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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 29 January 2025	Council Chamber, Town Hall

Members: 21, Quorum: 6

BOARD MEMBERS:

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

For information about the meeting please contact:
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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?

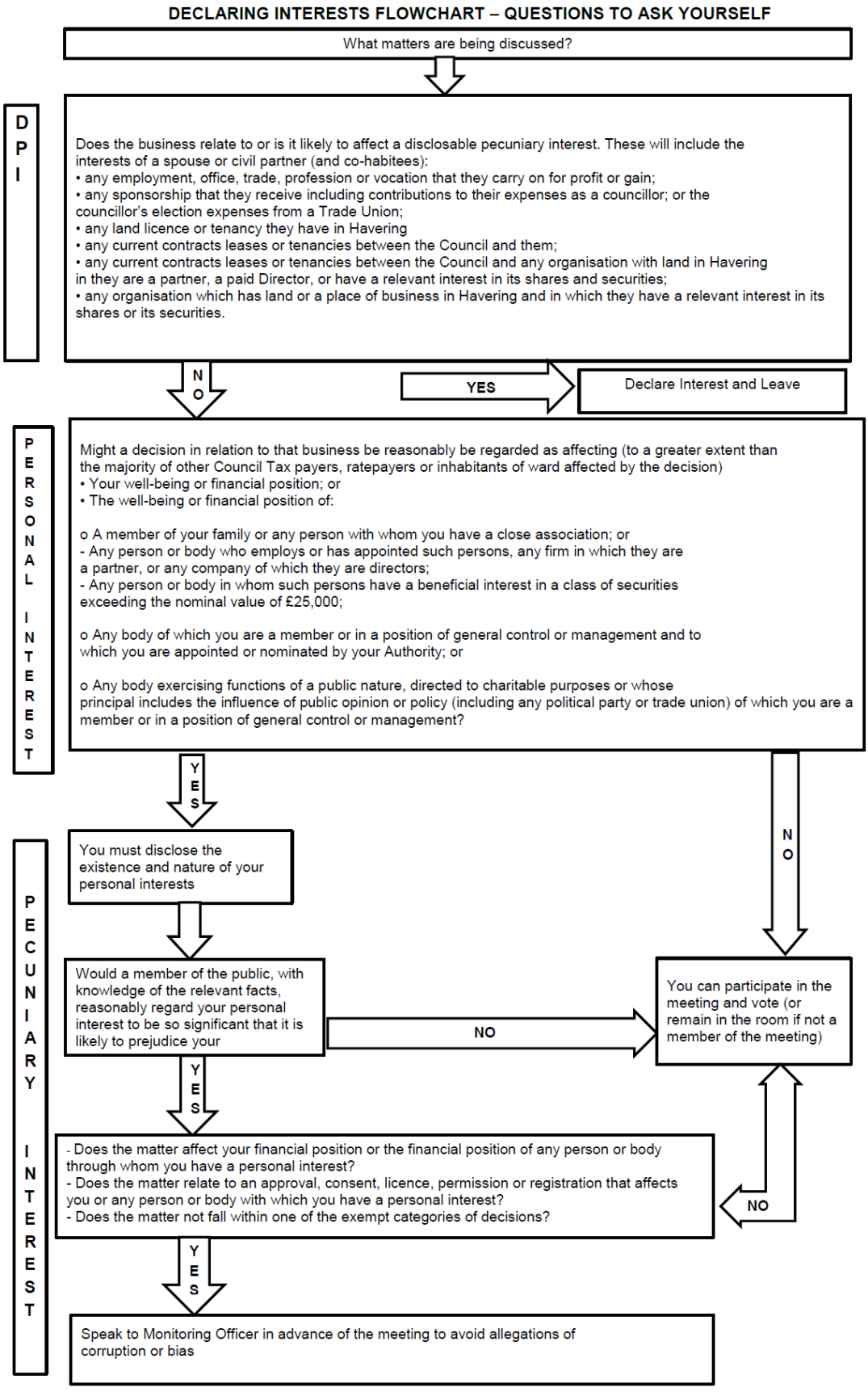
Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities 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



AGENDA ITEMS

1 CHAIR'S ANNOUNCEMENTS

The Chair 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 (Pages 7 - 14)

To approve as a correct record the minutes of the Committee held on **7th November 2024** and to authorise the Chair to sign them.

5 MATTERS ARISING

To consider the Board's Action Log

6 HEALTH & WELLBEING STRATEGY 2019-24 PROGRESS UPDATE

Report to follow

7 PRIORITIES FOR A REFRESHED JLHWS (Pages 15 - 22)

8 HAVERING ALL-AGE SUICIDE PREVENTION STRATEGY 2025-2030 (Pages 23 - 134)

9 HAVERING JOINT DEMENTIA STRATEGY (Pages 135 - 166)

10 DATE OF NEXT MEETING

The date of the next Board meeting is 23rd April 2025.

Zena Smith
Head of Committee and Election Services

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Council Chamber - Town Hall
7 November 2024 (1.01 - 2.09 pm)

Present:

Elected Members: Councillor Gillian Ford (Chair, Cabinet Lead Member for Adults and Wellbeing); Councillor Oscar Ford (Cabinet Member for Children and Young People); Councillor Natasha Summers (Cabinet Member for Climate Change and Housing Need); Councillor Paul McGeary (Cabinet Member for Housing and Property).

Officers of the Council: Andrew Blake-Herbert (Chief Executive), Mark Ansell (Director of Public Health), Barbara Nicholls (Strategic Director, People); Neil Stubbings (Strategic Director, Place); Kate Ezeoke-Griffiths (Assistant Director, Public Health); Natalie Naor (Public Health Strategist); Lucy Goodfellow (Head of Innovation and Improvement for Starting Well);

Also Present:

Paul Rose (Chair of the Havering Compact)
Lynn Warnett (Chair of the Carer's Board in Havering)
Max Tolhurst (Deputy Chief Operating Officer at Barking, Havering and Redbridge University Hospitals Trust)
Kirsty Boettcher (Deputy Director of Havering Integrated Team), substituting for Luke Burton.
Brid Johnson (Chief Operating officer, NELFT)
Vicky Kong (Havering Clinical Lead for Population Health Management and Inequalities)
Dr Sarita Symon

The meeting commenced at 13:01.

1 **CHAIR'S ANNOUNCEMENTS**

The Chair reminded members of the action to be taken in an emergency.

2 **APOLOGIES FOR ABSENCE**

Apologies were received from Anne-Marie Dean and Narinderjit Kullar. It was noted that Tara Geere would arrive later.

3 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

4 MINUTES

The minutes of the meeting held on 3 April 2024 were agreed as a correct record and signed by the Chair.

5 BCF PLANNING 2024-25 FOR APPROVAL

The report for this item has been withdrawn and will be re-submitted to the January meeting.

6 HAVERING'S INTEGRATED STARTING WELL PLAN 2024-27 - HAPPY, HEALTHY LIVES

The chair agreed for this item to be considered after item 7, the Tobacco Harm Reduction Strategy.

Report presented by Lucy Goodfellow.

The report contained two recommendations for the Health and Wellbeing Board:

- Note the contents of the Integrated Starting Well Plan and the approach that has been taken to its development; and

- Adopt the suggested five Starting Well JSNA recommendations - each of which is aligned to one of the five priorities within the Plan - for inclusion in Havering's refreshed Joint Local Health and Wellbeing Strategy.

It was reported that the Starting Well Plan brings together key strategies responding to evidence and recommendations from JSNA, and feedback from children and young people. The aim is to enable children and families to lead happy, healthy lives. The plan also builds upon the council's corporate plan, including that of the People and Place directorates. It also complements the Starting Well Improvement Plan. It is aimed at every child in the borough up to the age of 18, or up to the age of 25 for people with special educational needs or disabilities.

Five priorities have been identified. The first four aim for children and young people to be well, inspired, safe and heard. The fifth priority is to ensure children and young people in Havering are treated fairly. The Shout Survey (2022) provided information on the views of young people in the borough. The Havering Youth Wellbeing census of 2023 also informed these decisions.

The plan contains an action plan setting out some recommendations that were made in the Starting Well Joint Strategic Needs Assessment Chapter

that was published earlier this year. This action plan will be refined in the final version of the document.

It was requested that five JSNA recommendations in particular are adopted for inclusion in the refreshed strategy when it is published.

1. To develop a joint strategy for adolescents' mental health and wellbeing.
2. Early intervention to improve school readiness.
3. Statutory and voluntary partners to work together to consider ways of intervening earlier to prevent admission into hospital as a result of self-harm (aligned with the suicide prevention strategy for the borough).
4. Good quality engagement with young people to understand how we can better manage their transition from children's services to adult services for those requiring ongoing care and support.
5. Partners to work collectively to decrease inequalities in educational outcomes for young people.

A consultation on the draft plan was conducted in October. The plan was also shown to the Youth Council, who were happy with the priorities that have been identified. The Youth Council had agreed to help produce a child-friendly version once the plan had been adopted by full council.

Consultation feedback showed a lot of agreement with the priorities identified. There were mixed responses over whether the plan was clear enough on how the council will work with partners to achieve these outcomes. The document is being adjusted in response to feedback, specifically in the following areas: the role of the statutory partners will be shown more clearly; strengthened focus on children with special educational needs and disabilities; improved linkages between sections about Havering as a place; more focus on safety and crime; more focus on attendance in education; more on support available for parents; importance of very young children understanding their voices will be heard; more concrete action on tackling disproportionality; broader focus on inequalities; strengthening the section on the Violence Against Women and Girls Strategy.

There was no new funding associated with the delivery of this plan, so these activities (many of which are already underway) would need to be met from existing resources, which include the general fund, the Dedicated Schools Grant, and the Public Health Grant.

In response to a question about the historic shortfall in health visitors and nurses, it was stated that the council has committed to spend enough money to meet the minimum levels of health visiting, but it may be necessary to revisit estimates of the number of children in Havering. School nursing is underfunded.

In response to a question about how young carers can be identified and supported, it was stated that the support of education colleagues will be important in identifying this group of people.

It was suggested that leads in other areas such as Living Well and Ageing Well could consider creating a plan similar to this one.

It was AGREED:

- That the contents of the Integrated Starting Well Plan and the approach that has been taken to its development be noted by the Board; and

- That the suggested five Starting Well JSNA recommendations - each of which is aligned to one of the five priorities within the Plan – be included in Havering's refreshed Joint Local Health and Wellbeing Strategy.

- That it be proposed to leads in other areas that they consider undertaking a similar process to come up with five 'wishes' of their own.

7 TOBACCO HARM REDUCTION STRATEGY 2024-29

The chair agreed for this item to be considered before item 6, Havering's Integrated Starting Well Plan.

Report presented by Kate Ezeoke-Griffiths and Natalie Naor.

The Tobacco Harm Reduction Strategy was developed this year in partnership with a range of partners. Tobacco is a major cause of ill health, early death, and inequality. The strategy is aligned with national policies as well as local policies, including the council's corporate plan which aims to help residents stay well and lead healthy lives. This is a five-year strategy due to the government's funding commitment for five years. The strategy covers tobacco reduction as well as vaping. The government aims to create a smoke-free nation by 2030. The government had introduced a Tobacco and Vape Bill to Parliament in the last few days.

This strategy was a result of a Tobacco Harm Reduction Partnership including the NHS, the local pharmaceutical community, and other teams across the council. The partnership aims to oversee the development of the strategy, the implementation of the action plan, and the measurement of progress over time, using a set of indicators. The strategy has been informed by wider stakeholder events. The strategy has also been guided by a needs assessment which was conducted earlier this year. The vision of the strategy is to deliver a smoke-free future for Havering and improve the health and well-being of the local population as well as to achieve a smoke-free borough in line with the national ambition to reduce smoking prevalence to 5% or less. The prevalence of adult smokers in Havering is 12.4%. The prevalence is particularly high among mentally ill people, people in

treatment for alcohol or drug misuse, and people in private or social housing or rental properties, and people in manual or routine occupations. Smoking is less prevalent among pregnant women, largely because of a specialist pregnancy service locally, which is now run by the NHS. The strategy focusses on groups with the highest prevalence of smoking: men, people with long-term or severe mental illness, and people in treatment for drug or alcohol misuse.

It was reported that vapes can be useful for quitting smoking but they are not advisable for people who do not smoke or for children, because the long-term impact is unknown. 25% of young people aged 11 to 15 nationally tried e-cigarettes in 2023. 9% of young people vape frequently. In Havering, 12% of pupils have experimented with vaping. The report authors welcome the new Tobacco and Vape Bill. Havering's Trading Standards team are trying to increase the number of retailers who adopt the "challenge 25" approach.

It was reported that smoking costs Havering £256 million per year. People who are socially or economically disadvantaged are more likely to smoke and suffer the resulting income loss and harm to health. The strategy aims to help these groups. There is also an environmental impact to smoking, including deforestation and cigarette litter. There are four priorities to the strategy: prevention (raising awareness and providing training, working with trading standards and schools); supporting smokers to quit (expanding number of community pharmacies, creating specialist lead advisory service for priority groups); creating smoke-free environments (supporting Trading Standards with enforcement of legislation, working with social housing and property management companies, and working with health visitors to create smoke-free environments for babies and children); and regulation and enforcement (working with Trading Standards, raising awareness of the dangers of illegal items, developing reporting mechanisms).

Nine indicators have been chosen to measure progress. The main goal is a continued reduction in smoking prevalence, particularly amongst priority groups. An action plan is already being implemented, using a government grant received earlier this year. The majority of actions have already been implemented, but there are still a couple which are currently in progress. Completed actions include extending universal service, launching SMI service, training frontline staff, distribution of CO2 test kits, and creation of a communications plan. The goal by 2029 is a steady reduction in smoking prevalence in Havering, including amongst priority groups. The strategy also aims to reduce smoking and vaping among young people, and create a healthier Havering population by 2039.

The next step was to get approval for this strategy from the Health and Wellbeing Board, then get approval from the place-based partnership board, and then go to public consultation early in the New Year, before going to Cabinet for approval of the new strategy.

In reply to a question, resources have been provided to schools for use in lessons. There was also an intention for Trading Standards to engage with schools and provide them with information about reporting retailers.

It was observed that the indicators for measuring progress do not include a measurement relating to young people. In response, there was an intention to conduct a needs assessment around vaping amongst young people, and this needs assessment should provide measurements which can be used to monitor progress.

In response to a question regarding how the number of smokers in Havering is measured, data is currently being used from a national survey. However, there was also an intention to use GP data to provide a more detailed picture. Ward-level data will also be collected.

In response to a question about the influence exerted upon national policy setting, representatives from Havering participate in regional and national events to influence government. There has been mention of receiving further money from government for Trading Standards, but this money has not been received yet. There is a need to consider the possibility that free ports will facilitate the flow of more illicit products into Havering.

