, occupying almost half (48%) of all one-person households in Havering. This is the highest proportion among London boroughs (**London average 9.1%**) alongside Bexley (12.8%)

7.9% of Havering residents are **unpaid carers** and 51% of them provide unpaid care for 20 hours or more a week

The percentage of adult carers (65+ years) who have **as much social contact as they would like** (22.7%) is lower than both London (27.7%) and England (28.8%) averages

In 2022/23, the prevalence of **osteoporosis** among those aged 50 years and over in Havering (0.9%) was higher than the London average (0.6%)

Key findings: Ageing Well

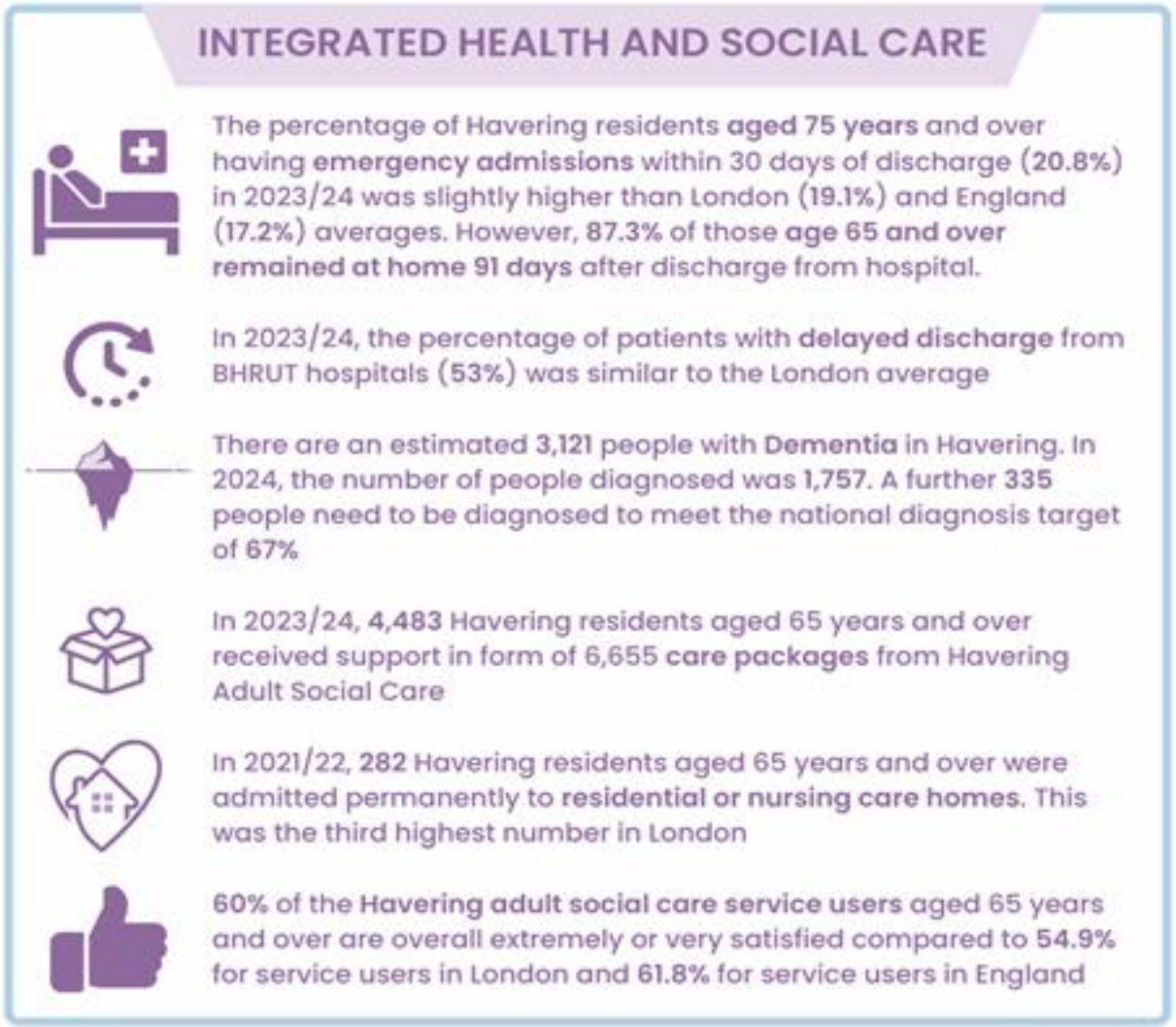
LIFESTYLE & BEHAVIOURS

In 2023/24, all Havering PCNs achieved the **bowel screening coverage** target of **60%**. Nonetheless, latest available data on cancer staging (2019-21, NDRS) found that nearly **70% of rectal cancers** and over **50% of colon cancers** in Havering were diagnosed in later stages

Havering has around **8,061 residents** who are recorded to be **frail.** Havering South PCN (3,758), Liberty PCN (1,587) and Havering North PCN (1,530) have the highest number of patients of age 65+ who have a frailty diagnosis

In 2023/24, the Havering coverage of both **pneumococcal and shingles vaccines** was above the London and England averages. Flu vaccine coverage of those aged 65 and over was **72.7%** (**below England average 77.8%**)

Key findings: Ageing Well



Key findings: Ageing Well

DYING WELL

In 2023, **11.3%** of people of pension age in Havering were **living in poverty** in their last year of life

The percentages of people **dying at hospitals** across all age groups in Havering were significantly lower than London averages. In addition, the percentages of people **dying at home** across all ages were marginally lower than London averages in 2022. Nonetheless, the percentages of the residents **dying at care homes** across all ages in Havering were significantly higher than London average

In 2024, **61%** of the service users at **Saint Francis Hospice** in Havering, were **cancer patients**, and **39%** had **dementia, frailty, COPD, heart failure, Parkinson's disease** and other **neurological conditions**

The **ethnicity** composition of those receiving **palliative care** at Saint Francis hospice (**White 85.7%, Asian 5.1%, Black 3.8% and others 5.5%**) reflects underlying population distribution of Havering residents

Havering's achievement of the **preferred place of death** in 2024 was just above **80%** in care homes and hospice sector.

Recommendations

The Havering JSNA steering group recommends that HWB members support the implementation of the following published strategies that will have a positive impact on Havering's population health:

- Poverty Reduction Strategy
- Serious Violence Strategy
- Healthy Weight Strategy
- Tobacco Harm Reduction Strategy
- Combating Substance Misuse Strategy
- North East London Sexual and Reproductive Health Strategy
- Suicide Prevention Strategy

The following recommendations are also made to the Health and Wellbeing Board by the JSNA steering group (Adults Delivery Board):

- To improve early diagnosis of cancers through further improving screening coverage, raising awareness of cancers with highest numbers of late diagnosis among the residents (lung, colorectal, upper GI, prostate), working with GPs to review opportunities for early detection and appropriate referrals, and strengthening diagnostic capacity including the use of the RDC (rapid diagnostic clinic) and targeted lung health check.
- To strengthen the community infrastructure and awareness to improve the detection of hypertension, obesity, atrial fibrillation and prediabetes and to use transformation and innovation (which includes digital health/medical technologies) to speed up diagnosis and management of LTCs.
- To review and improve where necessary the current approach to the delivery and monitoring of long-term conditions (e.g., diabetes, long-covid) to ensure access to effective care, self-management and peer support.
- To support individuals with mental health conditions to live, fulfilling, meaningful and healthy lives, and ensure equitable access to mental health services, and doing so in a timely manner to prevent deterioration of mental health to crisis presentations
- To support implementation of plans developed by the BHR Planned Care Transformation Board to reduce waiting times for planned care.
- To enable same day access to urgent care in the community whenever possible, and, if a visit to the Emergency Department is needed, to provide a positive experience
- To use Population Health Management (PHM) approach to identify the avoidable risk factors for learning disability and other care packages; and to recommend most effective mental health and physical support interventions, including the use of technology for better and efficient care.
- To empower older people to live independently in their own homes with appropriate care and support and to facilitate social connectivity.
- To support residents by ensuring that the last stages of their life happens in the best possible circumstances, receiving the right help at the right time from the right people, and place.

Thank you!

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Tobacco Harm Reduction Strategy Consultation
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Natalie Naor – Public Health Strategist Natalie.naor@havering.gov.uk

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

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

Havering
LONDON BOROUGH

SUMMARY

The Council has been working in partnership with numerous health and social care professionals, community organisations and Trading Standards, all part of the Tobacco Harm Reduction Partnership Group, to develop a five year strategy to address tobacco, and vape harm amongst young people in Havering.

The Havering Tobacco Harm Reduction Strategy 2024-2029 aims to focus on local challenges and to reduce both tobacco and vape harm in the borough over the next five years in line with the national ambition of creating a smoke-free society by 2030.

The vision is to deliver a smoke-free future for Havering and improve the health and wellbeing of the population by working in partnership with other organisations and services to focus and deliver on the following four priorities of the strategy:

- Prevent the uptake of smoking
- Support smokers to quit using evidence based support, reducing the variation of smoking
- creating smoke-free environments
- Regulation & Enforcement: tackling smoking and vaping amongst young people, clamping down on illegal selling of vapes/tobacco.

Evidence shows clear inequality of impact caused by smoking with rates higher amongst men, disadvantaged groups, routine and manual workers, people with substance addictions and also among those with long term mental health conditions or a Serious Mental Illness (SMI). The high rates of smoking within these groups further compound the negative impacts on their health, social and financial wellbeing.

Reducing smoking within these groups and in the wider population, as well as tackling or reducing vaping amongst young people, will improve the overall health and wellbeing of Havering residents. In addition, given the prevailing high cost of living, quitting smoking will provide additional benefits in terms of savings made to incomes.

Consultation

Public consultation on the Tobacco Harm Reduction Strategy took place from 17th February 2025 to 31st March 2025, primarily via survey questionnaire on Council's platform Citizen Space with hard copies made available in local libraries across the borough and also through our specialist stop smoking service provider.
Young people's views were also gathered through the Youth Council SAFE meeting in March to ensure diverse feedback was received from different ages.

The public consultation received 125 responses altogether from a combination of residents, businesses, charity/community workers, parent and young people and included comments. Responses to the consultation were then analysed. Please see consultation report in the papers attached.

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Overall, the consultation response showed that the priorities and commitments stated in the strategy were well supported from respondents.
A few changes have now been implemented in the Strategy following consultation feedback.
This report now seeks the Health and Wellbeing Board's recommendation for the strategy to go to cabinet for adoption.

RECOMMENDATIONS

Agree the Tobacco Harm Reduction Strategy to proceed to cabinet for adoption.

REPORT DETAIL

The consultation questionnaire covered the priorities of the strategy, the groups to focus on, the commitments made and the recommendations from the Needs Assessment. The survey was mainly tick boxes but also gave opportunity for respondents to extend their answers with free text allowed.

The consultation was promoted at a number of network meetings and circulated to a large variety of health and social care professionals and organisations, as well as community and voluntary organisations, internal departments and stakeholders to share and distribute. It was also presented to the Youth Council.