A training session was run in September for partners including the NHS and social care professionals.

It was observed that if smoking is to be banned outside hospitals as a result of national legislation, support will need to be given to smokers in hospitals.

In response to a question about how young people first gain access to smoking and vapes, the majority gain access from retailers who are selling these products to underage customers. These products are also promoted on social media by influencers.

A question was asked regarding the support available to smokers after they have left hospital. These patients will be referred to the specialist Stop Smoking Service, who will stay in touch with them and meet them in the community after they leave hospital.

The Health and Wellbeing Board APPROVED the Tobacco Harm Reduction Strategy 2024-29.

8 **ANY OTHER BUSINESS**

None.

9 **DATE OF NEXT MEETING**

The meeting originally scheduled for 4th December was likely to be re-scheduled for January. A new date would be advised.

The chair declared the meeting closed at 14:09.

Chair

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HEALTH & WELLBEING BOARD

Subject Heading:	Presentation of possible priorities for a refreshed JLHWS
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Mark Ansell, mark.ansell@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

A presentation will be made setting out potential priorities for inclusion in a refreshed joint local health and wellbeing strategy (JLHWS).

RECOMMENDATIONS

Board members will be asked to feedback within two weeks of the Board meeting regarding the priorities they would wish to be included in a new draft JLHWS. Those priorities will then be subject to a public consultation before the HWB is asked to formally adopt the new JLHWS.

REPORT DETAIL

A refresh of the JLHWS is overdue.

To this end, the HWB is asked to select potential priorities for inclusion in a draft strategy that would then be subject to public consultation.

These priorities have been drawn from the following sources: -

- The HWB has previously agreed to include 5 priorities selected from Happy, Healthy Lives – the integrated starting well plan for our children and young people in the refreshed JHLWS
- The January HWB meeting will receive a paper providing a review of each of the nine priorities included in existing JHWS with a recommendation as to whether they should be retained in a new strategy.
- The Adults Delivery Board of the Havering Place Based Partnership Board has now considered the findings of a refreshed live well / age well JSNA and identified priorities that sit within its remit and might benefit from inclusion in the JLHWS.
- The Adults Delivery Board excluded a number of pre-existing work programmes that sit outside their remit that they acknowledge have a significant impact on health and wellbeing e.g. regarding the wider determinants of health. These are also suggested for possible inclusion in the refreshed JLHWS.

To assist members of the HWB to make their decision, the presentation will map the proposed priorities against the 4 pillars of good health, the life stages approach and the NEL ICB interim integrated care strategy :

It is assumed that the HWB will wish to retain the existing approach whereby the priorities span the four pillars that underpin good health for all at population level:-

- The wider determinants of health
- The communities we live in

- Lifestyles and behaviours
- Health and care services

And reflect the life stages approach now employed by the Council and NHS at borough level

- start well
- live well
- age well
- die well

And the HWB has a duty to consider the ICB's plans when formulating the JLHWS.

The presentation will also score each priority against criteria that serve to: -

- Indicate their relevance to the remit of the health and wellbeing board - to improve health and reduce health inequalities at population level in the long term
- Minimise duplication with the Havering Placed Based Partnership Board, which now leads on the integration and improvement of health and care services in the short to medium term
- Confirm that the priority has adequate management focus to achieve progress. Acknowledging the HWB does not have a secretariat of its own and priorities in the JLHWS will only progress if they are pro-actively managed.

IMPLICATIONS AND RISKS

No specific implications or risks arise from adoption of a new Joint Local Health and Wellbeing strategy – any individual decisions relevant to the delivery of the JHWLS will be subject to the usual governance arrangements in each partner organisations effected.

BACKGROUND PAPERS

None

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HEALTH & WELLBEING BOARD

Subject Heading:	Joint Health and Wellbeing Strategy 2019-24 Priorities 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.
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Havering
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SUMMARY

The Havering Joint Health and Wellbeing Strategy (JHWS) 2019/20 – 2023/24 outlines a clear vision to ensure that everyone in Havering enjoys a long and healthy life with access to the best health and social care services. Developed as a statutory requirement under the Health and Social Care Act 2012, the strategy reflects the collective priorities of the Havering Council and key partners. The Joint Strategic Needs Assessment (JSNA) has identified key health determinants and community needs across four pillars: wider determinants of health, the communities and places we live in, lifestyles and behaviours, and local health and social care services

This progress update evaluates the achievements and challenges over the strategy's lifetime. Based on this evaluation, it provides recommendations for the upcoming JHWS refresh. For each priority, the report considers:

- Whether the issue remains significant and should continue as a priority in the refreshed strategy.
- If the priority is well-governed, supported by effective strategies, and adequately addressed, allowing it to be removed from the refreshed strategy.

This will inform the upcoming refresh of the JHWS, ensuring that the updated strategy remains aligned with current and emerging health and wellbeing needs.

RECOMMENDATIONS

The report recommends to retain the following priorities in the refreshed JLHWS:
Priority 1: Assisting people with health problems (back) into work
Priority 3: Provide strategic leadership for collective efforts to prevent homelessness and the harm caused.
Priority 6: Obesity
Priority 7: Reducing tobacco hard

The report recommends to not retain the following priorities in the refreshed JLHWS:
Priority 2: Further developing the Council / NHS Trusts as ‘anchor institutions’
Priority 4: Realising the benefits of regeneration for health and social care services
Priority 5: Improve support to residents whose life experiences drive frequent calls on health and social care services.
Priority 8: Early years providers, schools / colleges as health improvement settings
Priority 9: Development of integrated health and social care services for CYP and adults at locality level.

Please see attached.

REPORT DETAIL

The report provides current governance, strategies and activities currently supporting each of the priority. It then provides a conclusion and recommendation

based on if the priority is still significant and it has been addressed or endorsed by another partnership.

Please see attached.

IMPLICATIONS AND RISKS

All recommendations that are retained will continue their ongoing reporting into the Health and Wellbeing Board. Priorities that will not be retained will still have oversight by other partnership boards, have been addressed or have adequate strategies and ongoing services / activities.

BACKGROUND PAPERS

Please see attached.

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HEALTH & WELLBEING BOARD

Subject Heading:	Havering All-Age Suicide Prevention Strategy 2025-2030
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Samantha Westrop Samantha.westrop@havering.gov.uk Isabel Grant-Funck Isabel.grant-funck@havering.gov.uk

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

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SUMMARY

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

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

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

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

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

RECOMMENDATIONS

Agree the Havering All-Age Suicide Prevention Strategy attached.

REPORT DETAIL

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

- Executive summary
- Foreword
- Strategy on a page
- Introduction, including timescales and consultation details

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

IMPLICATIONS AND RISKS

Financial implications and risks:
This report is seeking approval for Cabinet to agree the Havering All-age Suicide Prevention Strategy.

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

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

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

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

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

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

Human Resources implications and risks:
There are no direct workforce implications with the implementation of the Strategy. It is therefore cleared from a HR perspective.

Equalities implications and risks:
The EHIA is attached that includes equalities implications.

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

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

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

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

BACKGROUND PAPERS

Strategy
Consultation Report
Easy-read version
EHIA
Needs Assessment

London Borough of Havering

Havering all-age suicide prevention strategy 2025-2030

Working together to save lives

Document Control

Document details

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

Version history

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

Equality & Health Impact Assessment record

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

This document sets out the local strategic approach for reducing deaths by suicide in the Borough. .</td></tr>
<tr><td>4a</td><td>Are you changing, introducing a new, or removing a service, policy, strategy or function?</td><td>Yes</td><td rowspan="3">If the answer to <u>any</u> of these questions is ‘YES’, Please continue to question 5.</td><td rowspan="3">If the answer to <u>all</u> of the questions (4a, 4b & 4c) is ‘NO’, please go to question 6.</td></tr>
<tr><td>4b</td><td>Does this activity have the potential to impact (either positively or negatively) upon people (9 protected characteristics)?</td><td>Yes</td></tr>
<tr><td>4c</td><td>Does the activity have the potential to impact (either positively or negatively) upon any factors which determine people’s health and wellbeing?</td><td>Yes</td></tr>
<tr><td>5</td><td>If you answered YES:</td><td colspan="3">Please complete the EqHIA in Section 2 of this document. Please see Appendix 1 for Guidance.</td></tr>
<tr><td>6</td><td>If you answered NO: (Please provide a clear and robust explanation on why your activity does not require an EqHIA. This is essential in case the activity is challenged under the Equality Act 2010.)

Please keep this checklist for your audit trail.</td><td colspan="3"></td></tr>
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Date	Completed by	Review date

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Executive summary

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

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

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

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

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

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

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

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

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

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

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

Foreword

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

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

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

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

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

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

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

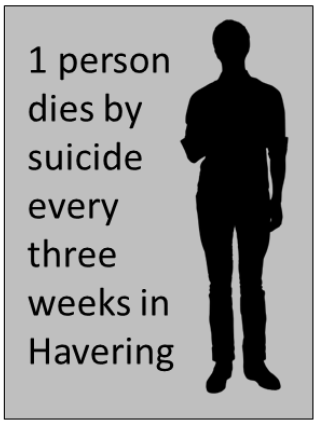
Dr Maurice Sanomi
Senior GP Partner and Havering Partnership Clinical and Care Lead for Mental Health (NEL ICB)

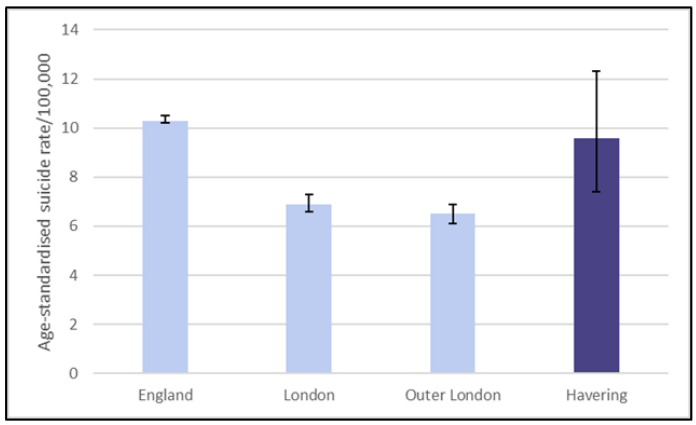
Strategy on a Page

Bereavement | Academic pressure | Substance misuse

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

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





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

Priority groups

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

For targeted prevention

Preventing suicide is everyone's business

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

Identify

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

Prevent

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

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

Stigma reduction
- Language, education, training and engagement

Support

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

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

Social isolation | Depression and severe mental illness (SMI)

Introduction

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

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

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

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

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

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

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

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

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

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

Timescales

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

Consultation

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

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

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

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

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

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

What we know about suicide

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

National Context

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

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

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

Havering Data

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

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

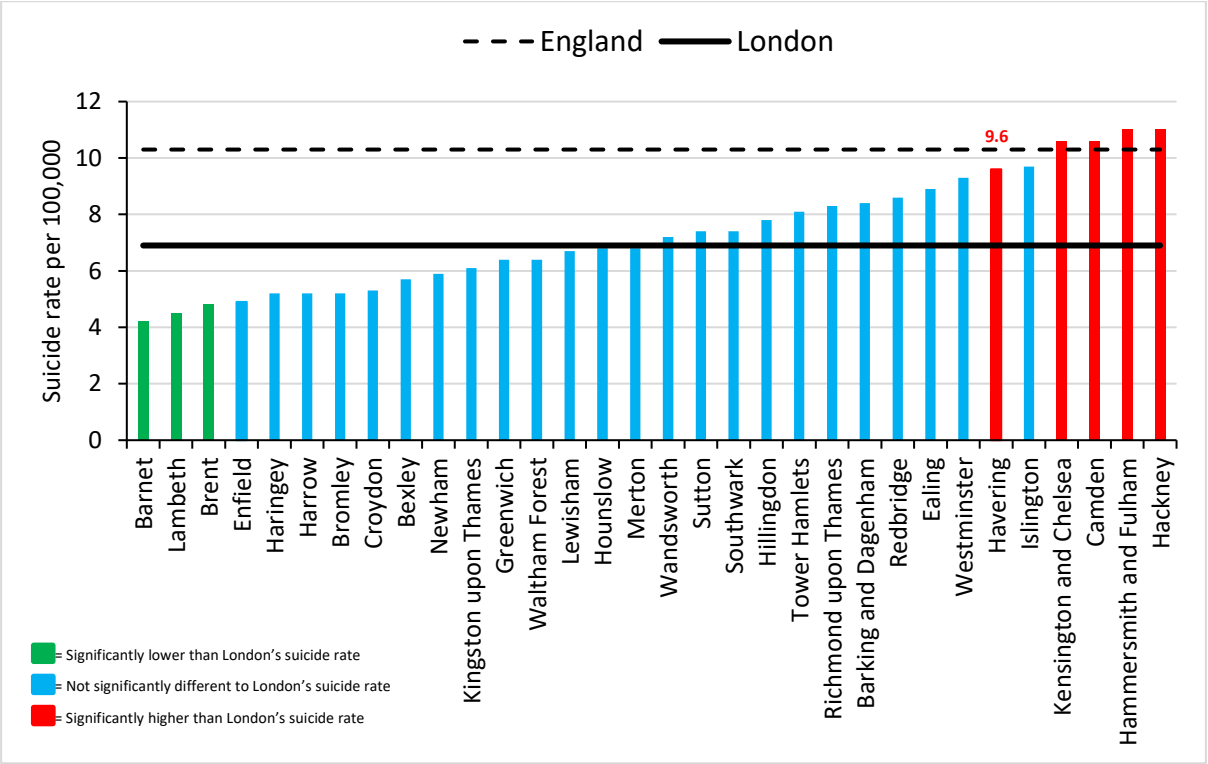


Figure 1 Three-year aggregate age-standardised suicide rates in London boroughs, London and England, 2020-2022*. Source: Office for National Statistics (2022). Suicides in the United Kingdom: 2022 Registrations.*