Accompanying the consultation questionnaire was the draft strategy, an easy read version of the strategy, and the needs assessment.

The consultation responses were analysed and a report created.

Conclusion:

The strategy, priorities, commitments and recommendations are overwhelmingly in line with the local views of residents/respondents. Additional comments received were analysed and themes were identified. However, they did not suggest a significant change to the strategy but rather a need to expand or make some areas more explicit. This included expanding the priority groups to include a focus on children as well as young people, around smoking and vaping with explicit commitments to tackle these areas further.

All changes based on the consultation have now been implemented in the Strategy.

To understand the extent of smoking and vaping among young people, more data and evidence will need to be gathered and analyzed, in particular around vaping amongst young people because this is a growing trend with limited data on long term impacts of vaping. This gives support to the need for a Needs Assessment on vaping amongst young people to enable a deeper dive into some of the feedback already received through this consultation from young people for example why they are reluctant to admit that they vape.

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IMPLICATIONS AND RISKS

Delivery of the strategy, particularly the establishment of and continuation of new services is dependent on continuation of government grant from 2024/25 to 2028/29 financial years.

In 2023, the government announced commitment to 5 year funding to local authorities from 2024/25 to 2028/29 financial years to boost stop smoking activities at local level as part of its drive to achieve a smoke-free England by 2030.

Havering was allocated £307,543 for 2024-25 year, and £315,471 for 2025-2026 year. The Funding from government is dependent on Havering continuing to maintain spend of £36,000 from the public health grant for local stop smoking activities. This is a condition of the grant allocation.

The cost for delivering the strategy will therefore be met from additional government grant over the next five years and from current public health spend on stop smoking.

Changes to government funding commitment will impact on the delivery of the strategy and pose a risk to continuation of local stop smoking services

BACKGROUND PAPERS

- Tobacco Harm Reduction Strategy (updated)
- Public Consultation Report

Natalie Naor, Public Health Specialist

Public Consultation

Consultation Period: 17 February - 31 March 2025.
Consultation availability: Online via Citizen Space, hard copies in Libraries, hard copies supplied by stop smoking service provider
Participation: 125 responses (majority online).

Communications campaign:

- **Presentations to key group:** Tobacco Harm Reduction Partnership, Practice Managers Forum, Social Prescribing and PCN Managers, Live Well Partnership, Youth Council
- **Online/email comms:** NHS, GP Federation, BHRUT newsletter, NELFT, Global, Living, Live Well Newsletter, local press
- **Outreach Events:** Mercury Mall/Liberty, Community Hubs, HOPEC
- **Audiences:** health and social care professionals, community workers, residents, priority groups, lead member/Councillors, young people/education

Demographics

90% Havering residents, 20% parents, 2% young people under 18

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- 47% female, 24% male
- 61% White British
- 26% reported a disability
- 46% had never smoked, 23% current smokers, 22% ex-smokers, 8% vapers

Youth Feedback: Received from Youth Council and SAFE meeting attendees (20 participants altogether, ages 13-18).

Postcode Location	Percentage of respondents
Hornchurch (RM12)	19%
Romford (RM1/RM7)	16%
Emerson Park (RM11)	14%
Rainham (RM13)	14%
Upminster (RM14)	14%
Harold Wood/Harold Hill (RM3)	13%
Gidea Park (RM2)	8%
Collier Row (RM5)	4%

Feedback

Overall support:

79% agreed with the strategy's four main priorities:

- **Supporting smokers to quit** – 86% agreement
- **Preventing smoking/vaping uptake among young people** – 86%
- **Creating smoke-free environments** – 74%
- **Strengthening regulation/enforcement** – 72%

Awareness of harm:

- 96% aware of **smoking** harms
- 62% aware of **vaping** harms

Feedback from Youth Services

- Strong **anti-smoking** sentiment
- Acknowledged **cost of cigarettes** as a deterrent
- Awareness of **harms of** smoking
- Confusion about harm and reluctance to admit **vaping habits**
- Evidence of **peer pressure** and normalization of smoking in apprenticeships/manual jobs due to earning money

Adjustments to Strategy

1. **Changed the name** of the priority group from just ‘Young People’ to ‘Children and Young People’.

2. Included **additional commitments** for tackling smoking and vaping among Children and Young People.

- Work with parents to raise awareness of the harms of smoking and vaping among children and young people.
- Signpost parents that smoke to local stop smoking support services, reducing harm from second hand and third hand smoking in the home.
- Identify and engage with youth groups and professionals working with children and young people in Havering to co-create resources and campaigns relevant to them.

3. Work with the **Licensing** as well as Trading Standards teams to ensure premises are compliant with the licenses that they have been issued.

Next Steps

- Obtain support from Health & Wellbeing Board to take the strategy to Cabinet
- Present strategy at cabinet meeting in June
- Publish strategy
- Create and implement Action Plan 2025-26

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Public Consultation Report

Tobacco Harm Reduction Strategy 2024-2029

April 2024

London Borough of Havering

Natalie Naor, Public Health Strategist

Executive Summary

The public consultation on the Tobacco Harm Reduction Strategy took place between 17 February and 31 March 2025. Primarily available online via Citizen Space. However, hard copy format of the survey questionnaire was made available in libraries in Havering and also via our specialist stop smoking service provider to allow participation from those unable to access the digital format.

A total of 125 responses were received, broken down by 113 online surveys completed, 2 responses at Collier Row Library, and 10 responses received by the specialist stop smoking service provider. 90% of respondents were Havering residents with the remaining from respondents who either worked in Havering or represented a charity/community group. 20% of respondents were also parents and 2% were young people, under 18. The highest number of responses came from people between ages of 55-74.

We also received views on the strategy from young people via a Youth Council meeting that took place on 26th March and consisted of 5 attendees, and also via the SAFE meeting held on 12th March which consisted of 15 attendees between the ages of 13-18 years old.

79% of respondents agreed with the four priorities identified in the strategy, with 'Supporting Smokers to quit' and Preventing uptake of smoking and vaping (amongst young people)' being slightly more supported than 'Creating Smoke-free environments' or 'Strengthening regulation and enforcement'.

Feedback comments on priorities were categorized into the following Key themes:

- Choice to smoke/vape
- Smoke-free environments
- Enforcement/Licensing of cigarettes and vapes
- The need to focus on cannabis and drugs
- Vaping
- Education

The most prominent group recommended as a priority was children and young people, followed by other ethnic groups, and people using drugs including cannabis.

The public consultation showed that the strategy covers all major areas of concerns and key priority groups. However, with the repeated reference of vaping and smoking among children and young people, we have now included children and young people as a priority group and also further expanded the strategy to highlight action in the following areas:

- Work with the Licensing and Trading Standards teams to ensure premises are compliant with the licenses that they have been issued.

Introduction

Smoking is the leading cause of avoidable ill health such as cancer, heart and lung disease and also results in premature deaths.

The Council has been working in partnership with numerous health and social care professionals, community organisations and Trading Standards, all part of the Tobacco Harm Reduction Partnership Group, to develop a strategy to address tobacco and vape harm in Havering.

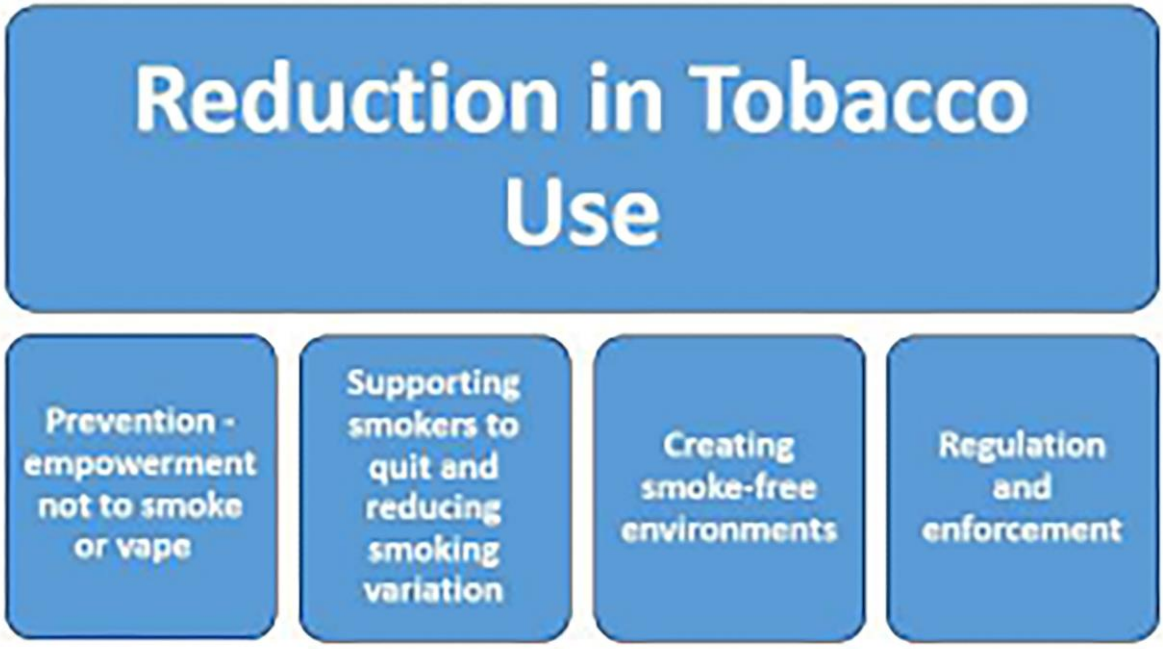
The Havering Tobacco Harm Reduction Strategy 2024-2029 aims to focus on local challenges and to reduce both tobacco and vape harm in the borough over the next five years in line with the national ambition of creating a smoke-free society by 2030.

The vision is to deliver a smoke-free future for Havering and improve the health and wellbeing of the population by working in partnership with other organisations and services to offer evidence based support to smokers to quit as well as making smoking less visible, creating smoke-free environments and tackling smoking and vaping amongst young people, an area of growing concern.

Evidence shows clear inequality of impact caused by smoking with rates higher amongst men, disadvantaged groups, routine and manual workers, people with substance addictions and also among those with long term mental health conditions or a Serious Mental Illness (SMI). The high rates of smoking within these groups further compound the negative impacts on their health, social and financial wellbeing.

Reducing smoking within these groups and in the wider population, as well as tackling or reducing vaping amongst young people, will improve the overall health and wellbeing of Havering residents. In addition, given the prevailing high cost of living, quitting smoking will provide additional benefits in terms of savings made to incomes.

The strategy focuses on four priority areas:



A public consultation was conducted to gather feedback from residents, businesses, people working in Havering and stakeholders before the strategy is finalised. The results and key themes of the consultation are discussed below. The final strategy has been updated to reflect feedback from the survey.

The survey was promoted and communicated widely across the borough through various channels and networks, and included presentations to key groups such as PHSE leads, Practice Managers Network, Learning Disabilities Board, PCN Managers, and the Youth Services including the Youth Council.