Risk factors for suicide

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

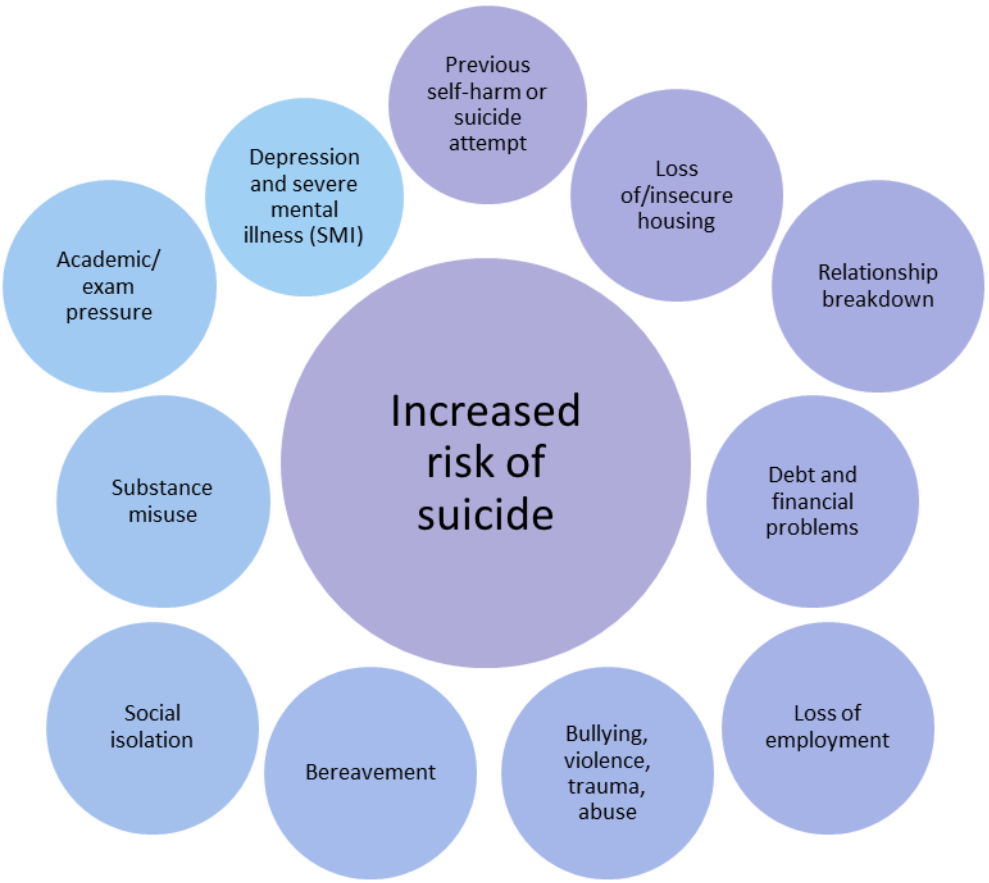


Figure 2 Multiple factors that have been linked to an increased risk of suicide[9]. *Examples of SMI include psychosis and paranoid schizophrenia. NB: Each of the factors can be experienced along with any of the others listed.*

Inequalities

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

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

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

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

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

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

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

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

Priority Groups

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

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

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

Working Together

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

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

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

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

Multi-agency case review panel

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

Aim

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

Objectives

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

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

Why an All-Age Strategy?

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

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

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

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

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

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

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

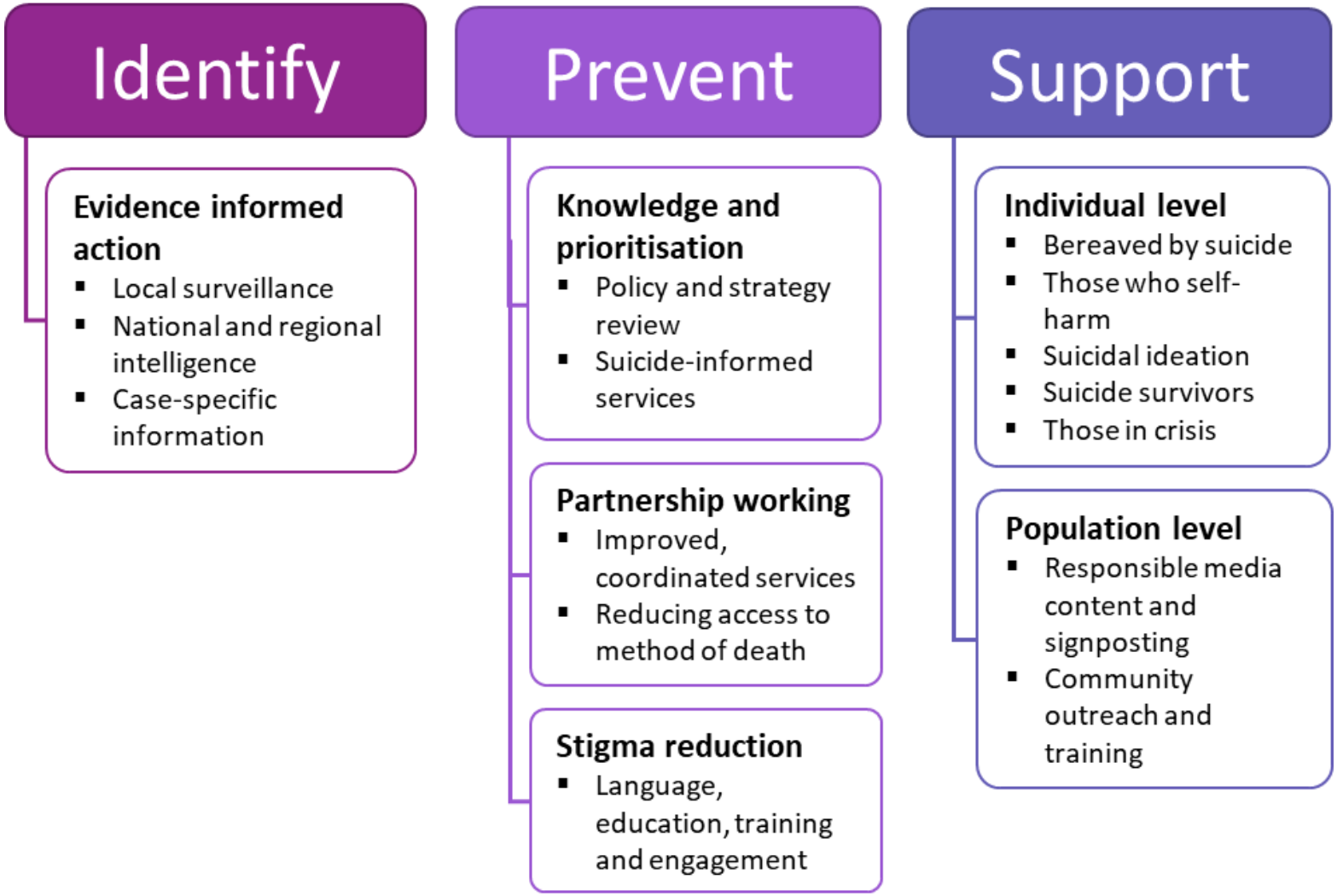


Figure 4 Overview of objectives

Identify

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

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

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

Prevent

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

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

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

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

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

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

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

Support

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

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

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

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

Governance

Suicide Prevention Steering Group

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

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

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

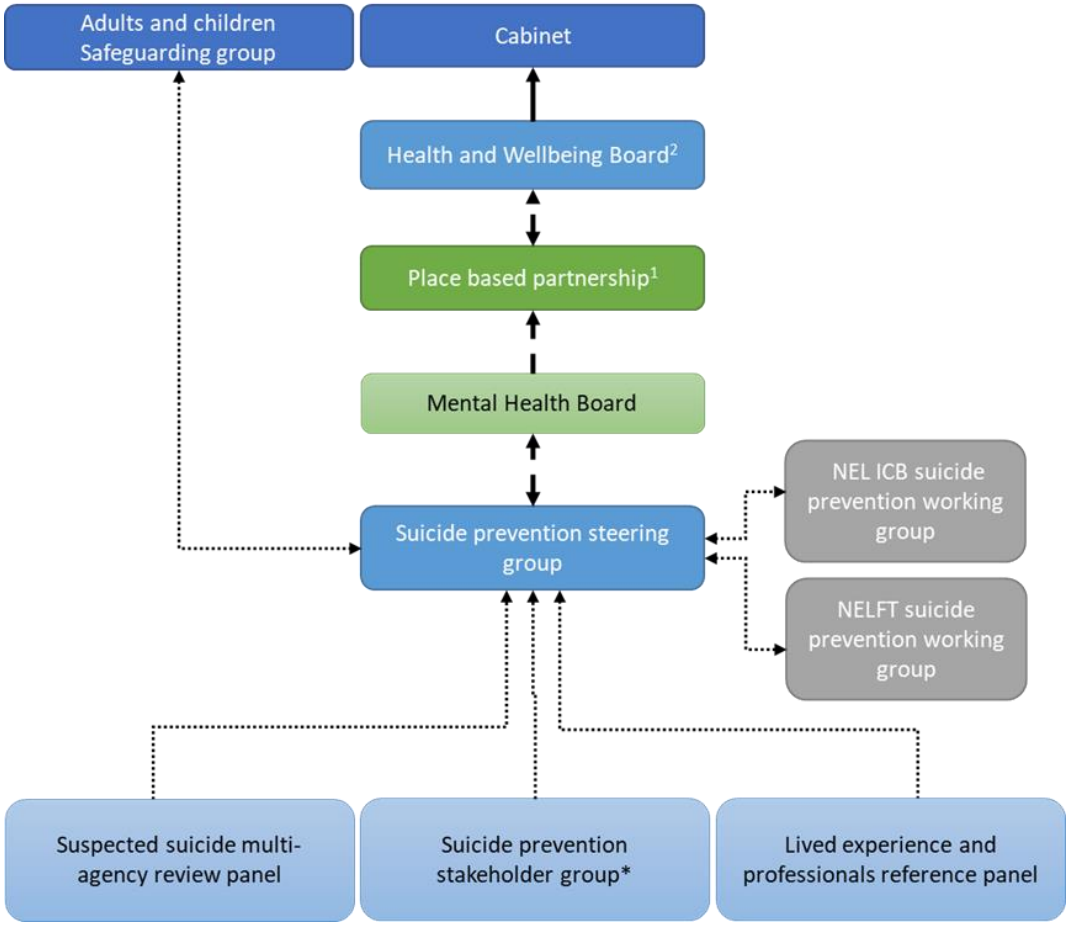


Figure 5 Proposed accountability structure for the Public Health led Suicide Prevention Steering Group. *Solid arrows indicate accountability, dashed arrows indicate responsibility and dotted arrows indicate sharing of information between groups. [1]Responsible for implementation.[2]Adoption of strategy.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

High-Level Action	Actions

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

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

for a complete list of stakeholder groups.

Informed by those with lived experience

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

Glossary

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

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

Appendices

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

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

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

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

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

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

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

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

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

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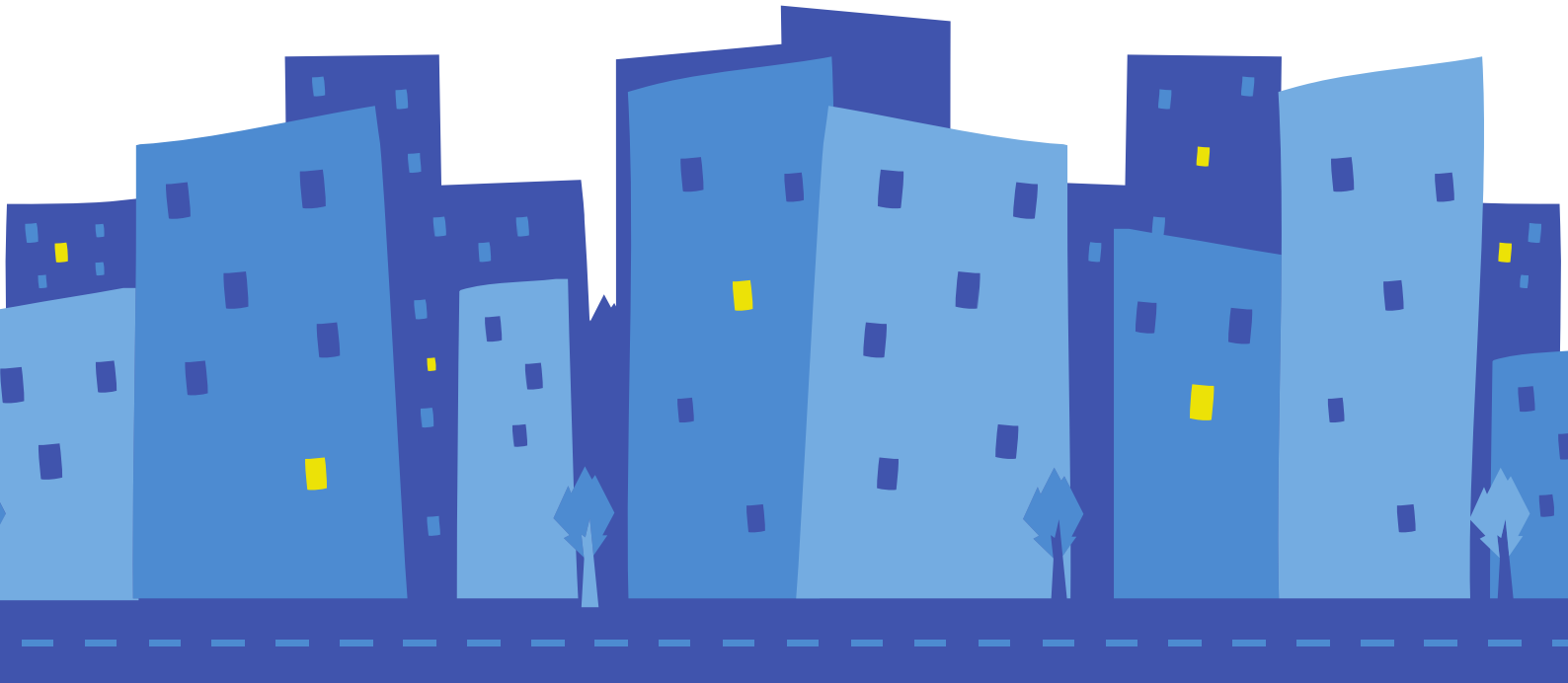
Suicide Prevention Strategy

Easy-Read Version

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

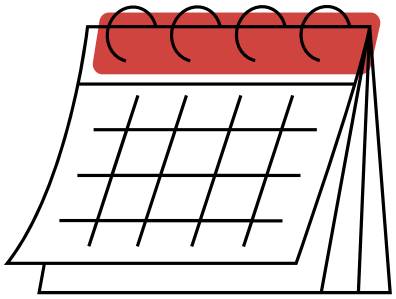
Support is available:

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



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

Every 3 weeks, someone in Havering dies by suicide.



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

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

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

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

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

Who is affected?

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

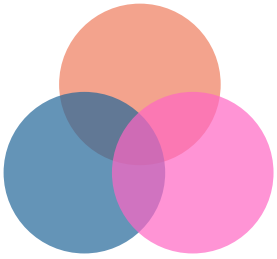
But some people are more likely to take their own life than others. We call them priority groups.
Priorities are the things that are most important.

Priority groups for suicide:

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

What causes suicide?