Methodology

The consultation was carried out using a survey questionnaire designed by the Tobacco Harm Reduction team with input from Tobacco Harm Reduction Partnership members as well as from other agencies such as Health Watch Havering. See Appendix 2 for survey questions.

This consultation included a public survey through Citizen Space – an online survey platform used by the London Borough of Havering, and hard copies which were available at Libraries across Havering, as well as provided to service users through the Specialist Advisor-led Stop Smoking Service.

The consultation was open from February 17th 2025 to March 31st 2025. The questions consisted of a mix of quantitative questions and space for qualitative follow-ups.

In addition to the survey on Citizen Space, the Havering Youth Services team were provided with the strategy document and asked to discuss the contents with service users including the Youth Council. This ensured feedback on smoking and vaping was received from young people and so their views could be analysed and used to determine any further changes to the strategy.

At the end of the consultation period all responses were analyzed with qualitative responses grouped into key reoccurring themes.

Summary from Public Consultation

Citizen Space Survey

This section of the report details the response to questions, share analysis of questions and highlight relevant themes. 125 survey responses were received with 116 responses completed in full and 9 partially completed, giving a validation rate of 93%.

The first part of the survey focused on the respondent's demographics and background including postcode, whether respondents live or work in the borough, whether they are parents or young people (under 18) and also captures their smoking/vaping status.

84% of respondents answered this question, and of those respondents 97% were residents and from a wide variety of Havering postcodes, indicating that the survey was successful in reaching residents across the whole borough. See figure 1 for breakdown. Of the 84% respondents, 20% were parents. With regards to smoking status, 23% of respondents reported being a smoker, whilst 22% were ex-smokers, and 46% never smoked, making the split between smokers (previous and current) and non-smokers even and therefore potentially more balanced in views. Only 8% of respondents reported vaping.

Figure 1: Respondent location breakdown

Postcode Location	Percentage of respondents
Hornchurch (RM12)	19%
Romford (RM1/RM7)	16%
Emerson Park (RM11)	14%
Rainham (RM13)	14%
Upminster (RM14)	14%
Harold Wood/Harold Hill (RM3)	13%
Gidea Park (RM2)	8%
Collier Row (RM5)	4%

The next section of the survey focused on key areas of the strategy such as awareness of harms of smoking and vaping, the 4 main priorities, commitments to reduce tobacco harm, and vape harm amongst young people, the priority groups with the highest levels of smoking, as well as key recommendations to tackle smoking and also vaping amongst young people. Respondents were given the opportunity to add their comments, opinions and recommendations. These responses were analyzed and results are presented below.

Harms

96% of respondents claimed to be aware of the harms of smoking indicating that it is generally understood that smoking is harmful and so campaigns and awareness raising has been effective. However, only 62% felt that they understood the harms of vaping with the rest of respondents claiming that they are not sure or don't know the harms. This is likely to be a result of the lack of information around harms of vaping, lack of evidence to support definitive harms and lots of mixed messaging about whether vaping is better than smoking causing confusion amongst the public.

Priorities

The table below outlines the responses to the 4 priorities of the strategy and the percentage that agreed with the priority.

Priority	Percentage of respondents that answered	Percentage in agreement of the priority
Supporting Smokers to quit	99%	86%
Preventing uptake of smoking and vaping, particularly amongst young people	98%	86%
Creating Smoke-free environments	99%	74%
Strengthening Regulation and Enforcement	99%	72%

It is clear that respondents were overall very supportive of all 4 priorities of the strategy with a higher number in favor of preventing smoking and vaping and supporting people to quit smoking as priorities . There were 36 comments provided by respondents who didn't agree or were not sure about the priorities and were grouped into two main themes below (5 or more respondents commenting on the same theme)

- Smoking is a choice
- Smoke-free environments already exist, are hard to enforce and do not need expanding

There were some comments about undertaking survey itself by some residents who viewed it as a negative due to time and money spent on developing and implementing the consultation. However, Public consultations for the introduction of a new strategy is a requirement of the Council and follows protocol. A minimum amount of money was spent on the consultation and this was approved through the decision making process.

When asked if respondents felt that there were other priorities that should be included in the strategy, 63% stated 'No' and 39% 'Yes' showing that the majority of respondents felt that the priorities included were sufficient. Of the 39% that answered yes to other priorities 40 comments were received and the most common themes for additional priorities were:

- Smoke-free environments
- Education – harms of smoking and vaping
- Tackling other drugs including Cannabis - substance misuse
- Enforcement/Licensing
- Vaping

However, with the exception of licensing all the above listed areas are covered within the strategy as either a priority area, a priority group, or a commitment made. As a result, we have now included within the Regulation and Enforcement section of the strategy a commitment to work with the licensing team as well as Trading Standards following the consultation feedback.

Commitments

With regards to additional commitments to be made in the strategy to reduce tobacco, and also vape harm amongst young people 95% of respondents answered this question with 83% answering 'No' to inclusion of additional commitments showing that the vast majority of respondents were in agreement with the commitments stated in the strategy. 32 people provided additional comments grouped along the following themes:

- Creating Smoke free environments
- Tackling Cannabis/drug usage
- Better education

However, these areas are already reflected in the strategy and therefore no additional commitments are required.

Priority Groups

The strategy explains that some groups have higher smoking rates, or are more affected by smoking compared to others and showed the groups with highest smoking rates. When the survey respondents were asked whether they felt that there were other priority groups to add in in the strategy, 32 responses received listed the below as priority groups::

- Children and young people
- Other ethnic groups including Eastern Europeans
- Cannabis/drug users

All of these suggested groups are currently within the strategy as identified priority groups, therefore, no additional groups have been included in the strategy. However, we have re-titled the section on 'Smoking and Vaping among Young People' as 'Smoking and Vaping among Children and Young People' to make it clear that children are included within this priority group.

In addition to this we have also included a commitment to work with parents, children and young people of different age groups to raise early awareness of harm arising from smoking and vaping.

Recommendations

The strategy sets out key recommendations to tackle smoking in the borough. 100% of respondents answered this question with 70% agreeing with the recommendations provided showing overall good support.

78% agreed with existing recommendations again showing good support for the strategic recommendations. Additional comments were received from 34 respondents and grouped under the below headings:

- Smoke-free environments
- Education
- Enforcement/underage smoking & vaping

The cost and time spent developing and implementing the survey was highlighted again as a negative theme amongst respondents, recommending that time and money should be spent elsewhere. However, as explained earlier, the public consultation of a strategy is a requirement of the Council and therefore this activity could not be avoided. Minimum costs were associated with the survey creation and communication activities to raise awareness of the consultation and these were agreed through the appropriate decision making process.

The other most common themes identified with regards to recommendations within the strategy are already included in the strategy as either a priority, commitment or recommendation suggesting that the strategy covers the relevant areas for focus and activities and would be supported by residents. No additional recommendations are required.

Further comments on strategy

In this section of the survey, respondents were given a final opportunity to comment on the strategy as a whole. 25% of respondents answered this part with the main themes identified as either 'No further comments' showing further support of the strategy, negative comments towards cost and time of survey as explained previously and again that smoking is a choice. None of the comments in this section require any changes to be made to the strategy.

Feedback from Youth Services

Youth Services were provided with the draft strategy and asked to discuss the contents with the SAFE user group and the consultation was also presented at the Youth Council

to encourage participation and to gather feedback on smoking and vaping from young people. The SAFE group meeting consisted of 15 attendees between ages of 13-18 years old. The feedback received by the SAFE group was as follows:

- All group participants thought it was a good idea to reduce smoking.
- Smoking was not something they consider due to the high cost of cigarettes.
- All participant, of all ages, were aware of the harms of smoking and were 'anti-smoking'.
- Only 1 person said their parents used to smoke but now vape, the rest did not have smoking in the family.
- A young person who is an apprentice and works with approximately 15 other apprentices aged 16-19 claimed the majority of his peers were smokers. He felt this was due to them earning money but this may also be due to peer pressure. There is also evidence of high smoking rates in routine and manual occupations and exposed to a culture of smoking, as the apprenticeship may be for one of these occupations.
- It was felt by the support worker that the young people in the group were reluctant to admit to vaping, reasons for this unknown, but that they understood smoking to be bad for their health but vaping not as bad.

Changes to Strategy/Action Plan

We have amended the Strategy with the following:

- Changed the name of the priority group from just 'Young People' to 'Children and Young People'.

- Included additional commitments for tackling smoking and vaping among Children and Young People. These are as follows:

  - Work with parents to raise awareness of the harms of smoking and vaping among children and young people.
  - Signpost parents that smoke to local stop smoking support services, reducing harm from second hand and third hand smoking in the home.
  - Identify and engage with youth groups and professionals working with children and young people in Havering to co-create resources and campaigns relevant to them.

- Included a commitment under the Enforcement and Regulation priority to work with licensing as well as Trading Standards as follows:

- Work with the Licensing and Trading Standards teams to ensure premises are compliant with the licenses that they have been issued.

Conclusion

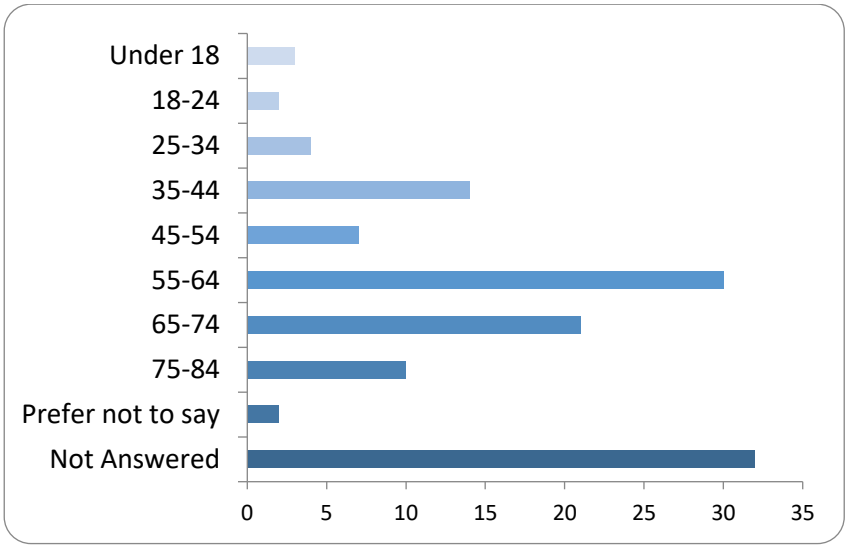
The consultation shows that the strategy, priorities, commitments and recommendations are overwhelmingly in line with the local views of residents/respondents. Additional comments received did not suggest a significant change to the strategy but rather a need to expand or make some areas more explicit. .This includes expanding the priority groups to include a focus on children as well as young people, around smoking and vaping with explicit commitments to tackle these areas further.

To understand the extent of smoking and vaping among young people, more data and evidence will need to be gathered and analyzed, in particular around vaping amongst young people because this is a growing trend with limited data on long term impacts of vaping. This gives support to the need for a Needs Assessment on vaping amongst young people to enable a deeper dive into some of the feedback already received through this consultation from young people for example why they are reluctant to admit that they vape.

Appendices

Appendix 1: Participant background data

Age: 93 responses, predominantly 55-74 year olds



Gender: 92 responses, predominantly female.

Option	Total	Percent
Male	30	24.00%

Female	59	47.20%
Non-binary	1	0.80%
Another description	0	0.00%
Prefer not to say	2	1.60%
Not Answered	33	26.40%

Ethnic Origin:

Predominant ethnic group was White British.

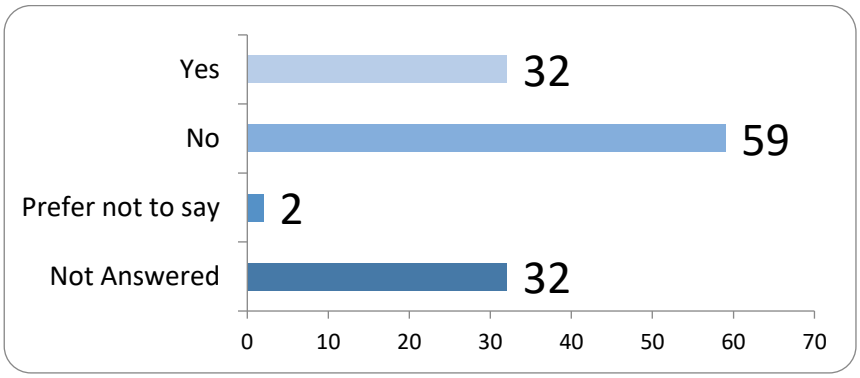
Option	Total	Percent
White - British	76	60.80%
White - Irish	1	0.80%
White - Gypsy or Irish Traveller	0	0.00%
White - European	5	4.00%
Other - White background	1	0.80%
Mixed/multiple groups - White and Black Caribbean	0	0.00%
Mixed/multiple groups - White and Black African	1	0.80%
Mixed/multiple groups - White and Asian	0	0.00%
Mixed/multiple groups - Other mixed background	0	0.00%
Asian/Asian British - Indian	0	0.00%
Asian/Asian British - Pakistani	2	1.60%
Asian/Asian British - Bangladeshi	0	0.00%
Asian/Asian British - Chinese	0	0.00%
Asian/Asian British - Other Asian background	0	0.00%
Black/Black British - African	1	0.80%
Black/Black British - Caribbean	1	0.80%
Black/Black British - Any other Black/African/Caribbean background	0	0.00%

Faith, Religion or Belief:

Option	Total	Percent
Buddhist	0	0.00%
Christian	45	36.00%
Hindu	0	0.00%
Jewish	2	1.60%

Muslim	3	2.40%
No Religion	34	27.20%
Sikh	0	0.00%
Other religion	2	1.60%
Prefer not to say	7	5.60%
Not Answered	32	25.60%

Disability: 93 responses, 32 (26%) of overall survey respondents considered themselves to have a disability showing a good representation of people.



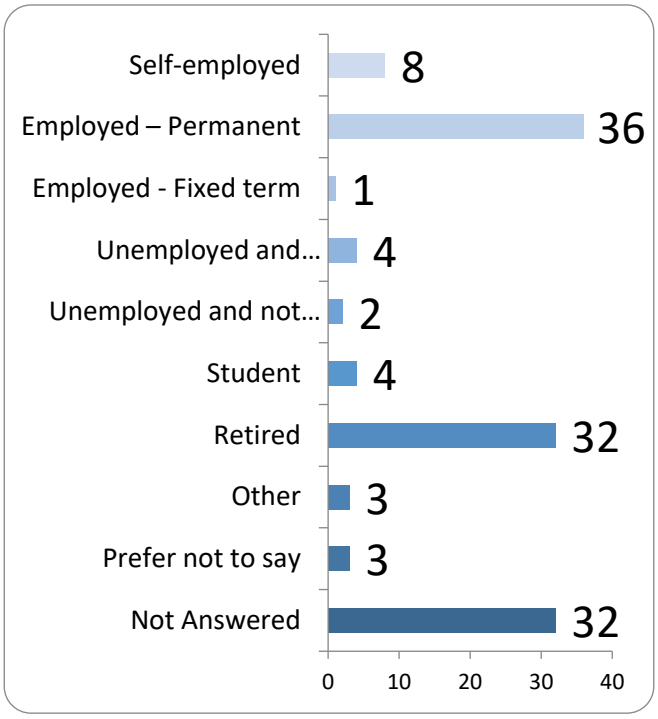
Impairment

26% responded to this question. Highest impairment of those responded was Long Term Illness (10%).

Option	Total	Percent
Sensory - e.g. mild deafness; partially sighted; blindness	7	5.60%
Physical - e.g. wheelchair user	7	5.60%
Mental Illness - e.g. bi-polar disorder; schizophrenia; depression	7	5.60%
Development or Educational - e.g. autistic spectrum disorders (ASD); dyslexia and dyspraxia, neurodiversity	3	2.40%
Learning Disability / Condition - e.g. Down's syndrome; Cerebral palsy	0	0.00%
Long-term Illness / Health Condition - e.g. cancer, HIV, diabetes, chronic heart disease, stroke	13	10.40%
Other	5	4.00%
Not Answered	92	73.60%

Employment status

There were 93 responses to this part of the question. The majority of respondents were either employed, retired or did not wish to comment.



Appendix 2: Consultation Survey Questions

1. **Please tell us the first part of your postcode or location of where you live or work in the borough?**

2. **Please state your ethnicity:**

3. **Please tell us in what capacity you are completing this consultation. You may choose more than one answer that applies.**

- I am a resident
- I work in Havering but not resident
- I am a Councillor
- I represent / own a local business
- I work in a public sector organisation (e.g. NHS, Local Council, Education)
- I work for or represent a community group or a charity
- I am a young person (under 18)
- I am a parent

4. Please choose which of the following applies to you. Please tick all that apply:

- I am a smoker
- I vape

- I vape and smoke
- I am an ex smoker
- I care or live with someone that smokes/vapes
- I have family/friends/colleagues that smoke/vape
- Never smoked
- Other (please specify)

5. Are you aware of the harms associated with:

a. Smoking
b. Vaping

Yes/No/Not Sure

6. Do you agree with the 4 priorities within the Havering Tobacco Harm Reduction Strategy?

- Supporting smokers to quit
- Preventing uptake of smoking and vaping – particularly amongst young people
- Creating smoke free environments
- Strengthening Regulation and enforcement

Yes/No/Not Sure

If no/not sure, please briefly tell us why (30 words)

7. Is there another priority that you feel should be included?

Yes/No

If yes, please state briefly (30 words)

8. Under each priority area, the strategy sets out broad commitments to reduce tobacco and vape harm. Are there any additional commitments that you feel should be included?

Yes/no

If yes, please state briefly (30 words)

9. **In the strategy, we explain that some groups have higher smoking rates, or are more affected by smoking compared to others.**

   Are there any other groups that you think we have missed that are affected by smoking and should be included as a priority?

   Yes/No

   If yes, please state briefly (30 words):

10. **The strategy sets out recommendations to tackle smoking and vaping among young people. Do you have any additional recommendations?**

    Yes/No

    If yes, please state briefly (30 words):

11. **If you have any further comments about the strategy, please state briefly below:**

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London Borough of Havering

Havering Tobacco Harm Reduction Strategy 2024-2029

Name	
Version number	
Status	
Author	
Lead Officer	
Approved by	
Scheduled review date	

Version history

Version	Change	Date	Dissemination
V.1	Structure aims and vision		Internal
V.2	Updated with separate section on young people	13.9.24	Internal and external to THR Partnership

V.3	Added Foreword, updated data and governance structure	30.1.25	External – public consultation
V.4	Additional commitments and other amendments implemented into strategy following from the consultation feedback.	25.04.25	Internal

Contents

Foreword

Smoking is often a long-term habit developed at a young age and may take several attempts to stop but giving up smoking, which harms nearly every organ of the body and a major cause of ill health and premature deaths, is the right step to take.

We are therefore committed to supporting residents who smoke, particularly those most affected with higher smoking rates such as males, those experiencing mental health conditions and those living in rented accommodation to quit. We are also keen to address the rising concern of youth vaping among parents, schools and residents.

We are pleased to present the Tobacco Harm Reduction Strategy which is focused on local challenges and tackling both smoking and youth vaping over the coming five years. The strategy adopts a whole system approach to work collaboratively with a wide range of partners with clear priority around four areas of:

- Supporting smokers to quit
- Prevention - empowering people including the young not to smoke and vaping
- Creating smoke free environments
- Strengthening Regulation and enforcement

With the anticipation of the new Tobacco and Vapes Bill being passed by Parliament we are committed to drive forward our plans to reduce both smoking and youth vaping and this strategy aligns with government's ambition of achieving a smoke-free nation by 2030.

We believe and share the vision that we can do more to make Havering a healthier place and support our residents to live healthier and longer lives.

We thank everyone who contributed or fed comments to inform the strategy and with our action plan already in place and refreshed annually, we are confident that we are travelling in the right direction to reduce smoking and vape harm thereby enabling our residents and those who work in Havering, to lead more healthy lives.

1. Introduction

Cigarette Smoking is a behaviour often formed at young age, engineered to be addictive, driven by the tobacco industry through advertising, ease of access[1] and normalised by society.

The addictive nicotine substance in tobacco makes it difficult to quit resulting in majority of people continuing to smoke for many years despite wanting to quit.

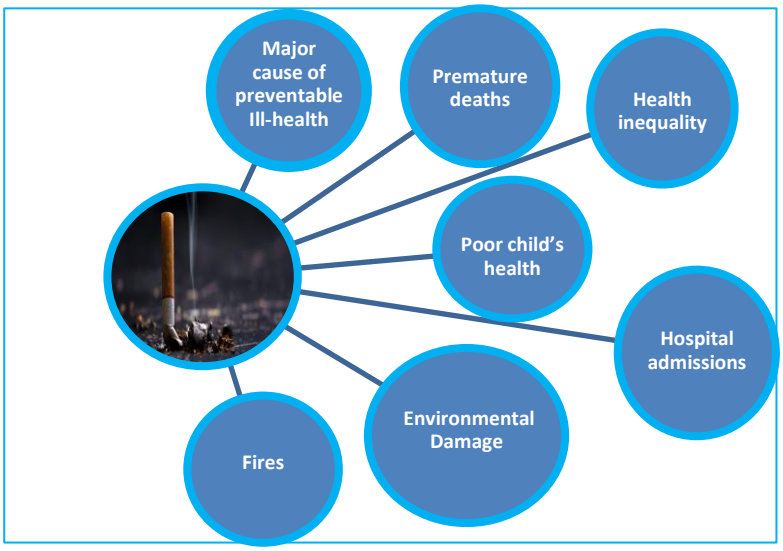


Figure 1: Harms of smoking

Smoking harms nearly every organ of the body and causes serious harm to the health of both smokers and non-smokers. Many preventable illness such as cancer, heart and lung diseases which result in premature deaths are primarily caused by smoking. 72% of lung cancer cases in the UK are caused by smoking[2]. Smoking in pregnancy increases the risk of miscarriage, premature birth, stillbirth and low birth-weight as well as linked to increased risk of sudden infant death after birth. Smoking is a major risk factor for impotence in men[3] and in women it is associated with an increased risk of early natural menopause in women[4].