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



There are groups who will be at risk, including:

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

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

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

What we want:

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

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

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

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

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

What we will do:

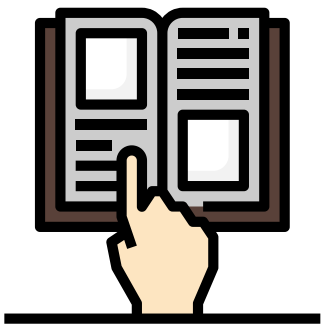
We will offer training and support to a range of services and people.

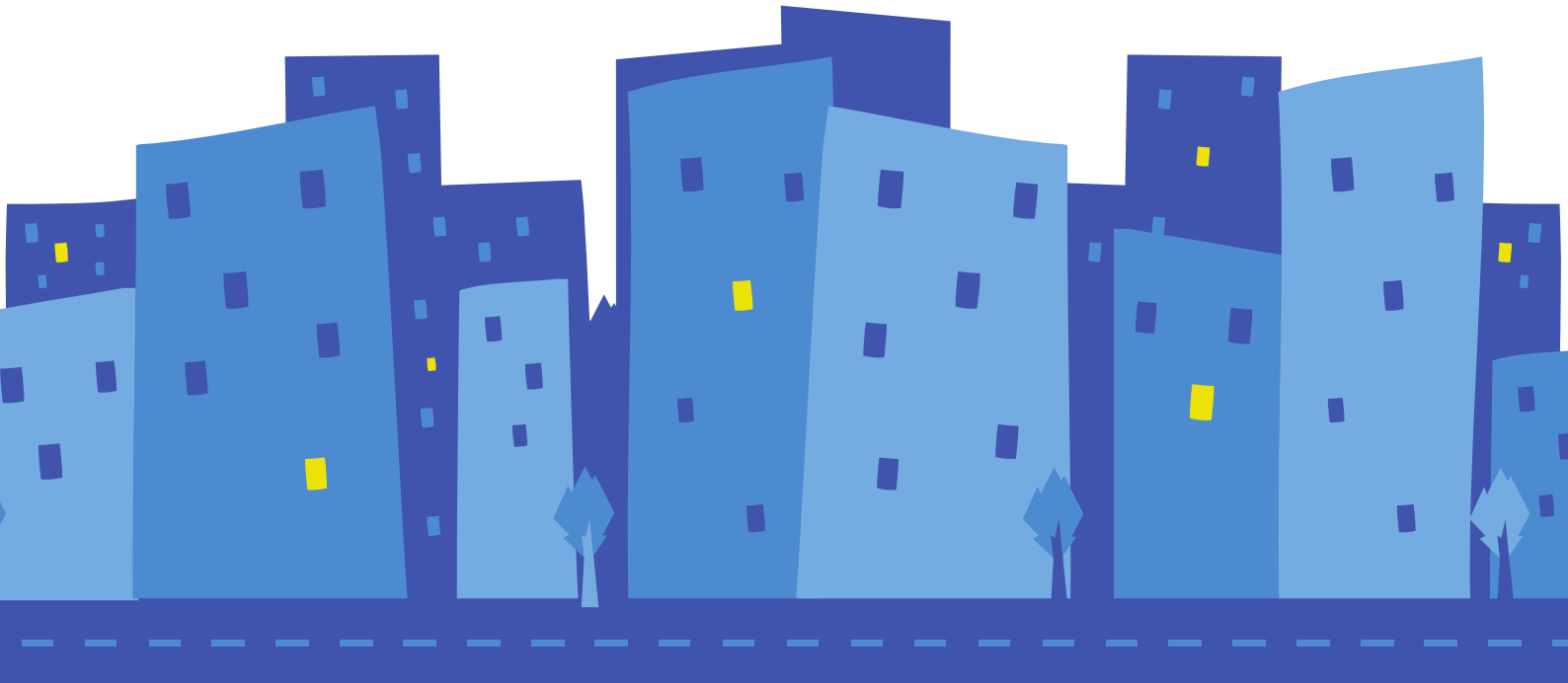
We will make sure services work together to give people all the support they need.

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

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

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





Public Consultation Report

Havering All-age Suicide Prevention Strategy 2025-2030

Working together to save lives

December 2024

London Borough of Havering

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

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

Executive Summary

Citizen Space Survey

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

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

Focus Groups

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

Summary of Findings

Public Consultation on Citizen Space

Local actions to focus on, based on feedback::

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

Main changes to strengthen strategy, based on feedback:

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

Focus Groups

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

Introduction

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

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

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

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

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

Methodology

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

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

Summary from Public Consultation

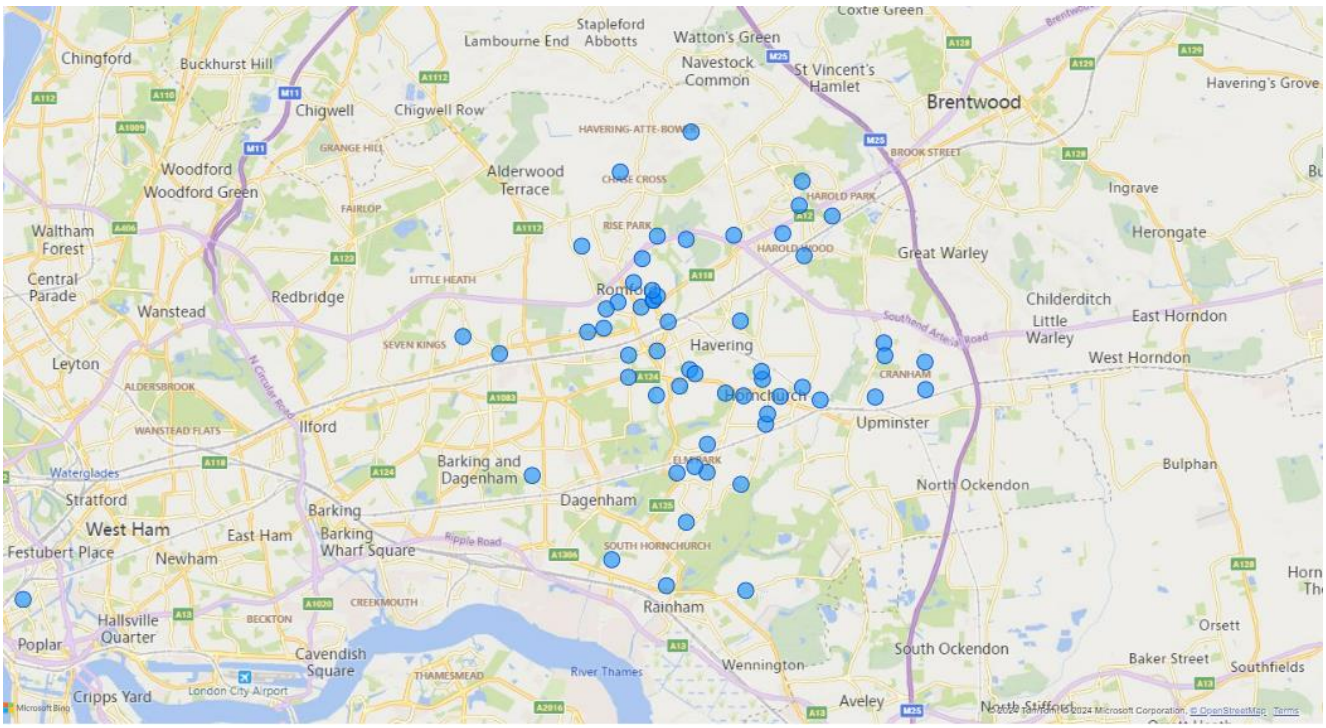
Citizen Space Survey

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

Questions

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

100% of respondents answered this question.



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

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

100% of respondents answered this question.

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

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

Question 3. What capacity are you responding in?

100% of respondents answered this question.

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

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

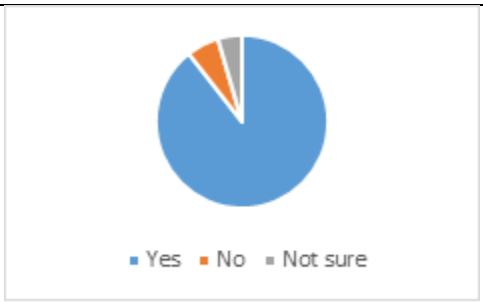
100% of respondents answered this question.

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

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

100% of respondents answered these questions.

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

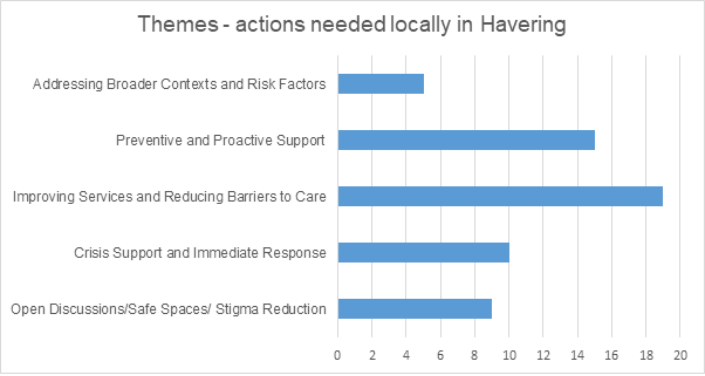
6	Reducing stigma (Making it easier to talk about suicide and help others)	59 (89%) respondents said yes. 5 (8%) respondents said no. 2 (3%) respondents were not sure.	
7	Helping people (those bereaved, those engaging in self-harm, those with suicidal thoughts, those who have survived suicide attempts)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

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

50% of respondents answered this follow-up question.

Themes identified included:

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



Overview of feedback from respondents:

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

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

2. Crisis Support and Immediate Response

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

3. Improving Services and Reducing Barriers to Care

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

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

4. Preventive and Proactive Support

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

5. Addressing Broader Contexts and Risk Factors

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

6. Other

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

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

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

Overview of feedback from respondents:

1. **Specific Groups**

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

2. **Improving Services and Accessibility**

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

3. **Raising Awareness and Reducing Stigma**

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

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

4. Expand Prevention

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

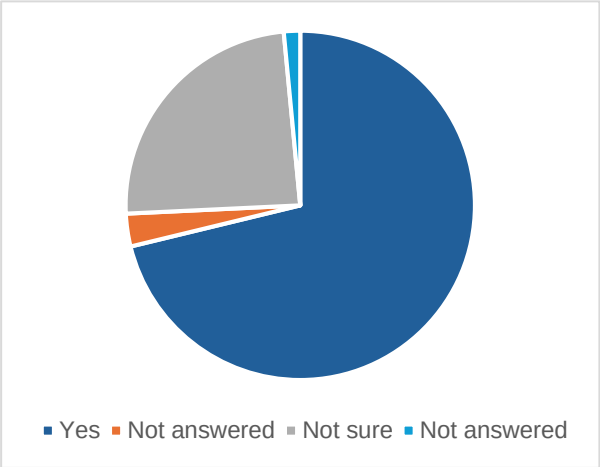
5. Other

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

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

100% of respondents answered this question.

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



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

100% of respondents answered this question.

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

Those who disagreed used the space to explain further.

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

Overview of feedback from respondents:

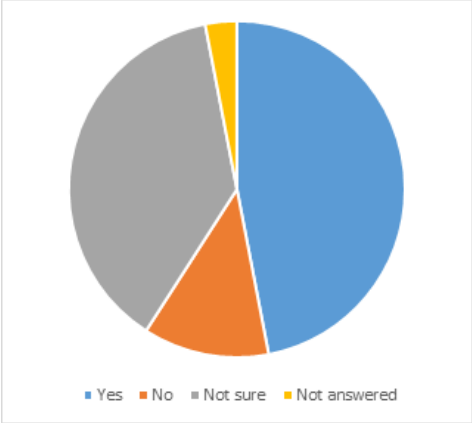
- Did not understand how prevention works for stopping someone from harming or ending their life.
- Existing resources exist, such as bereavement support groups for those affected by suicide.
- Prevention may not be necessary if individuals receive timely and appropriate support.
- Broaden the identification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

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

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

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

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



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

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

Overview of feedback from respondents:

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

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

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

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

Overview of feedback from respondents:

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

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

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

3. Improving services and reducing barriers

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

4. Collaboration

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

5. Other

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

Changes to Strategy and Action Plan

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

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

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

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

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

3. **Crisis support**

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

4. **Children and Young People**

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

5. **Prevention**

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

Focus Groups

Primary Care Networks (PCNs)

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

Key points from Havering Crest PCN included:

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

Key points from Havering Liberty PCN included:

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

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

Youth Council

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

Key points from the engagement with the Youth Council include:

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

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

2. **Communicating with young people**

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

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

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

4. **What schools can do better**

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

Primary and Secondary School Networks

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

Primary School Network: PSHE Meeting

Key points:

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

Secondary School Network: BAP Meeting

Key points:

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

Conclusion

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

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

Appendix

Appendix A: Questions for Havering Crest PCN

Questions on Objective 1

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

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

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

Questions on Objective 2

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

Questions on Objective 3

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

Appendix B: Questions for Liberty PCN

Questions on Objective 5:

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

Appendix C: Questions to Youth Council with quoted answers

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

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

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

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

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

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

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

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

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

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

5. Other things mentioned

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

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

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

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

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

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

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

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

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

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

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Suicide Prevention Needs Assessment

November 2024

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

Support is available:

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

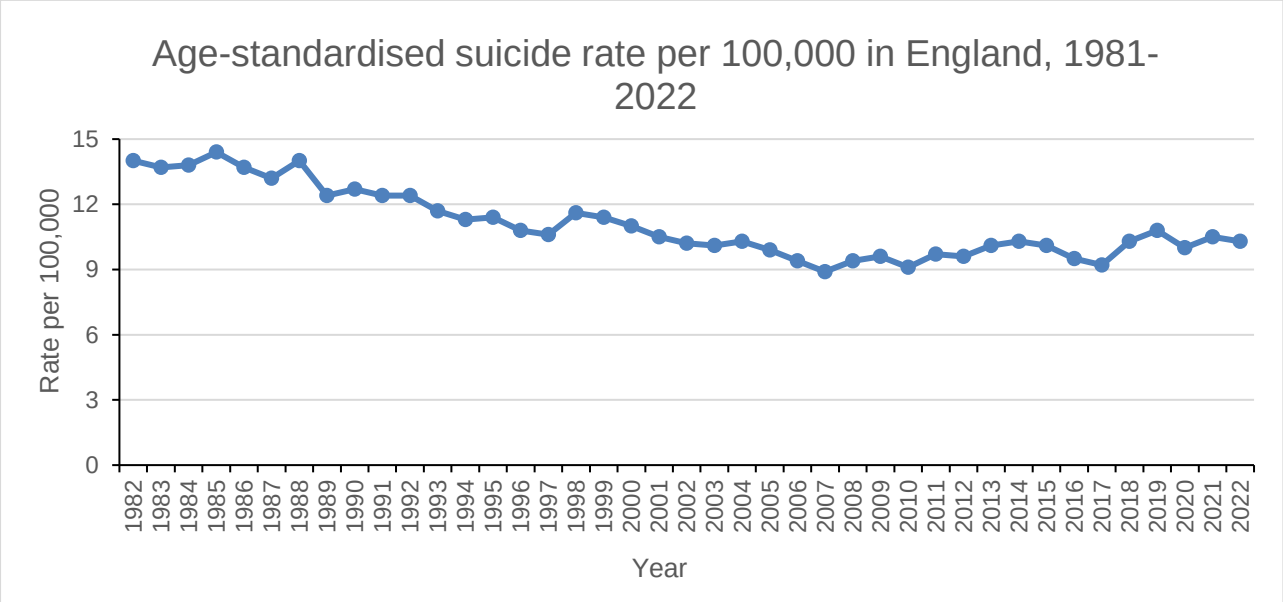
1. Introduction

1.1 Every suicide is preventable

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

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

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



Source: Office for National Statistics (ONS), 2022

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

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

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

1.2 Policy Context

National Context

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

Havering Context

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

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

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

1.3 Purpose and Process

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

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

1.4 Who is at risk and why?

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

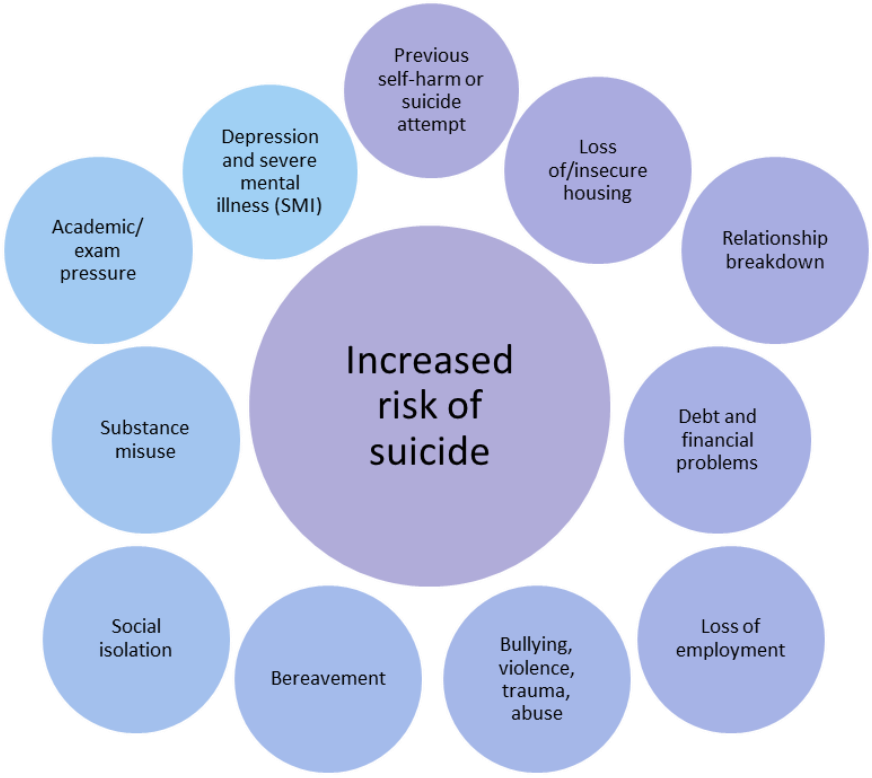


Figure 1: Multiple factors that have been linked to an increase risk of suicide[7]***. Examples of SMI include psychosis and paranoid schizophrenia. NB: Each of the factors can be experienced along with any of the others listed.***

1.5 The impact of suicide

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

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

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

1.6 Inequalities

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

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

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

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

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

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

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

2. Key Findings

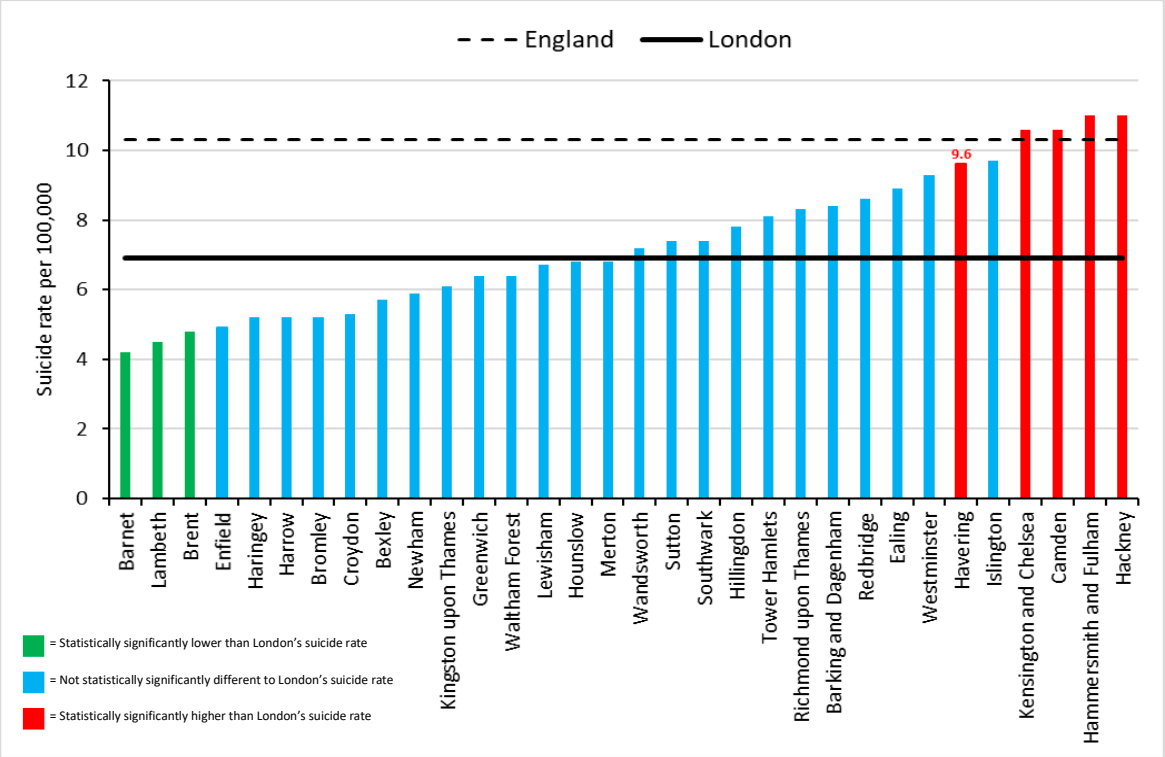
This section presents data on suicide prevalence, sociodemographics, methods and risk factors in Havering, contextualised with national data. While national data shows higher suicide risk among certain population groups, local data is insufficient to identify these differences due to small sample sizes.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

2.1 Suicide Prevalence

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

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

[18] NEL Suicide Prevention Data Dashboard

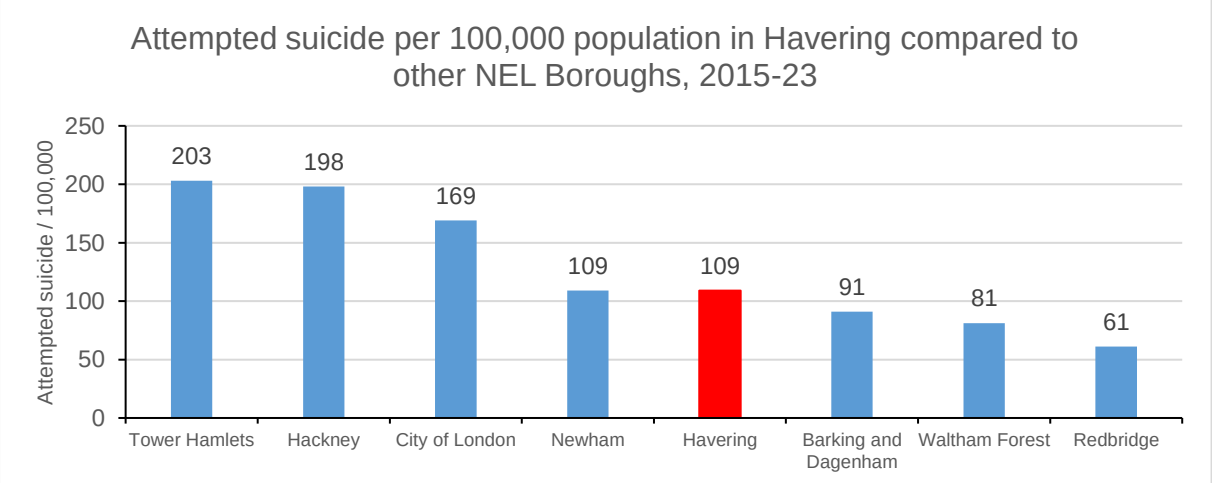


Source: Office for National Statistics (ONS), 2022. **Error! Bookmark not defined.**

2.2 Attempted Suicide

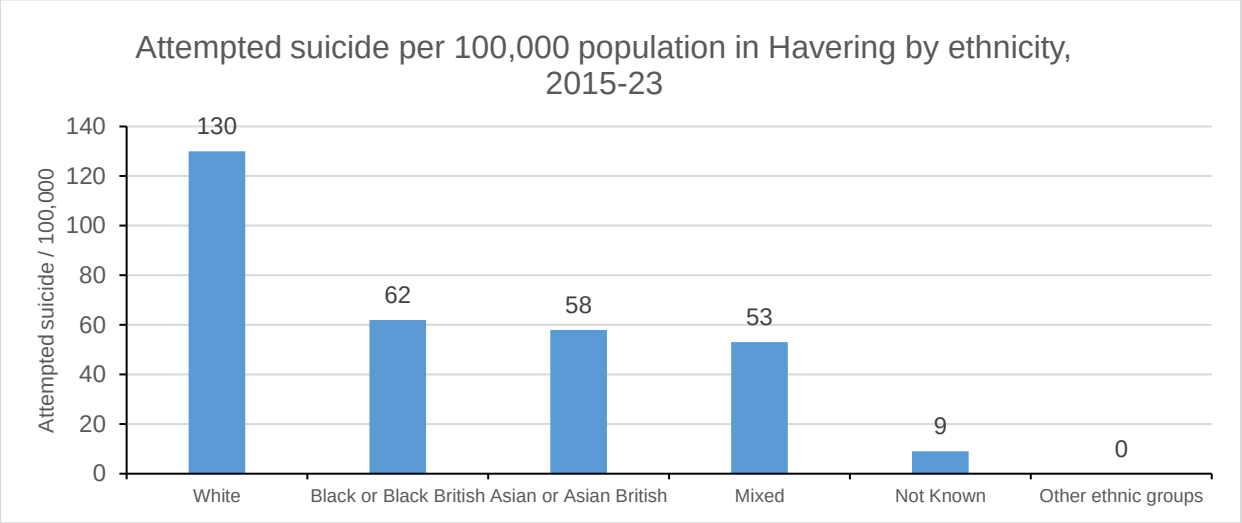
From 2015 to 2023, Havering reported an overall attempted suicide rate of 109 per 100,000, higher than neighbouring NEL boroughs (Barking & Dagenham, Redbridge and Waltham Forest). In Havering, the attempted suicide rate per 100,000 population between 2015 and 2023 was highest in the White population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

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



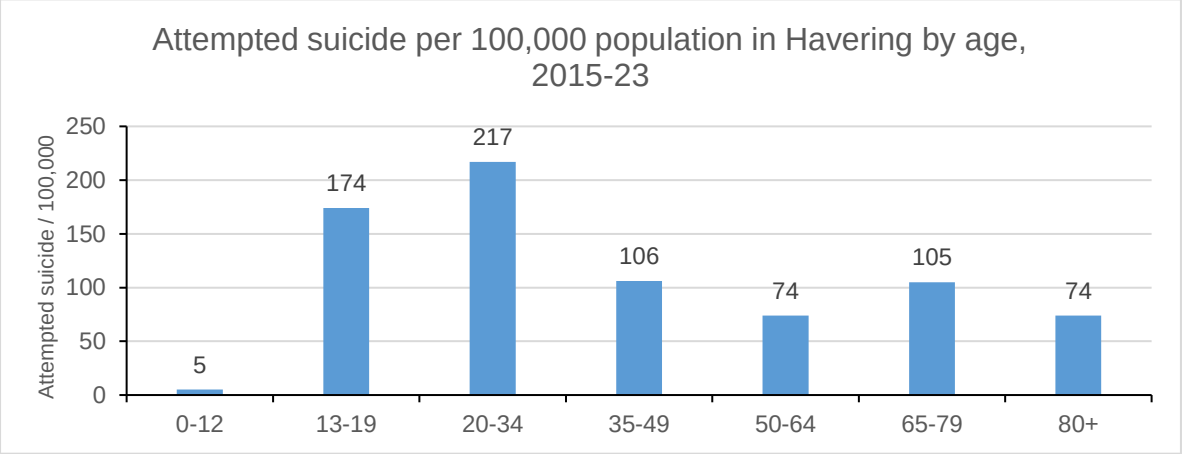
Source: Primary Care Discovery Data Service from the Suicide Prevention NEL Data Dashboard, 2015-23. N.B. This data may not always reflect the actual date of the event, as it might correspond to the date of the encounter with the GP. The primary care observation uses SNOMED code 82313006 – Suicide attempt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

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



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

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



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

2.3 Prevalence by demographic

Suicide rate by gender

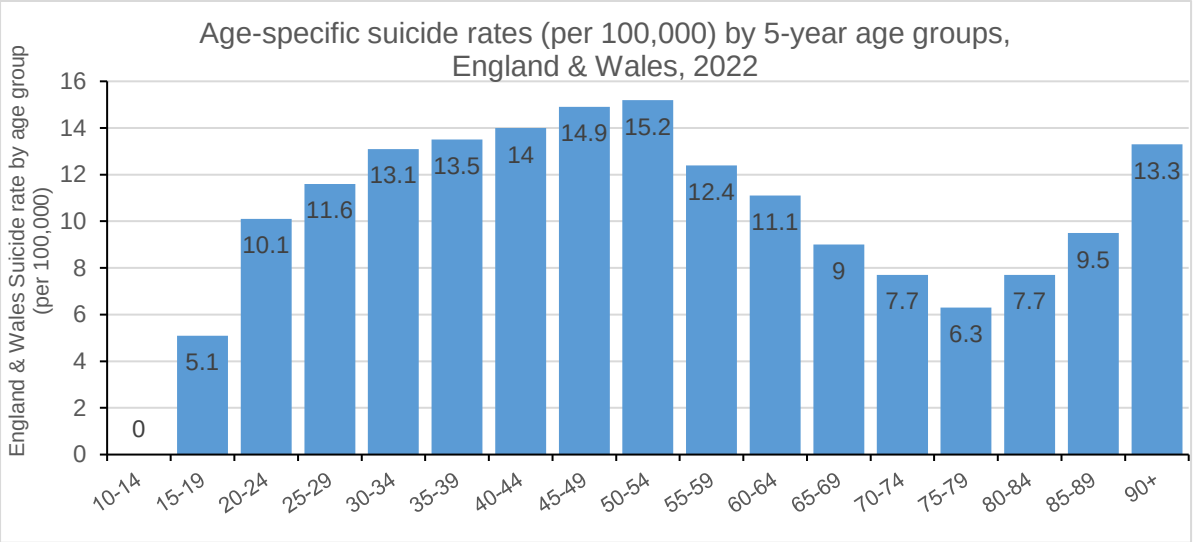
From 2015-16 to 2021-22, the average death by suicide by gender was 73.92% males and 26.08% females. This is similar to the England and Wales data, as three-quarters of suicides registered in England and Wales in 2022 were males (74.1%), equivalent to 16.4 deaths per 100,000[4].