There are wider impacts of smoking to the individual and the society including through working days lost due to sickness absence, costs for treatment of illnesses caused by smoking as well as costs of damage and injury by cigarettes fires.

Smoking is major driver of persistent health inequalities - the harm caused is not evenly distributed. People in more disadvantaged areas are more likely to smoke and less likely to quit. About 1 in 4 people in routine and manual occupations smoke compared with 1 in 10

[1] https://news.cancerresearchuk.org/2022/04/01/health-inequalities-why-do-people-smoke-if-they-know-its-bad-for-them/
[2] Lung cancer risk | Cancer Research UK
[3] Ms Allen, Ee Walter. Health-Related Lifestyle Factors and Sexual Dysfunction: A Meta-Analysis of Population-Based Research. Vol. 15, The journal of sexual medicine. J Sex Med; 2018
[4] Whitcomb BW, Purdue-Smithe AC, Szegda KL, Boutot ME, Hankinson SE, Manson JE, et al. Cigarette Smoking and Risk of Early Natural Menopause. American Journal of Epidemiology. 2018 Apr 1;187(4):696–704.

people in managerial and professional occupations. Those experiencing mental health conditions and those with substance misuse also have higher levels of smoking. Pregnant women from more disadvantaged areas and those younger tend to smoke more compared to pregnant women in older and more affluent groups. The association between smoking and deprivation underscores the critical role of socioeconomic status in shaping smoking behaviours.

Children's exposure and access to tobacco is strongly determined by both their environment and social circumstances with parental environment being very powerful determinant[5]. Risk factors associated with Childhood smoking initiation include parental and sibling smoking, the ease of obtaining cigarettes, smoking by friends and peers, socio-economic status, maternal education, adverse childhood experiences, exposure to tobacco marketing, and the media. Children living with smoking parents or siblings are up to 3 times more likely to become smokers themselves than children of non-smoking households[6].

Havering smoking prevalence has varied in recent years. However, data from a three year range (2021 to 2023) shows adult smoking prevalence as 12.4%, similar to 11.6% London and 12.4% England.

Challenges faced in tackling smoking are wide ranging and include deprivation, reduction in stop smoking services due to cost saving measures, insufficient joined up approach across key organisations, lack of engagement of communities with higher level of smoking as well as Trading Standards reduced capacity.

Whilst vaping is less harmful than smoking cigarette and can help smokers to quit, there is emerging concern around the long-term impacts of vaping among young people due to the increasing trend in youth vaping driven by concerted marketing, proliferation of outlets selling illicit and disposable vapes and social media.

This Havering 2024-2029 Tobacco Harm Reduction Strategy aims to focus on local challenges and to reduce both tobacco and vape harm over the next five years through joined up and sustained action with a multi-faceted approach focused on the needs of the different groups.

[5] https://news.cancerresearchuk.org/2022/04/01/health-inequalities-why-do-people-smoke-if-they-know-its-bad-for-them/
[6] https://ash.org.uk/uploads/Youth-Smoking-Fact-Sheet-2024.pdf?v=1710950114

2. Vision

To deliver a smoke free future for Havering and improve health and wellbeing of the local population.

3. Aim

To work in partnership with other organisations and services to offer evidence based support to smokers to quit, make smoking less visible, create smoke free environments and tackle vaping among young people.

4. Policy and Strategic Context

This strategy does not sit in isolation and is aligned to and supported by a range of national, regional and local strategies and initiatives including those listed below.

National Strategies	Regional Strategies	Local Strategies
• Stopping the Start: our new plan to create a smokefree generation (2023) • Towards a smoke-free generation: A tobacco • control plan for England (2017) • Smoking (2017) • PHE Strategy 2020-25 • NHS Long Term Plan	• Interim North East London Integrated Care Strategy (2023)	• Havering Health and Well-being strategy • Havering Corporate plan

5. National Picture

In the UK, smoking remains the primary contributor to preventable health issues, resulting in approximately 74,000 deaths annually[7]. The association between smoking tobacco and healthcare burden is clear, with over 500,000 hospital admissions each year and with smokers facing a 36% higher likelihood of hospitalisation compared to non-smokers[8]. In

[7] Public Health England, 2019: Smoking and tobacco: Applying all our health.
[8] Royal College of Physicians, 2018: Hiding in plain sight: Treating tobacco dependency in the NHS

terms of deaths attributable to smoking, 35% of all deaths for respiratory diseases, 25% of all deaths for cancers were estimated to be due to smoking.

The government Tobacco Control Plan, TCP (2017-2022) outlined four principal areas of action to reduce tobacco harm – focusing on supporting smokers to quit, achieving smoke free pregnancy, improving access to support services and providing equal support to those with mental health conditions. A 2023 Command paper, *Stopping the Start: our new plan to create a smokefree generation*, set out a measures to drive forward the smoke free ambition with *no more than 5% of the population smoking by 2030* and a commitment to tackle youth vaping. Measures to achieve the ambition include:

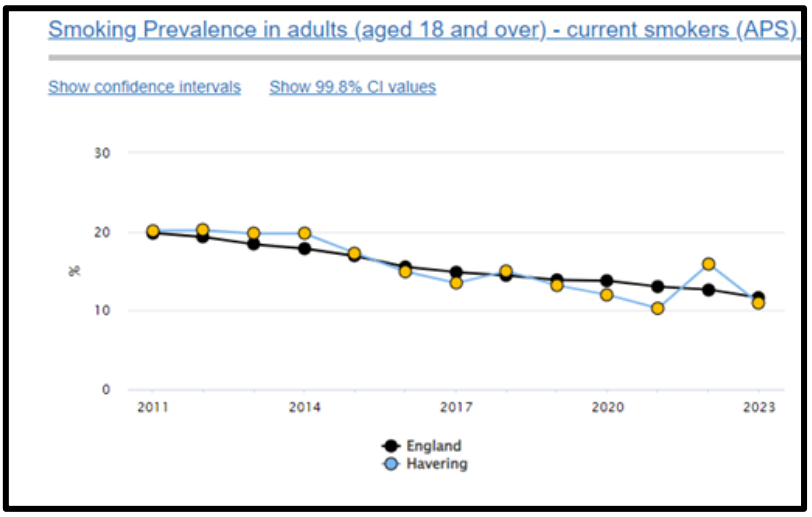
- New Legislation to gradually increase age of sale of tobacco by one year annually from 2027 onwards, to ensure children born on or after January 1st, 2009, cannot purchase tobacco products
- Strengthening support for people to quit smoking.
- Swap to stop vape programme as well as Incentives to pregnant women to stop smoking
- Legislation on youth vaping

6. Smoking in Havering

Havering has seen a fluctuation in adult smoking prevalence in recent years rising from 10.3% in 2021 to 15.9% 2022. However, 2023 data shows a smoking prevalence of 10.9% and a three year range (2021 to 2023) indicates 12.4% (25,560)[9] of adults smoking prevalence, similar to 11.6% London and 12.4% England.

Figure 2: Smoking Prevalence in Adults (18+)

[9] Estimated number of smokers (2023 populations)



Source: Office for Health Improvement and Disparities (OHID) Smoking Profile - Data - OHID (phe.org.uk)

6.1 Who are smoking across Havering

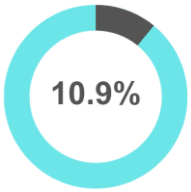
Smoking in Havering varies by ethnicity, gender and across different age and socioeconomic groups with close links to deprivation[10]. Certain demographics groups are more disproportionately affected by smoking with higher rates among the main white population, males, those with substance misuse, severe mental health conditions. There are also higher levels of smoking amongst those living in rented accommodation. Among routine and manual workers smoking rates has dropped from 28.1% in 2022, to 14.4% in 2023[11]. In terms of age, smoking prevalence is highest amongst working age group 31-35 (18.99%) and lowest among adolescents aged 12-15 (0.10%).

Amongst pregnant women the percentage smoking at the time of delivery in Havering has shown a falling trend over the past decade, from 13.1% in 2012/13 to 3.7% in 2023/24. Amongst this group local data from the pregnancy stop smoking service shows that socio economically, smoking is more predominant among pregnant women from more deprived areas of Havering such as Rainham (25%), Harold Hill (22%) with 50% in routine and manual occupations and 33% having never worked or are long-term unemployed[12].

Figure 3: Smoking prevalence by demographics in Havering

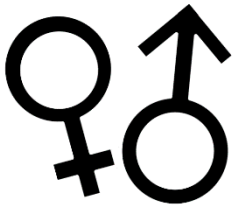
[10] Havering tobacco harm reduction needs assessment
[11] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132900/pat/6/par/E12000007/ati/402/are/E09000016/yrr/1/cid/4/tbm/1/page-options/car-do-0 Smoking Profile - Data | Fingertips | Department of Health and Social Care (phe.org.uk)
[12] Havering Tobacco Harm Reduction Needs Assessment,2024

Smokers



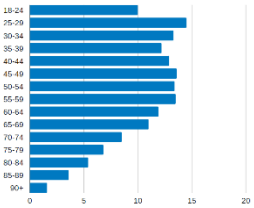
10.9% of Havering 18+ population smoke. Over 1 in 10 adults

Smoking by Gender



13.4% males and 9.9% of female smoke. Males are 35% more likely to smoke than females

Smoking by age group



14.5% of 25-29 year olds nationally smoke, the highest age group for smoking Additionally, 30-34 year olds and 40-59 year olds also have smoking rates significantly above the national average.

Mental Health

29.2% of adults with long term mental health conditions smoke in Havering, compared to 26.3% in London and 25.1% nationally. **29.4%** of those with serious mental illness SMI smoke

Socio Economic Group

14.4% of routine and manual workers (aged 18-64yrs) in Havering smoke compared to 15.2% in London and 19.5% nationally.

Social Housing

26% of social housing tenants smoke against11.5% of those who own their property smoke.

Learning Disability

7.9% of those with a learning disability In Havering, smoke.

Smoking in pregnancy

3.7% of pregnant women smoked at the time of delivery in 2022/23.

Alcohol Users

60% of Havering adults admitted to treatment for alcohol and non-opiate misuse smoke.