Suicide rate by age

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

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

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



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

Suicide rates by occupation

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

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

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

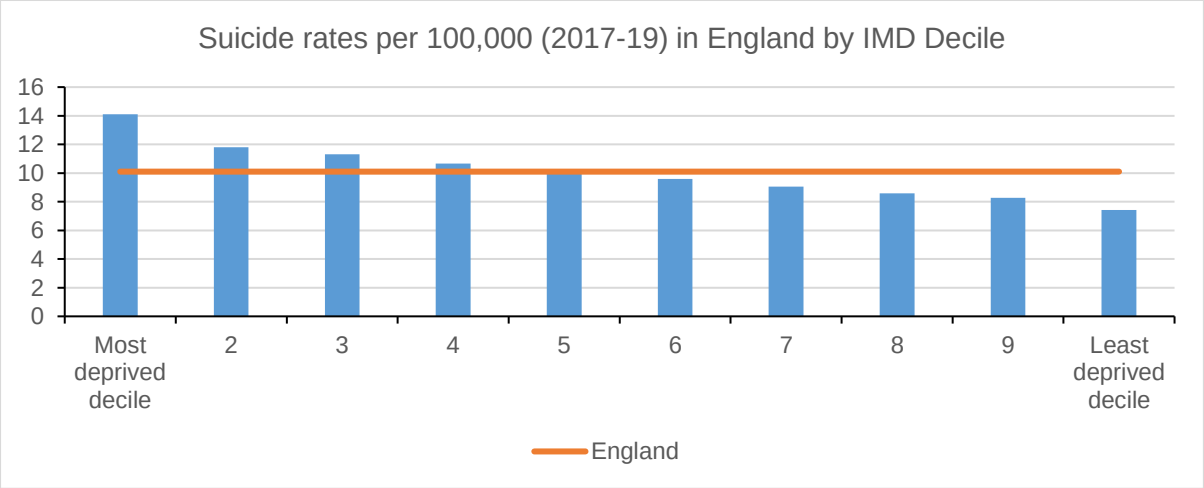
Suicide rates by ethnicity

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

Suicide rates by deprivation

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

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



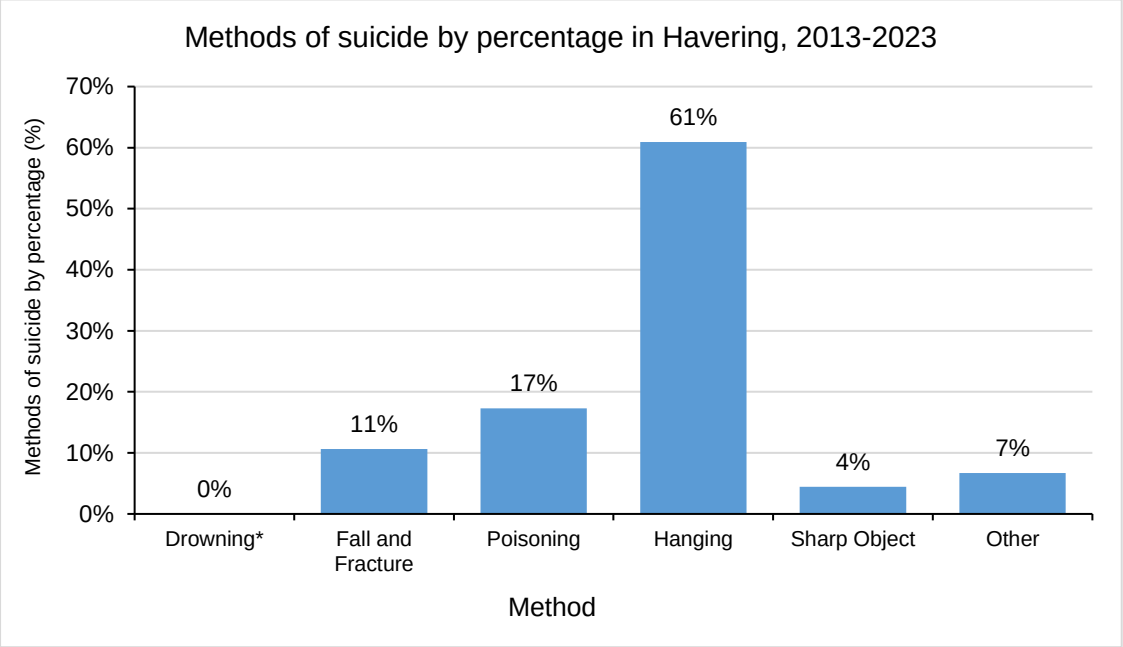
Source: OHID Fingertips Rates of suicide by deprivation decile in England, 2017-19.[22]

2.4 Prevalence of suicide by method

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

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

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



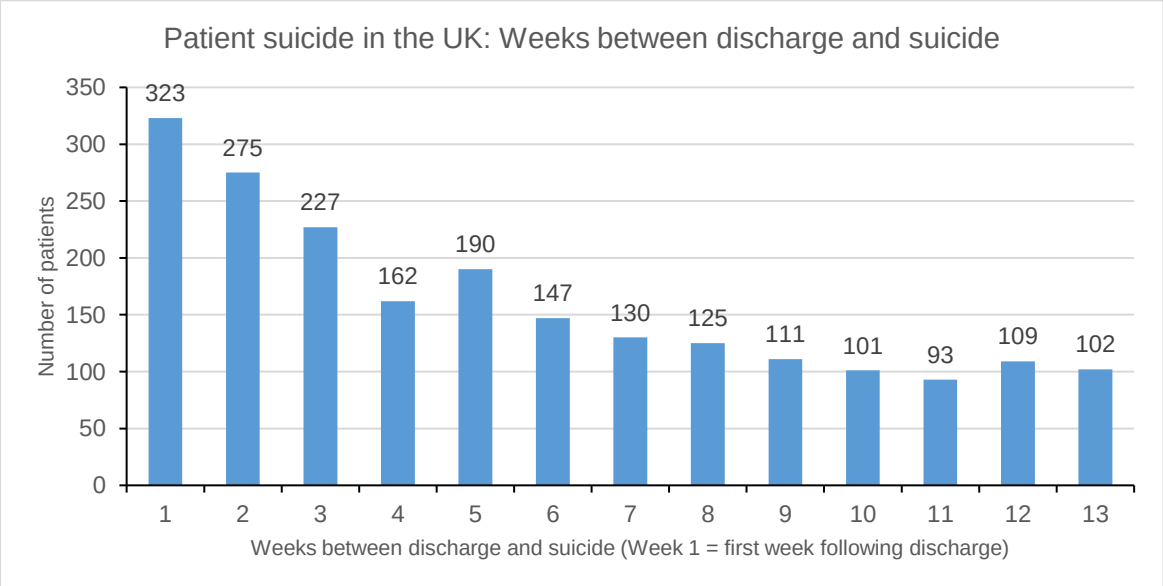
Source: PCMD. Produced by LBH PHI team. N.B. Data on suicides by drowning is suppressed due to the small number of cases (four or fewer) to prevent identification of individuals.

2.4 Prevalence by risk groups

Suicide among people in contact with mental health services

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

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



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

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

Suicide among people who have self-harmed

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

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

Suicide among people diagnosed with severe health conditions

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

Suicide among people diagnosed with Autism

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

Suicide among those in the LGBTQ+ community

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

[24] Royal College of Psychiatrists. *College report CR229: Self-harm and suicide*. Retrieved from https://www.rcpsych.ac.uk
[25] North East London Suicide Prevention. (2018-2023). *Suicide prevention NEL data dashboard*.
[26] Office for National Statistics. *Suicides among people diagnosed with severe health conditions, England: 2017 to 2020*.
[27] Government Events. High suicide rates among neurodiverse individuals: Why it matters and what can be done about it.
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[30] Kidd, G., Marston, L., Nazareth, I. *et al.* Suicidal thoughts, suicide attempt and non-suicidal self-harm amongst lesbian, gay and bisexual adults compared with heterosexual adults: analysis of data from two nationally representative English household surveys. *Soc Psychiatry Psychiatr Epidemiol* **59**, 273–283 (2024)

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

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

Suicide among women in the perinatal period

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

Suicide among those in contact with the criminal justice system

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

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

2.6 Suicide prevention training uptake in Havering

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

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

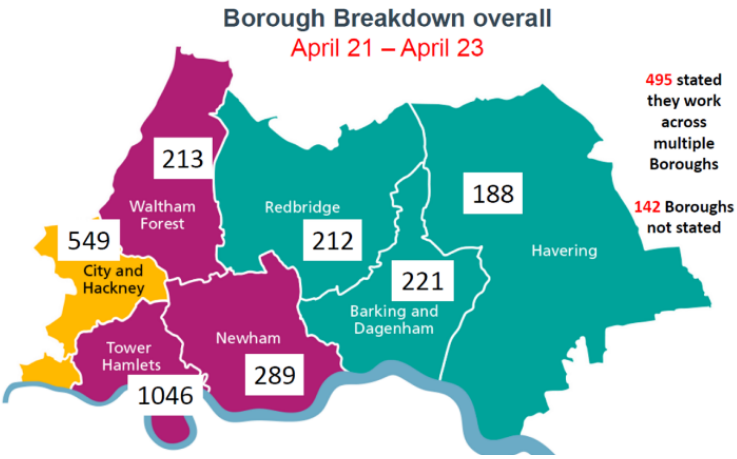

Figure 2: ***Uptake of NEL Training Hub suicide prevention training courses by NEL borough from April 2021-April 2023*** *Source: North East London Training Hub: Multi-Agency Mental Health & Suicide Prevention Training 2021-April 2023.*

3. NEL ICS Level

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

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

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

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

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

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

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

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

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

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

4. Recommendations

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

4.2 Promoting suicide prevention across Havering

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

4.3 Review each death by suspected suicide amongst Havering residents

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

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

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

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

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

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

Contact Person

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Appendices

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

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

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

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

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

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

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

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[39] SMI Adviser & Suicide Prevention Resource Center. *Suicide and serious mental illness: An overview of considerations, assessment, and safety planning*. Zero Suicide. Retrieved from https://zerosuicide.edc.org/resources/resource-database/suicide-and-serious-mental-illness-overview-considerations-assessment

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

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

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

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

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

[51] Probert-Lindström, S., Berge, J., Westrin, A, Öjehagen, A., & Skogman Pavulans, K. (2020). Long-term risk factors for suicide in suicide attempters examined at a medical emergency inpatient unit: Results from a 32-year follow-up study. *BMJ Open, 10*(10).
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[53] West Midlands Police & Crime Commissioner. (2020). *Domestic abuse links to suicide: Rapid review, fieldwork, and quantitative analysis report*. West Midlands Police & Crime Commissioner. Retrieved from https://www.westmidlands-pcc.gov.uk/
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[61] Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.

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

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[67] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (2015). *Suicide in primary care in England, 2002–2011*. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
[68] O'Dwyer, C. (2017). *Unpaid carers and their mental health: Policy brief*. University of Exeter. Retrieved from https://www.exeter.ac.uk/media/universityofexeter/research/policy/briefs/ODwyer_Unpaid_carers_Policy_Brief.pdf
[69] Autistica. (2020). *Personal tragedies, public crisis: Autism and suicide*. Autistica. Retrieved from https://www.autistica.org.uk/downloads/files/Personal-tragedies-public-crisis-ONLINE.pdf

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

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

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

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

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

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

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

Appendix D: Methodology and Data Description for suicide by occupation

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

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

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

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

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

Equality & Health Impact Assessment (EHIA)

Document control

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

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

1. Equality Health Impact Assessment Checklist

About your activity

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

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

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

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

Background/context:

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

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

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

Who will be affected by the activity?

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

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

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

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

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

Overall impact:

The Havering Suicide Prevention Strategy takes into account the needs of different age groups, addressing age-related vulnerabilities associated with suicide, as well as the proportional years of life lost when a younger person dies by suicide. Actions from the strategy will have a positive impact on all age groups, with one of the focuses being on preventing suicide and self-harm in children and young people, who are a national priority group due to the years of lives lost.

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

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

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

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

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

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

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

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

Overall impact:
Overall impact:
The Havering Suicide Prevention Strategy will be published electronically to ensure that it is fully accessible to people who are partially sighted or blind. Accessibility standards to enable assisted technology will be considered and worked towards prior to publication of the final version of the strategy. An easy read version of the strategy will also be published.

Furthermore, the Strategy includes considerations for suicide prevention concerning individuals living with disabilities and long-term conditions. Public health will raise awareness of suicide prevention to services that are working with different vulnerable groups, such as the Autism Hub in Liberty Mall (provided by Sycamore Trust) and the Havering Carer's Hub, which supports carers of autistic individuals. These services will then disseminate the information we share with those they support and work with.

The distribution of suicide prevention training to the Havering workforce, especially those engaging with high-risk groups (including those with learning disabilities) will improve awareness of suicide and its associated risk factors.