Opiate Users

69.7% of Havering adults admitted to treatment for all opiate misuse smoke

Children Smoking

480 children start smoking in Havering very year

Second-Hand Smoke

10,200 children live in smoking households and exposed to second hand smoke

Youth Vaping

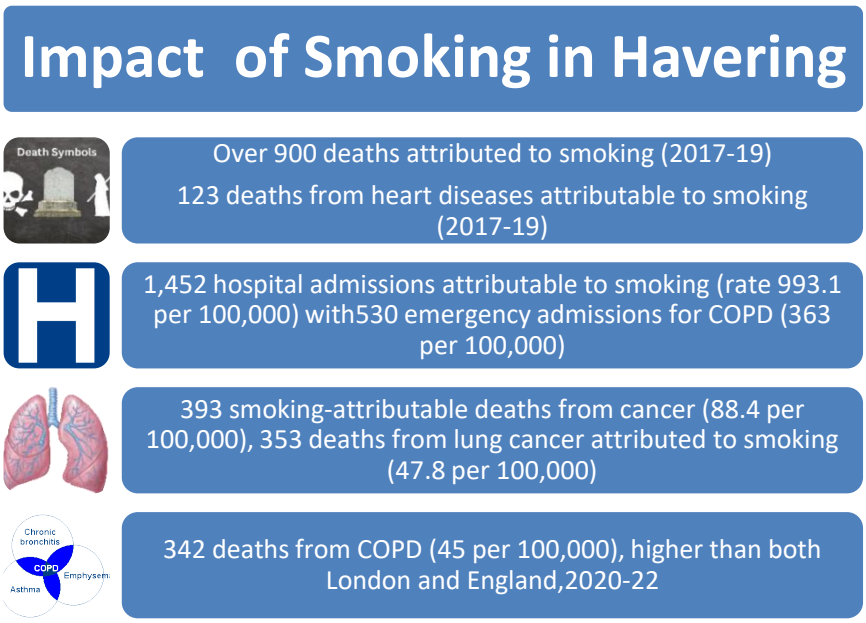
18% of 11–17-year-olds have tried vaping nationally

£69,000 worth of counterfeit tobacco and vapes including 2,500 vapes, 58, 000 cigarettes and 223 packet of hand rolling tobacco seized by trading standards in 2023, [13]

7. Impact of Smoking in Havering

[13] Havering Trading Standards, 2024

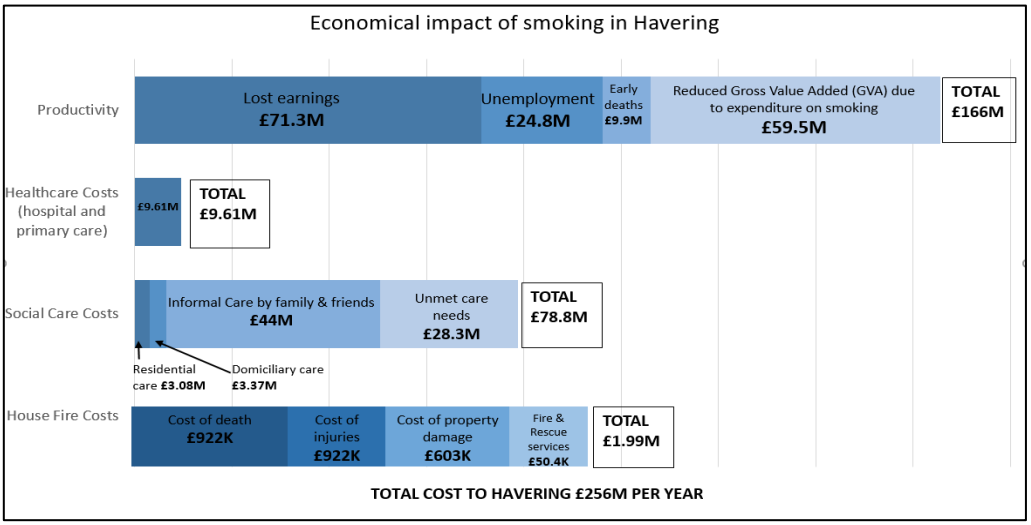
Figure 4: Impact in Havering [14]



Economically, smoking leads to costs for individual and Havering and it is estimated that:

- 32,500 residents that smoke collectively spend £78.5M annually on tobacco, equating to around £2,400 per smoker per year.
- smoking costs Havering £256 million per year (see Figure 1) whilst revenue from cigarettes and hand rolled tobacco taxation (excluding VAT) only brings in about £40.6 Per year[15].

Figure 5: Breakdown of costs to society of smoking in Havering [16]



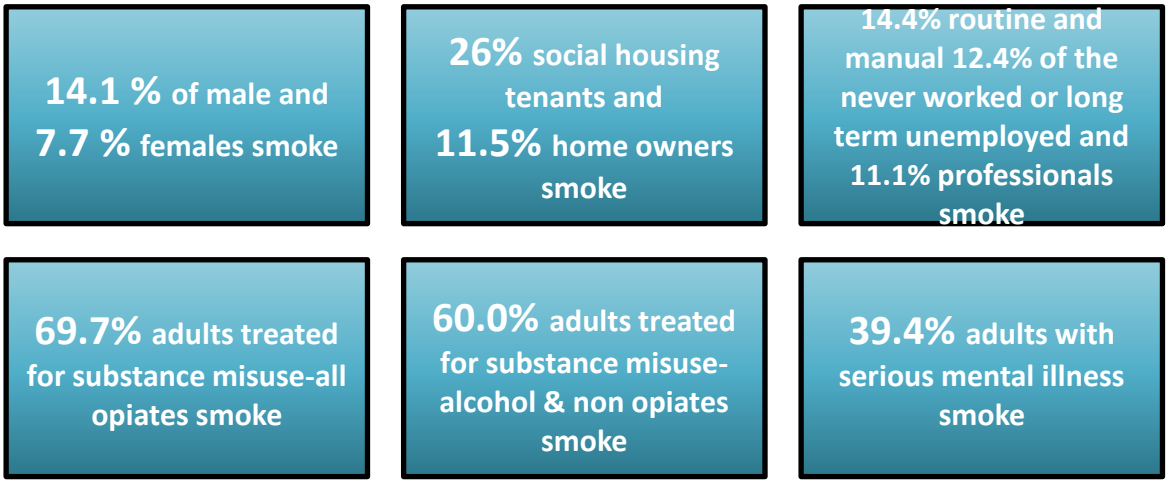
[14] https://fingertips.phe.org.uk
[15] https://ashresources.shinyapps.io/ready_reckoner
[16] ASH Economic & Health Inequalities Dashboard

Environmental impact associated with smoking is evident in every stage of the tobacco supply chain –includes deforestation for cultivation, energy-intensive curing processes, manufacturing and packaging and cigarette butt litter (the most common type of litter worldwide). According to Keep Britain Tidy research, smoking related litter is the most prevalent form of litter in England, 68% of all littered items.

8. Inequalities

Smoking is major driver of persistent health inequalities nationally and within Havering. Levels of smoking are higher among males compared to females and differ by socio economic status, occupation and age. Higher levels of smoking levels exist among those living in rented accommodation compared to those who own their homes. Variation exists among those experiencing mental illness and across all substance misuse groups, the level of smoking is higher (53%) than the general adult population in England.

Figure 6: Inequalities in Havering [17]



Smoking is strongly associated with deprivation with residents living in social housing largely located in the most deprived areas of the borough such as Romford, Rainham, Collier Row exhibiting higher smoking prevalence compared to those in more affluent areas.

[17] https://fingertips.phe.org.uk

9. Smoking and Vaping among Children and Young People

The prevalence of smoking in Havering varies across age groups and highest among those aged 30-35 at 18.99% and lowest among adolescents aged 12-15 at 0.10%[18].
This shows that smoking is predominant among those of working age groups in Havering.

Vapes (E-cigarettes) are effective tools for smoking cessation however, it is not recommended for young people. There are concerns around growing trend of vaping among children and young people. A national Youth Survey in 2024 found 18% of 11–17-year-olds tried vaping, with 72% of 11–17-year-olds reported exposure to some form of vape promotion, mainly from shops (55%) and online (29%)[19]. In Havering a Youth Wellbeing Census (2023) revealed 12% of Havering pupils have experimented with vaping. Youth exposed to vaping are at risk of developing chronic respiratory issues like coughing, bronchitis and exacerbation of asthma, along with potential long-term cardiovascular consequences. Furthermore, vaping at young age can lead to nicotine dependence, which can adversely affect brain development.

Havering faces multiple challenges in reducing both tobacco and vapes use among young people due to widespread promotion through social media, local shops, and advertisements deliberately designed to appeal to children with sweet flavours and colourful packaging. Additionally, there is limited capacity locally to tackle illicit and underage sale through robust enforcement measures. The recent ban on disposable vape due to come in June 2025 and proposed new legislation on smoking and vapes are aimed at driving down access and availability of vapes to young people and will strengthen local efforts.

No single organisation or service can tackle the challenges of reducing smoking and vaping in the borough. The Tobacco Harm Reduction Strategy places emphasis on a joined up approach across different organisations and the adoption of multi-faceted actions to reduce smoking and youth vaping to ensure local residents, including children and young people, have the best chance of healthy lives.

[18] ICB GP Data, September 2023
[19] https://ash.org.uk/resources/view/use-of-e-cigarettes-among-young-people-in-great-britain

10. Recommendations from Tobacco Harm Reduction Needs Assessment

The 2023 needs assessment highlighted the key issues and challenges faced by Havering and outlined a set of recommendations to help drive forward the ambition for a smoke-free borough. Additional recommendations were also made for specific groups particularly those with high level of smoking. The main recommendations include:

- Expand service provision and ensure availability of the full range of cessation aids.
- Prioritise tailored support for groups with high smoking levels and in deprived areas.
- Improve data collection including ward-level data and for Eastern Europeans and Gypsy, Roma and Traveller communities to facilitate more targeted interventions.
- Provide training for front line health and social care staff to improve knowledge, skills.
- Ensure services are culturally and linguistically sensitive and accessible to those with learning disabilities and the homeless.
- Raise awareness of tobacco harm and local stop smoking services through campaigns.
- Provide tailored information resources and support to families on dangers of second-hand smoke, especially in households with pregnant women and children.
- Collaborate with community organisations to better reach underrepresented groups.
- Strengthen Trading standard capacity to address illegal vapes and cigarettes.
- Work with educational establishments and young people to raise awareness of harm from tobacco and Vapes.
- Conduct a needs assessment on vaping and young people in Havering.

The key recommendations for specific groups are captured in the below tables:

Recommendations-Pregnant women	Recommendations-Children and Young People
• Provide carbon monoxide (CO) monitors to Health Visitors to assess smoking status of women at 28 week pregnancy and new birth visits • Use Making Every Contact Count (MECC) to offer Very Brief Advice (VBA) on smoking. • Raise awareness of risks of second and third hand smoke	• Develop materials with young people to educate and empower them not to start smoking and to de normalize smoking • Encourage Smoke free Champions working with schools signed up to Healthy schools • Work with young people to develop campaigns relevant to them, to dispel myths and discourage smoking and vaping • Undertake needs assessment on vaping

• Seek ways to engage pregnant women outside of healthcare setting • Review and strengthen monitoring of pregnancy service • Ensure more robust and regular data collation to address inequality	• Improve data on demographics of children and young people smoking and vaping • Encourage more retailers to implement Challenge 25 (Age ID verification) • Conduct outreach programmes in schools and community centres to support child smoking cessation and vaping

Recommendation - Serious Mental Illness	**Recommendations -Substance Misuse**
• Develop specialist stop smoking service for people with SMI • Increase targeted support in local services frequented by those with SMI • Expand access to alternative nicotine products for those at risk to poor mental health • Provide training on VBA+ and speciality mental health module to frontline staff, charities and mental health providers • Raise awareness of impact of smoking on mental health through engagement	• Develop a specialist stop smoking service tailored for people with drug/alcohol dependency and smoking • offer in-reach cessation support through providers • Strengthen referral pathways from treatment into smoking cessation service • Offer pharmacotherapy/vapes within treatment centres • Train substance misuse providers and addiction charities to offer VBA

Recommendations – Learning disabilities	**Recommendations - Homeless, social housing and private renters smokers**
• Increase awareness about smoking exposure risks • Provide VBA training and information for LD staff • Distribute accessible educational materials on smoking for LD individuals	• Facilitate a joint approach between Public Health and homeless services • Offer VBA Training to those working with the homeless and to social housing providers • Work with housing to develop policies to reduce smoking in social housing • Embed social housing-based tobacco control programmes within other strategies such as the Housing strategy and Poverty Reduction Strategy • Collaborate with landlords and property management companies to promote smoke-free living and provide resources for private tenants interested in quitting

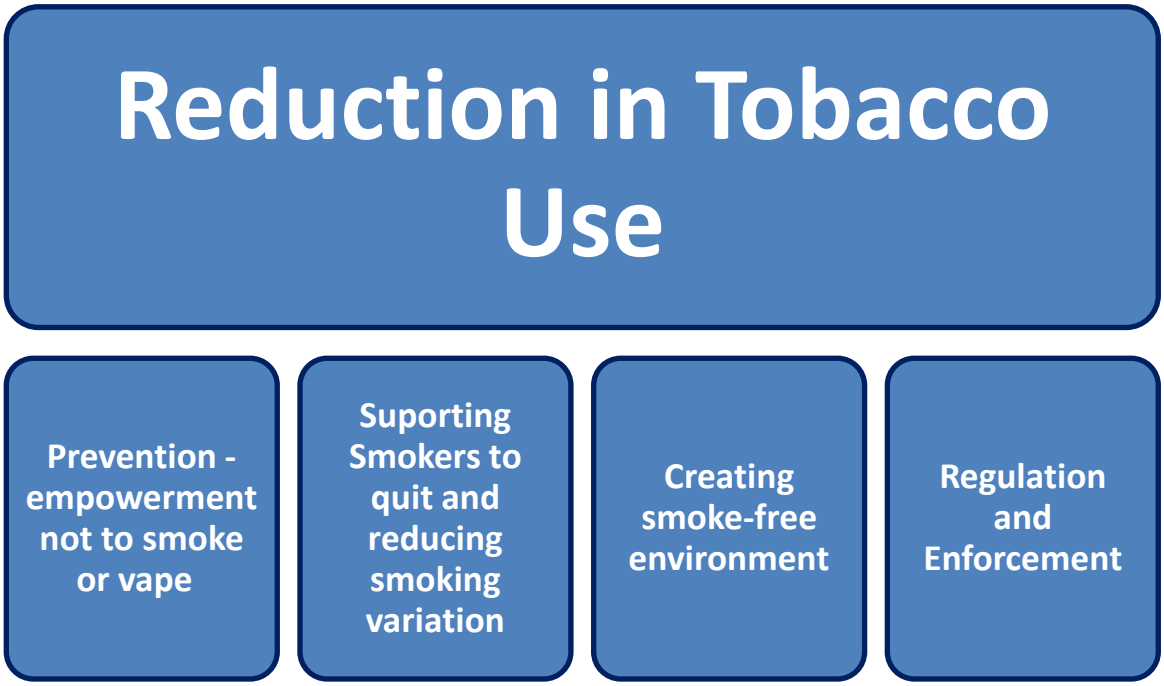
11. The Priorities for 2024-2029

This Havering strategy will focus on following four strategic priority areas:

- Supporting smokers to quit with focus on eliminating variation in smoking rates
- Prevention - empowering people including the young not to smoke and vaping
- Creating smoke free environments
- Strengthening Regulation and enforcement

Below diagram illustrates how these areas fit together to support the delivery of the strategy. Reducing tobacco use requires strong partnership and a whole system approach across different organisations to succeed.

Figure 7: Priorities



11. 1. Prevention

Prevention aims to empower people including young people not to take up smoking as evidence indicates that most people start smoking during teenage years. This requires bold and ongoing initiatives such as raising awareness of the harm caused by smoking and potentially by vaping. It require reduction in promotion of cigarette and to de-normalise smoking with ongoing measures to reduce the availability, attractiveness and affordability of tobacco products together with enforcing legislation. Clear messaging on vapes, as well as information on risks posed by illicit tobacco and vape is needed. Engagement of young people in developing relevant messages is crucial. Our priority actions on prevention, informed by needs assessment recommendation, are below:

We will

- Improve data on smoking at ward level and for key groups
- Improve partnership with organisations including NHS and key services to ensure key strategies include reducing tobacco harm
- Provide training on Very Brief Advise for health and social care professionals
- Conduct annual campaigns in line with national campaigns, encouraging greater awareness of tobacco harm and to promote local Stop Smoking Services
- Provide tailored information resources and support on second-hand smoke
- Engage with community organisations to better reach and support underrepresented groups
- Commission research to gain insight into groups with high smoking levels for better understanding of why they smoke and to develop targeted interventions

To prevent smoking and vaping among children and young people we will:

- Work with schools signed up to Healthy schools to develop Smoke free Champions
- Work with educational establishments including schools and colleges to highlight the impact of smoking and vaping
- Undertake needs assessment on vaping among children and young people
- Work with parents to raise awareness of the harms of smoking and vaping among children and young people
- Signpost parents that smoke to local stop smoking support services, reducing harm from second hand and third hand smoking in the home

- Identify and engage with youth groups and professionals working with children and young people in Havering to co-create resources and campaigns relevant to them

11.2 Supporting smokers to quit and reducing variation in smoking rates

Whilst latest data indicate a drop in prevalence of those smoking in Havering the wide variation in smoking prevalence amongst different groups continue to pose a challenge. There is close link of groups with higher smoking levels in more deprived areas of Havering. National guidance (NICE) for commissioning stop smoking services recommends that at least 5% of smokers should have an initial consultation (treating at least 5% of the estimated local population who smoke each year)[20]. 5% of Havering smokers in 2023 would be 1,127 (estimated population of smokers 22,546 in 2023).

Since 2023 local stop smoking provision, has been expanded resulting in the following:

- Six community pharmacies supporting smokers to quit in more deprived parts of the borough to reduce inequality of access to support to stop smoking
- An Adviser led stop smoking service providing tailored support to the groups with high level of smoking such as routine and manual workers, and social housing. This service has incorporated a specialist service to pregnant women and following birth, to help them quit and to stay smokefree
- A dedicated service for people with serious mental illness (SMI) established
- Very brief advice training provided to frontline health and social care staff
- Regular campaigns to raise awareness of local services and harm of smoking

The momentum needs to be continued with stronger engagement with key stakeholders' and services including mental health, substance misuse, respiratory and cardiovascular services as well as housing services, and those working with men.

We will:Continue work to reduce health inequality in smoking by strengthening and expanding provision in more deprived locationsContinue to prioritise support to high-smoking prevalence groups to reduce health inequalities

[20] https://www.nice.org.uk/guidance/ng209/chapter/Recommendations-on-policy-commissioning-and-training

• Ensure services offer full range of tobacco harm reduction aids to maximise opportunity for more quits • Strengthen the referral system to the local stop smoking services • Promote services and encourage smokers to quit attempt via a range of communication channels
For specific groups we will: • Provide carbon monoxide monitors to health visitors to record smoking status of pregnant women and new mums and offer them support to quit • Monitor and review service for people with SMI • Explore provision of tailored to support people with substance misuse including in-reach cessation support • Strengthen referral pathways from treatment into smoking cessation programmes. • Offer pharmacotherapy/vapes within treatment centres • Explore work with local GPs and PCNs around smoking • Work with key services and programs including Lung health check programme, cardiovascular and respiratory services to ensure staff are trained on VBA, check smoking status and promptly refer smokers into cessation programmes • Work with voluntary and community sector to engage high smoking groups

11.3. Creating more Smoke free Environments

Passive smoking, or second hand smoking, means breathing in other people's tobacco smoke either from cigarettes, pipes, cigars or shisha pipes (hookah). Most tobacco smoke is invisible but it spreads and can stay in the air for hours as well as build up on surfaces and clothes. This is called third hand smoke.

Creating and promoting a more smokefree environment will contribute to protecting residents including children and the other vulnerable people second-hand smoke. Further restriction on areas where people can smoke will further reduce smoking visibility and help de normalise smoking. National policies and legislation restricting tobacco marketing have been effective because of the successful promotion an uptake of smoking through advertising by the tobacco industry.

Previous legislations, including 2007 legislation raising the legal age for purchasing tobacco from 16 to 18 in England, ban on cigarette vending machines in England in October 2011, the smoking ban in cars (with passengers under 18) in England and Wales in October 2015 have helped to dramatically reduce smoking. The proposed legislation to raise the age of sale of tobacco one year every year (from 2027 onwards) is being awaited and expected to positively impact the take up of smoking in future (See appendix 1 for other legislations). Below priority actions will help to consolidate a smokefree borough.

We will:

- Encourage workplaces to promote smokefree environments and support staff to quit
- Work with housing to develop policies to reduce smoking in social housing
- Embed social housing-based tobacco control programmes within other strategies such as the Housing strategy
- Work with landlords, property management companies to promote smoke-free living
- Work with partner organisations including NHS to ensure wider smokefree policies
- Support organisations and staff working across the community including the voluntary sector to promote smokefree environments - at homes, cars, play parks and schools
- Promote smokefree environments as part of our annual campaigns
- Support proposed national legislations by participating in consultation process
- Explore ways to increase local enforcement capacity to enforce legislation locally
- Signpost parents that smoke to local stop smoking support services, reducing harm from second hand and third hand smoking in the home environment

11.4 Local Regulation and Enforcement

Illicit tobacco includes products which fail to comply with legislation and can cover genuine tobacco goods for other countries smuggled as well as counterfeit or fake tobacco products not regulated. These are often available at cheaper prices, undermining the effectiveness of taxation and making it harder for smokers to quit.

Raising awareness of underage and illicit sales of tobacco, how to report them as well as active seizure of such goods will reduce proliferation and harm.

The Trading Standards Service has an intelligence led approach to enforcement which has led to more targeted work and a greater focus on those traders causing the most harm. Some Local Authorities have carried out enforcement activities to raise awareness amongst local people about the issue of dropping cigarette litter.