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

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

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

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

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

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

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

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

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

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

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

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

Evidence:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sources used:
Stonewall YouGov survey
https://www.stonewall.org.uk/lgbt-britain-health

Protected Characteristic - Gender reassignment: Consider people who are seeking, undergoing or have received gender reassignment surgery, as well as people whose gender identity is different from their gender at birth		
Please tick (✓) the relevant box:		**Overall impact:** The Havering Suicide Prevention Strategy's actions will benefit those seeking, undergoing or have receive gender reassignment surgery, as well as people whose gender identity is different from their gender at birth. As mentioned above, the Strategy will work closely with LGBTQ+ organisations through distributing suicide prevention training to organisations and also promoting specific LGBTQ+ training, which includes gender reassignment. The steering group will also include those will lived experience from the LGBTQ+ community, so the action plan will be reviewed and amended by the steering group to inform inclusive actions. The London Borough of Havering is developing a suspected suicide review panel, chaired by public health, which will support our surveillance function by analysing information from the London RTSSS, as part of the Havering Suicide Prevention Strategy. Any learning from this panel should be shared with the transitions panel in the event that suspected suicide was an individual who identified as transgender.
Positive	✓	
Neutral		
Negative		
Evidence: People identify as non-binary or transgender are at an increased risk of suicide and self-harm. Almost half of trans people (46 per cent) have thought about taking their own life in the last year. This is compared to one in twenty adults in the general population who reported thoughts of taking their own life in the past year and fewer than one per cent said they attempted to take their own life in the last year (according to research for NHS Digital).Forty-one per cent of non-binary people said they harmed themselves in the last year compared to 20 per cent of LGBT women and 12 per cent of GBT men. This is compared to around six per cent of adults in the general population who said they had self-harmed in the last year (according to research for NHS Digital).		
Sources used: Stonewall YouGov survey https://www.stonewall.org.uk/lgbt-britain-health		

Protected Characteristic – Marriage / civil partnership: Consider people in a marriage or civil partnership		
Please tick (✓) the relevant box:		**Overall impact:** The Strategy is inclusive of people of all relationship types. If people suffer relationship breakdown then this is a suicide risk factor. However, people in a marriage and civil partnership that is stable are going to be impacted neutrally by the suicide prevention strategy.
Positive		
Neutral	✓	
Negative		
Evidence: N/A		
Sources used: N/A		

Protected Characteristic - Pregnancy, maternity and paternity: Consider those who are pregnant and those who are taking maternity or paternity leave		
Please tick (✓) the relevant box:		**Overall impact:** The Havering Suicide Prevention Strategy aims to address the needs of pregnant and postpartum women by promoting suicide prevention services and training opportunities, particularly targeting services/organisations with
Positive	✓	

Neutral		women during the perinatal period (e.g. GPs, midwives, council workforce incl. housing, health visitors). Public Health will also raise awareness of different vulnerable groups and the services available for women in the perinatal period e.g. Mums Matter (perinatal support provided by Mind).
Negative		

Evidence:
Maternal suicide is still the leading cause of direct (pregnancy-related) death in the year after pregnancy. Almost a quarter of all deaths of women during pregnancy or up to a year after the end of pregnancy were from mental health-related causes. Assessors felt that improvements in care might have made a difference in outcome for 67% of women who died by suicide.

Sources used:
MBRRACE-UK published their latest Confidential Enquiry into Maternal Deaths in the UK and Ireland. “Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19"

Socio-economic status: Consider those who are from low income or financially excluded backgrounds

Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	The Havering Suicide Prevention Strategy will promote targeting services/organisations in contact with people in financial difficulties (e.g. Council workforce incl. housing, food banks, citizen’s advice bureau, DWP / Job Centres, community hubs financial support services and debt advice, housing associations). Public Health will raise awareness of different vulnerable groups and the services available for people in financial difficulties such as Harold Hill Community Hub and promote evidence-based approaches to improving mental health in specific groups e.g. alternative crisis support through housing team.
Neutral		
Negative		

Evidence:
Suicide is complex and is rarely caused by one thing. However, there is strong evidence of associations between financial difficulties, mental health and suicide. Struggling to make ends meet can lead to feelings of anxiety and shame. These feelings can themselves affect our motivation and ability to manage our money, and some people may experience a sense of entrapment or loss of control. All of these feelings are associated with suicide. Not everyone will experience these stressors equally, with those already in lower income households or with pre-existing mental health conditions likely to be among those worst impacted. More specifically, we know that men in the lowest social class, living in the most deprived areas, are up to ten times more at risk of suicide than those in the highest social class, living in the most affluent areas. Economic risk factors that can increase someone’s risk of suicide include living in areas of deprivation, being in debt, being homeless or facing homelessness, living in poor quality or insecure housing.

Sources used:
Samaritans report: Insights from experience: economic disadvantage, suicide and self-harm

Health & Wellbeing Impact:
Consider both short and long-term impacts of the activity on a person’s physical and mental health, particularly for disadvantaged, vulnerable or at-risk groups. Can health and wellbeing be positively promoted through this activity?

Please tick (✓) all the relevant boxes that apply:		**Overall impact:**
Positive	✓	The Havering Suicide Prevention Strategy promotes health and wellbeing positively; it has short-term impacts: increased awareness, working with partners to increase crisis intervention, work with partners to increase access to services, reduce stigma and promote community resilience. Regarding long-term impacts, the strategy works for sustained mental health improvements and a reduction in suicide rates.
Neutral		

Negative		**Do you consider that a more in-depth HIA is required as a result of this brief assessment?** **Yes** ☐ **No** ✓

Evidence:
Public health measures aimed at limiting access to methods of suicide and enhancing care for individuals at risk have contributed to a reduction in the national suicide rate since the 1980s. Suicide is preventable and it is our collective responsibility to do all that we can to reduce deaths through suicide. This must be through a multi-agency approach bringing together the Council, primary care and secondary care services, voluntary and community sector organisations as well as communities and individuals. A strategy that is to succeed in reducing suicide deaths needs to combine a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. We need to ensure that suicide prevention and mental health are everyone's business.

Distributing suicide prevention training to the Havering workforce as widely as possible particularly to those working with high-risk groups will raise awareness of suicide and self-harm, the risk factors, provide people with the confidence to have important conversations around suicide, and ensure that those working with people who may be at risk of suicide can recognise warning signs and assist in a crisis.

Reduce suicide rates in priority groups by raising awareness of evidence based approaches, services and training opportunities tailored to improving mental health in specific groups providing people with crisis support and other forms of support they need around broader risk factors for suicide e.g. economic risk factors, reducing stigma & encouraging help seeking behavior. Tailored support is available to priority groups in times of need e.g. Grief in Pieces (bereavement support service for those impacted or bereaved by suicide in NEL).

Suspected suicides reviewed by the panel should identify if anything could have been done to reduce access to the means of suicide e.g. ligatures, medications especially if the individual was a service user. The panel could also identify if communication between services in contact with the individual could have been improved. Suspected suicides that occur in public places will be reviewed by the panel to identify any lessons that can be learnt with the involvement of Planning and Network rail. Making Havering a safer place through borough design to reduce access to means of suicide e.g. tall places and railways.

Suicides in Havering should be reported sensitively without personal identifiable information or information regard location or method of suicide to prevent imitational suicidal behaviour or contagion. Media reports should also be used as an opportunity to promote suicide prevention services and training.

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

3. Health & Wellbeing Screening Tool

Will the activity / service / policy / procedure affect any of the following characteristics? Please tick/check the boxes below

The following are a range of considerations that might help you to complete the assessment.

Lifestyle YES ☐ NO ☒	**Personal circumstances** YES ☒ NO ☐	**Access to services/facilities/amenities** YES ☒ NO ☐
☐ Diet	☐ Structure and cohesion of family unit	☐ to Employment opportunities
☐ Exercise and physical activity	☐ Parenting	☐ to Workplaces
☐ Smoking	☒ Childhood development	☐ to Housing
☐ Exposure to passive smoking	☒ Life skills	☐ to Shops (to supply basic needs)
☐ Alcohol intake	☐ Personal safety	☐ to Community facilities
☐ Dependency on prescription drugs	☐ Employment status	☐ to Public transport
☐ Illicit drug and substance use	☐ Working conditions	☐ to Education
☐ Risky Sexual behaviour	☐ Level of income, including benefits	☒ to Training and skills development
☐ Other health-related behaviours, such as tooth-brushing, bathing, and wound care	☐ Level of disposable income	☒ to Healthcare
	☐ Housing tenure	☐ to Social services
	☐ Housing conditions	☐ to Childcare
	☐ Educational attainment	☐ to Respite care
	☐ Skills levels including literacy and numeracy	☐ to Leisure and recreation services and facilities
Social Factors YES ☒ NO ☐	**Economic Factors** YES ☐ NO ☒	**Environmental Factors** YES ☒ NO ☐
☒ Social contact	☐ Creation of wealth	☐ Air quality
☒ Social support	☐ Distribution of wealth	☐ Water quality
☐ Neighbourliness	☐ Retention of wealth in local area/economy	☐ Soil quality/Level of contamination/Odour
☒ Participation in the community	☐ Distribution of income	☐ Noise levels
☐ Membership of community groups	☐ Business activity	☐ Vibration
☐ Reputation of community/area	☐ Job creation	☐ Hazards
☐ Participation in public affairs	☐ Availability of employment opportunities	☐ Land use
☐ Level of crime and disorder	☐ Quality of employment opportunities	☐ Natural habitats
☐ Fear of crime and disorder	☐ Availability of education opportunities	☐ Biodiversity
☐ Level of antisocial behaviour	☐ Quality of education opportunities	☐ Landscape, including green and open spaces
☐ Fear of antisocial behaviour	☐ Availability of training and skills development opportunities	☒ Townscape, including civic areas and public realm
☒ Discrimination	☐ Quality of training and skills development opportunities	☐ Use/consumption of natural resources
☒ Fear of discrimination	☐ Technological development	☐ Energy use: CO2/other greenhouse gas emissions
☐ Public safety measures	☐ Amount of traffic congestion	☐ Solid waste management
☐ Road safety measures		☐ Public transport infrastructure

4. Outcome of the Assessment

The EHIA assessment is intended to be used as an improvement tool to make sure the activity maximises the positive impacts and eliminates or minimises the negative impacts. The possible outcomes of the assessment are listed below and what the next steps to take are:

Please tick (✓) what the overall outcome of your assessment was:

✓	1. The initial screening exercise showed a strong indication that there will be no impacts on people and need to carry out an EHIA. 2. The EHIA identified **no significant concerns** OR the identified **negative concerns** have already been **addressed**		**Proceed with implementation** of your activity
	3. The EHIA identified some **negative impact** which still needs **to be addressed**		**COMPLETE SECTION 5:** **Complete action plan** with measures to mitigate the and finalise the EHIA
	4. The EHIA identified some **major concerns** and showed that it is **impossible to diminish negative impacts** from the activity to an acceptable or even lawful level		**Stop and remove** the activity or **revise** the activity **thoroughly.** **Complete an EHIA on the revised proposal.**

5. Action Plan

The real value of completing an EHIA comes from identifying the actions that can be taken to eliminate/minimise **negative** impacts and enhance/optimise positive impacts. In this section you should list the specific actions that set out how you will mitigate or reduce any **negative** equality and/or health & wellbeing impacts, identified in this assessment. Please ensure that your action plan is: more than just a list of proposals and good intentions; if required, will amend the scope and direction of the change; sets ambitious yet achievable outcomes and timescales; and is clear about resource implications.

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
Age Disability Sex/Gender Ethnicity/Race Religion/faith Sexual orientation Gender reassignment Pregnancy Socioeconomic status	By 2030, we should expect to see an improvement in suicide prevention efforts relating to age, including for, but not limited to, middle-aged men and increased prevention efforts in schools for children and young people. By 2030, we should expect to see an improvement in suicide prevention efforts relating to disability, increased working with carers, working with different sexes, genders, religion groups, members of the LGBTQ+	• Public Health will work with PCN Leads to increase uptake of suicide prevention training among primary care staff, making sure they know that middle-aged men are at highest risk and they understand inequalities that contribute to the distribution of suicide risk factors. • Public Health Team to ensure that anchor organisations (e.g., the NHS, schools, police, fire service) to ensure that frontline staff receive support for dealing with the impact of suicide in their profession. • Public Health Team to encourage partners to promote suicide prevention training for community members that support people who have an increased risk of suicide or self-harm, or that provide support to people around distressing life events.	Outcomes include: a) embedding changes in the Havering system through an all systems approach b) introducing an approach which makes suicide prevention everyone's business, tapping into professions that have not been prioritized before Monitoring: • Suicide rates by age group • Suicide rates by disability	5 years, annual reviews and suicide panel annual report	Sam Westrop, Assistant Director of Public Health

	community, those who are pregnant or have recently had a child, and those from lower socioeconomic statuses.	• Children and Young People's Emotional Wellbeing and Mental Health Strategy is planned and planned to include young adults who are care experienced (up to age 25) in transition to adults services. • Public Health to form a reference group comprising selected professionals and individuals with lived experience to provide feedback on documents produced and activities led by the suicide prevention public health team, leveraging existing connections with established groups. This group will aim to include members with disabilities, carers, those of different sex and genders, members of the LBGTQIA+ community, those who have experienced perinatal depression, those from all socioeconomic status to ensure diversity of insights and feedback.	• Suicide rates by ethnicity • Suicide rates by religion • Suicide rates by sexual orientation • Suicide rates in perinatal • Suicide rates by socioeconomic status		

6. Review

In this section you should identify how frequently the EHIA will be reviewed; the date for next review; and who will be reviewing it.

Review: The EHIA will be reviewed upon the refresh of the Suicide Prevention Strategy.

Scheduled date of review: February 2030

Lead Officer conducting the review: Suicide Prevention Lead, Public Health Team

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:
Joint Havering Dementia Strategy 2024-2029

Board Lead:
Barbara Nicholls, Strategic Director of People

Report Author and contact details:
Kirsty Boettcher, Deputy Director of Havering Place, NEL ICB k.boettcher@nhs.net

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

This report provides an overview of the Joint Dementia Strategy for Havering, 2024-2029. Dementia remains a key national and local priority. It is therefore important that a locally agreed Joint Strategy is in place.

The strategy was approved and adopted by Cabinet in November 2024.

RECOMMENDATIONS

Members of the HWBB are asked to:

- Note the contents of the report and the accompanying Strategy.
- Adopt the local Joint Dementia Strategy for Havering.

REPORT DETAIL

Background

Dementia and dementia services remain a key national priority, and key related areas, such as the dementia diagnosis rate, are coming under significant scrutiny. Within the National Dementia Strategy: 'Living Well with Dementia: A National Strategy' (DH, 2009), Objective 14 sets out the requirement for every local area to have a joint commissioning strategy in place for dementia. The strategy has been developed to meet the national requirement, and most importantly, to set out a locally agreed vision, strategy and plan which is publicly accessible for the residents of Havering.

Process of Strategy Development

The strategy has been developed in partnership with key commissioning stakeholders, and Havering Integrated Team.

Engagement sessions have been undertaken with groups of people with dementia and their carers, and key issues and themes which they have identified so far have been included within the Strategy. These issues include:

- Need for a range of accessible, advertised information about services and support available
- Mixed experiences of accessing help and support from primary care, and the need for an increased awareness of the needs of people with dementia and their carers in primary care

Summary of key areas contained within Strategy

The Strategy sets out the local vision and principles to be achieved within Havering, and this is aligned to the Havering Health and Wellbeing Strategy.