Educational campaigns alongside enforcement on cigarette litter can help address the environmental and cost burden of tobacco litter.

We will:

- Adopt a joined-up approach to tackling the supply of illicit tobacco with key partners
- Raise awareness of what are illicit tobacco, the effects on society
- Develop clear mechanism on how and where to report underage and illicit tobacco sales through mass-media campaigns and information sessions
- Increase the number of people who volunteer intelligence and develop a mechanism to report illicit or illegal sale of tobacco and Vapes products
- Expand tests of underage purchase of tobacco by Trading standards-Challenge 25
- Take actions to ensure compliance to regulation relating to electronic cigarettes
- Raise awareness of cigarette littering and increase enforcement for littering
- Continue joint raids with other enforcement agencies of outlets and businesses selling illicit tobacco and Vapes products jointly within available resources
- Work with the Licensing and Trading Standards teams to ensure premises are compliant with the licenses that they have been issued

12. Measuring progress - Targets and Indicators

The overarching target of the strategy is to achieve continued reduction in smoking prevalence between 2024 and 2029. A range of national outcome indicators will be use to measure progress according to targets agreed by the Tobacco harm reduction partnership. By 2025 we aim to achieve the following:

Table of indicators

	INDICATOR	TARGET OVER 5 YRS TO 2028/29
1	Adult Smoking prevalence*	Continue to maintain a reduction in adult's smoking prevalence from current 10.9%
2	Smoking by Gender	Reduce smoking prevalence in men 14.1% by 4%
3	Persons in treatment for all opiates	Reduce the prevalence of smoking from the current baseline of 69.7%
4	Persons in treatment for alcohol, non-opiates & smoking (19/20)	Reduce the prevalence of smoking from the current baseline of 60.0%
5	Smoking at time of Delivery	Maintain the 3.7 % smoking prevalence at the time of delivery (national target 6%)
7	Severe mental illness	Maintain a reduction in smoking prevalence from the current baseline of 39.4%[21]
8	Routine and manual workers	Maintain a reduction in smoking prevalence, from 14.4%orking towards the target of 10%, similar to 2019
9	Social housing	Maintain a reduction in smoking prevalence from current baseline of 26%

13. Governance and Action plan

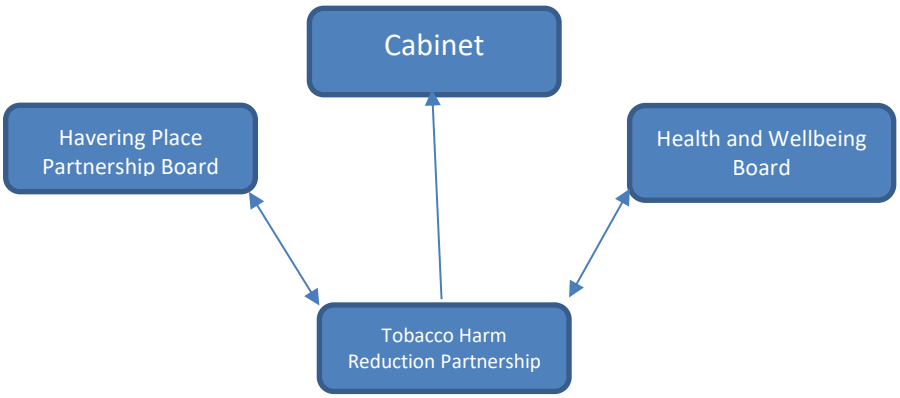
A Tobacco Harm Reduction Partnership, which reports to both the Borough Partnership Board and the Havering Health and Wellbeing Board has been established to drive forward ambition of making Havering smoke free. The partnership responsibilities are to:

- Oversee development of a tobacco harm reduction strategy and action plan with key priorities in line with national policy and evidence of best practice and, to also advise on changes required to either strategy or plan
- Provide opportunity for stakeholders to share information and network
- Identify opportunities for funding tobacco control interventions including economies of scale from working in partnership to provide services

[21] 2014/15 data

- Review progress regularly using clear set of indicators linked to agreed outcomes

Figure 8: Governance



Action Plan, supported by government grant funding is being implemented through the multi-sector partnership to help achieve a sustained downward trend in smoking prevalence. This will be refreshed annually setting out activities to be delivered with clear objectives, milestones and leads. Responsible leads will report on progress activity and outcomes at quarterly meetings. Updates may be required for presentation to Borough Partnership Board and Health and Wellbeing Board.

Appendices

Appendix 1- Major UK Tobacco Control Milestones

1965: all television adverts for cigarettes banned

1986: adverts banned in cinemas

The Tobacco Advertising and Promotion Act (2002) was responsible for getting rid of the remaining forms of tobacco advertising:

• February 2003 – Ban on print media and billboard advertising

• May 2003 – Ban on tobacco direct marketing (promotions)

• July 2003 – Sponsorship of events within the UK

• December 2004 – Large adverts in shops, pubs and clubs banned

• 2005 – Sponsorship of global events, including Formula 1 and snooker tournaments A smoking ban, making it illegal to smoke in all enclosed workplaces (which includes offices/shops/restaurants/bars) in England, came into force in July 2007.

The legal age for purchasing tobacco was raised from 16 to 18 in England, Scotland and Wales in October 2007. In Northern Ireland this came into force in September 2008.

Cigarette vending machines banned in England in October 2011, in Scotland in April 2013, in Wales in February 2012 and in Northern Ireland in March 2012.

A tobacco point of sale display ban was introduced in large shops (>280 m2 floor area) in England in April 2012.

The sale display ban was extended to small retailers across all jurisdictions in April 2015.

A smoking ban in cars (with passengers under 18) came into force in England and Wales in October 2015. Scotland introduced the same law in December 2016. The ban is not yet in place in Northern Ireland.

Rules that cigarettes and tobacco must be sold in plain green packets came into force across the UK in May 2017.

Consultation

The Tobacco Harm Reduction strategy (2024 to 2029) has been developed with members of the Havering Tobacco Harm Reduction Partnership (THRP)

In line with governance process Equality impact Analysis of the strategy will be conducted and the strategy will then be presented to

- Havering Tobacco Harm Reduction Partnership (THRP) Group for discussion and agreement, including of priorities and targets to be achieved
- Health And Well-Being Board for approval and
- Havering Place based Partnership board for authorisation to proceed to wider public consultation and engagement with feedback integrated and
- Presentation to Cabinet by the relevant manager for authorisation

Evaluation and review

The strategy will be reviewed refreshed midway into the 5 year period to assess progress and make adjustments in line with any new developments or national policy changes. A stakeholder workshop will be undertaken to ensure involvement in shaping a refreshed strategy.

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HEALTH & WELLBEING BOARD

Subject Heading:	Health Protection Forum Annual Report 2024
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Samantha Westrop, Assistant Director Public Health Samantha.westrop@havering.gov.uk Esosa Edosomwan, Public Health Practitioner esosa.edosomwan@havering.gov.uk

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

☒ The wider determinants of health
- Increase employment of people with health problems or disabilities
- Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.
- Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.

☒ Lifestyles and behaviours
- The prevention of obesity
- Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups
- Strengthen early years providers, schools and colleges as health improving settings

☒ The communities and places we live in
- Realising the benefits of regeneration for the health of local residents and the health and social care services available to them
- Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.

☒ Local health and social care services
- Development of integrated health, housing and social care services at locality level.

☒ BHR Integrated Care Partnership Board Transformation Board
- Older people and frailty and end of life
- Long term conditions
- Children and young people
- Mental health
- Planned Care
- Cancer
- Primary Care
- Accident and Emergency Delivery Board
- Transforming Care Programme Board

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SUMMARY

The Havering Health Protection Forum (HPF) supports the Director of Public Health (DPH) in fulfilling their statutory duty to protect the health of Havering's residents, by both supporting and constructively challenging local health protection arrangements.

Over the past year, our resilience, dedication, and adaptability have been tested as we navigated emerging health threats, sustained efforts against longstanding challenges, and advanced initiatives to promote equitable access to health protection measures. This 2024 Annual Report highlights our ongoing commitment to proactive preparedness, effective response, and continuous improvement in public health outcomes.

Overall, health protection arrangements in Havering continue to function effectively. Throughout the year, we have seen strong partnerships that have enhanced our capacity to prevent, detect, and mitigate health risks. Through vaccination programmes, disease surveillance, community engagement, and environmental health monitoring, these collaborative efforts have played a vital role in protecting and promoting public health across the borough.

Each section of the report outlines how the local health protection system operates in relation to a particular topic, provides key data trends or a visual system overview, summarises current concerns or notable developments, and highlights significant actions underway.

We have reviewed the actions arising from the 2022/23 Annual Report and outlined the progress made. In addition, proposed actions for 2025 are included (see pages 6 to 9).

It is intended that this report will be presented to the Borough Partnership for further discussion on strengthening health protection arrangements across Havering.

RECOMMENDATIONS

For the Health and Wellbeing Board to note the contents of the report, including proposed key topics of focus for 2025, and Health Protection Forum plans to present the report to the Borough Partnership to consider where local health protection arrangements may be further strengthened

REPORT DETAIL

As attached.

IMPLICATIONS AND RISKS

There are no additional risks beyond those already addressed by the relevant organisations responsible for health protection functions.
BACKGROUND PAPERS
None

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HEALTH & WELLBEING BOARD

Subject Heading:	Joint Local Health And Wellbeing Strategy update
Board Lead:	Mark Ansell
Report Author and contact details:	Parth Pillai parth.pillai@havering.gov.uk

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

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

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SUMMARY

The Health and Wellbeing Board (HWB) received two papers on 29th January 2025, detailing the process of updating the progress on the previous strategy's priorities and also a list of 20 possible priorities which were being recommended to adopt into the refreshed Joint Local Health and Wellbeing Strategy (JLHWS).

Since then the JLHWS has been progressing well. Using a survey HWB members narrowed an initial set of 20 proposed priorities down to 12 key priorities strategically aligned with local health needs and distinct from other partnership responsibilities.

We now present to the HWB the final set of priorities that will be adopted into the JLHWS refresh.

Members will also be provided with two additional presentations. A presentation on the questions we would like to ask residents about the 12 priorities that have been selected, and a presentation on the planned process of the public consultation that will confirm the 12 priorities.

RECOMMENDATIONS

To agree the final set of priorities listed below (priorities have been listed from most votes to least out of 11 responses):

1. Adolescent mental health and wellbeing strategy
2. Prevention of self harming by young people
3. Reduce inequality in educational outcomes
4. Reduce homelessness and harm caused
5. Reduce obesity and harm caused
6. Support people with mental health problems to live fulfilling, meaningful and health lives
7. Empower older people to live independently
8. Early intervention to improve school readiness
9. Improve transition from child focused to adult services
10. Improve diagnosis and support of dementia
11. Improve employment and wage levels to reduce poverty
12. Reduce tobacco related harm - including from vaping

To agree public consultation process and questions to be asked during.

REPORT DETAIL

See attached papers.

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IMPLICATIONS AND RISKS
None
BACKGROUND PAPERS
See attached.

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