This includes the intention to seek every opportunity for commissioners to test out the following outcome statements:

- I was diagnosed early
- I understand, so I make good decisions and provide for future decision making
- I get the treatment and support which are best for my dementia and my life
- Those around me and looking after me are well supported
- I am treated with dignity and respect
- I know what I can do to help myself and who else can help me
- I can enjoy life

- I feel part of a community and I'm inspired to give something back
- I am confident my end of life wishes will be respected

The Strategy also includes detail about:

1. The current provision and range of services within the locally agreed pathway
2. The intentions to raise public awareness and understanding of dementia, via the work of the Havering Dementia Action Alliance, JoyApp website, GP's and support of the forthcoming national Public Health England Dementia Friends Campaign.
3. How we are striving to improve the local dementia diagnosis rate, via training for GP's and primary care staff, ongoing work with Public Health, undertaking individual practice visits to provide support, piloting an iPad based dementia assessment tool in primary care and developing information sharing processes across the whole system.
4. How we are working with NELFT, as the provider of the Memory Service, to develop a revised model of service delivery, including an integrated community-based service model working with local organisations to deliver different types of support.
5. Services which are currently commissioned to enable people to live well with dementia, which includes the Dementia Advisory Service, peer support, respite care, extra care housing, and care in residential and nursing homes.
6. The work being undertaken with BHRUT to improve services within the hospital for people with dementia.
7. Intentions in relation to End of Life care, including the provision of Gold Standards Framework

IMPLICATIONS AND RISKS

Financial implications and risks:
There are no direct financial implications, as a result, of approving the Joint Dementia Strategy.

However, a number of services underpinning the delivery of the strategy are funded on a time-limited basis, and it will be vital to monitor and review these services to ensure outcomes are achieved, as well as making timely decisions as to future funding, and if necessary to agree exit strategies with providers.

Legal implications and risks:
The Council has various duties under the Care Act 2014

- to promote wellbeing (s1)
- preventing needs for care and support (s2)
- promoting the integration of health and care provision with its health partners (s3)
- providing information and advice for adults with needs for care and support and their carers (s4)
- meeting the needs of adults who require care and support (s18)

Under the National Health Service Act 2006 s 2B The Council has the duty to take such steps as it considers appropriate for improving the health of the people in its area, which includes:

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 Dementia Strategy fulfils these duties.

Otherwise the recommendations made in this report do not give rise to any identifiable Legal implications or risks.

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

Equalities implications and risks:
Havering has a diverse community made up of many different groups and individuals. The council values diversity and believes it essential to understand and include the different contributions, perspectives and experience that people from different backgrounds bring.

The Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010 requires the council, when exercising its functions, to have due regard to:

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

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

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

People with dementia and their carers are amongst the most vulnerable in society. It is therefore vital that they are informed and supported to access the full range of high quality services available to them, in order that they live well with their dementia.

An EqHIA (Equality and Health Impact Assessment) is usually carried out and on this occasion this isn't required.

The Council seeks to ensure equality, inclusion, and dignity for all in all situations.

There are not equalities and social inclusion implications and risks associated with this decision.

Health and Wellbeing implications and Risks
The recommendations made in this report do not give rise to any identifiable Health and Wellbeing risks. The renewal of the strategy with new information and the commitment to use this strategy to deliver high quality dementia care will have positive implications on

health and wellbeing outcomes of the residents suffering from dementia and their families and carers.

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

Joint Dementia Strategy 2024-2029

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Havering Joint Dementia Strategy 2024 - 2029

Developed by the Havering Integrated Care Partnership (part of the North East London Health and Care Partnership) – a partnership of NHS, Local Authority, care and community and voluntary sector leads in Havering

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Foreword

Dr Maurice Sanomi, GP and Havering Partnership Mental Health Clinical Lead

I feel privileged and delighted to be writing this foreword for our Joint Strategy which sets out a clear vision for Dementia, in Havering, over the next 5 years.

As a GP and Mental Health Lead, I am acutely aware of the challenges we face in Havering, with regards to Dementia, giving our high elderly population, which continues to rise, compared to the rest of London.

The strategy sets out **our ambitions** and our shared vision; it builds on our experience of collaborating with stakeholders to care for, and support people living with dementia, their families, and their carers.

It also builds on our achievements and the lessons learnt from our previous strategy.

Our vision for Dementia care is "to *make sure that people with dementia, their families and carers are supported to live life to their full potential*."

The strategy sets out **our principles** which include putting people living with dementia, their families and carers at the centre of what we do and to ensure we listen to them and engage with them and their families and carers. This is to support and enable them to make decisions, and informed choices about their care and their lives.

It has taken time and resources along with contribution and dedication from various stakeholders to put this strategy together. We have consulted widely with stakeholders to enable us to understand more clearly the current state of Dementia care in Havering, and the relevant issues. It has enabled us to develop a strategy fit for purpose, in our quest to improve Dementia care for our local population.

We are confident that this Joint Strategy will go a long way to improve Dementia care, both before diagnosis and after diagnosis. It will enhance care and support for our people living with dementia and their carers.

We have set the strategy around five key priorities which are, *preventing well, diagnosis well, supporting well, living well, and dying well.*

As we know, Dementia does not just affect the person with the diagnosis, it affects all of us; both the immediate families and carers and impacts the wider society through increasing health and social care costs. It is therefore essential for us to work together, to ensure we deliver on our priorities within the Joint Strategy

The Joint Strategy sets out **key outcomes** along with an **action plan** for delivering these outcomes; we hope this strategy will bring along the much-needed positive steps towards improving Dementia care, all round, for our Havering population.

We are conscious of the pressures experienced across the entire system in terms of resources, but at the same time we are hopeful that the changes in government policy and the increasing investment in Dementia Care will help us deliver our strategy for Dementia Care in Havering within the limited resources available.

We therefore need all hands to be on deck to deliver on the ambitions set out within this strategy; I appreciate that it will not be easy, but where there is sincerity of purpose and a shared vision, as we all have in developing this Joint Strategy, nothing is impossible.

Lastly, I would like to thank all our stakeholders (individuals and organisations), and everyone who has one way or the other contributed to making this Joint Strategy possible.

Foreword

Cllr Gillian Ford, Lead Member for Health, London Borough of Havering

I would first of all thank Havering Dementia Partnership Board, people with lived experiences and the numerous groups and organisations who have all contributed to development of The Havering Dementia Strategy.

Since the last Dementia Strategy we continue to see growth in Dementia internationally, in part due to an ageing population, making it the most prevalent health issue. We have also seen the government introduction of the Integrated Care System: Havering is part of the North East London ICS. This provides a greater opportunity to work with partners and the Havering Place Based Partnership Is working collaboratively with health partners, care providers, Healthwatch and the voluntary sector, to support people living with dementia and recognise the need for support for people who are in caring roles.

The aim of this strategy is to raise the profile and importance of dementia care and support, to recognise the positive improvement that has taken place and to outline the areas that need greater focus and change. The Partnership is committed to using this strategy to deliver high quality dementia care and support and have appointed a dedicated dementia lead through the Primary Care Network.

Executive Summary

The overall aim of this strategy is to raise the profile and importance of dementia care and support, and to build on the progress that Havering has already made in improving the lives of those with dementia. It is vital that the public, stakeholders, commissioners and providers develop a shared vision of aspirations for the future with regard to dementia care and services. This is particularly crucial to Havering, given the ageing population and anticipated rise in the numbers of people with a diagnosis of dementia.

Up to 40% of dementia is considered potentially preventable. What is good for the heart is also good for the brain, which is why the strategy will also include actions to tackle high blood pressure, physical inactivity, alcohol and obesity, and to promote healthy eating.

The government has already announced other measures which will help those with dementia, including:-

- ✓ the integration white paper to better link health and social care systems
- ✓ the Health and Care Act, which will put the person at the centre of care, with local systems designed to deliver seamless care and support people in retaining their independence, health and wellbeing
- ✓ levelling up healthcare and reducing disparities across the country so everyone has the chance to live longer and healthier lives, wherever they come from and regardless of their background

Our Vision

Our vision is to make sure that people with dementia, their families and carers are supported to live life to their full potential. We want the people in Havering to be able to say:-

- I can live a life of my own
- I live in a dementia friendly community
- I know who/where to turn to for information, support and advice
- I have access to timely and accurate diagnosis, delivered in an appropriate way
- I have access to the right support that enables me to live well at home for as long as possible
- My voice is heard, listened to, and is taken into account in relation to my own health and wellbeing
- I know that when the time comes, I can die with dignity in the place of my choice

Our Principles

We will strive to:

- Listen to and engage with people with dementia and their carers
- Enable and facilitate people to make informed choices and exercise choice and control over their lives
- Involved people in decisions about their lives
- Support people to access the right services at the right time
- Involve, engage and support carers
- Strive to tackle the stigma associated with dementia
- Commission integrated services which are straightforward to navigate and access support
- Support people living with dementia in the work place and those who care for someone living with dementia
- Advise on technological support, equipment and adaptations

What we have Achieved through 2017-2020 Strategy

This strategy builds on the work of the previous 2017-2020 Dementia strategy and the learning from this.

- ✓ Dementia Friendly status by the Alzheimer's Society
- ✓ Dementia Cafés
- ✓ More awareness about dementia
- ✓ Linking person with the diagnosis to their carer on IT systems
- ✓ Dementia and Delirium Team at BHRUT
- ✓ Breakthrough in treatment with drugs to manage the progression of the disease
- ✓ More support networks run by volunteers who have experience with living and looking after someone with dementia
- ✓ Havering Dementia Action Alliance
- ✓ Prevention and Wellbeing contract commissioned with the Alzheimer's Society
- ✓ Joint Carers Strategy

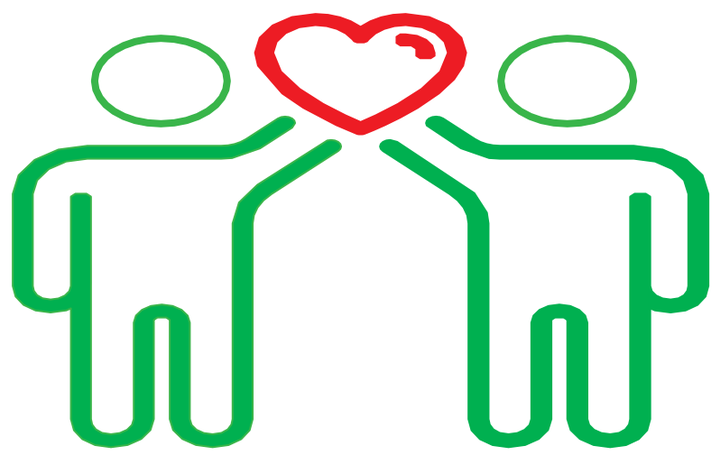
Development of this strategy

Development of this strategy has involved input from a number of key leads, local people, and groups.

A Dementia World Café Event was held in September 2023 and May 2024, which included ex carers, GPs, Managers of different service provisions and voluntary organisations who come into contact with people with a diagnosis of dementia and their carers.

These included:-

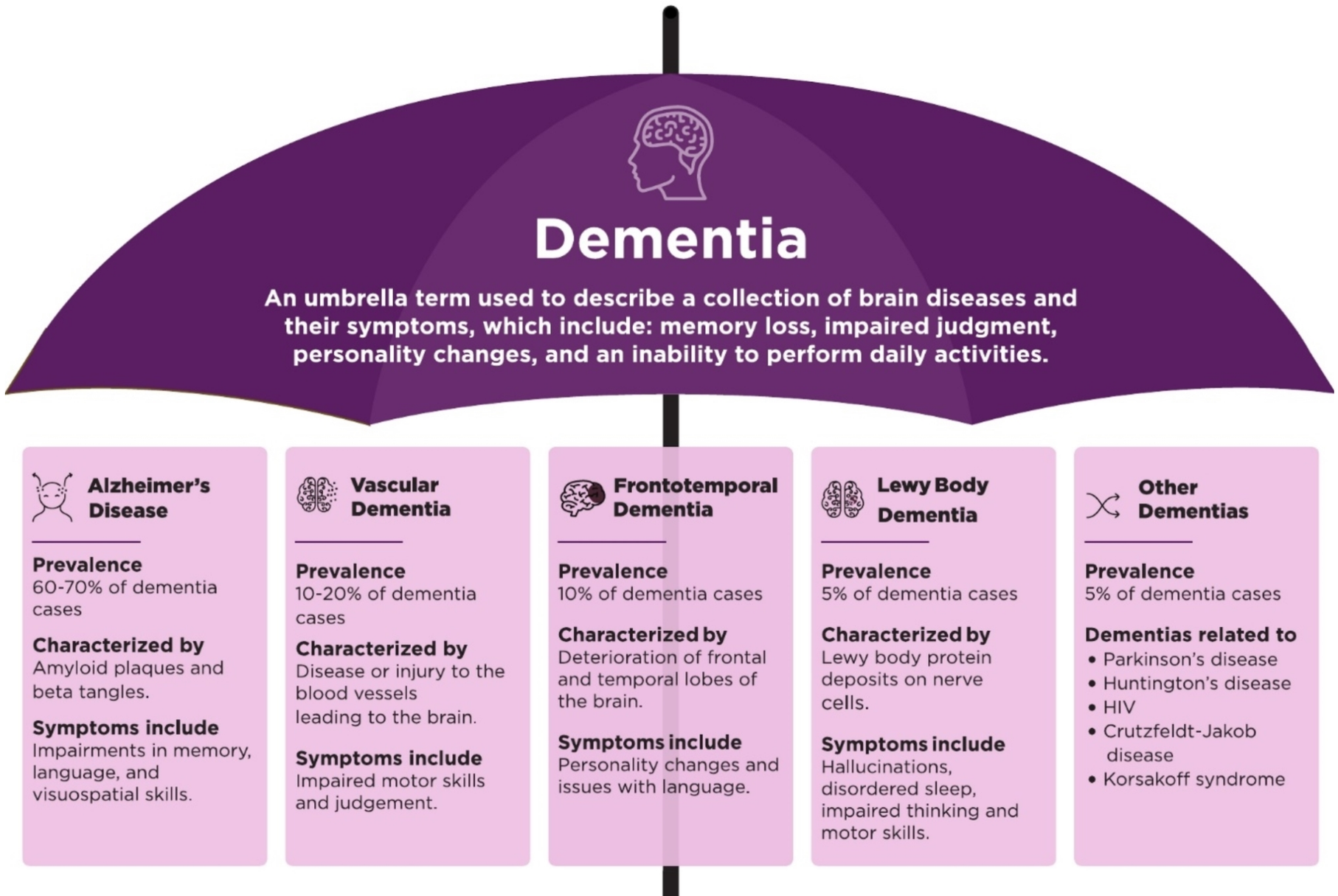
- The Havering Dementia Carers Group
- Singing for the Brain Group
- Age UK
- Councillor Gillian Ford
- Havering Over 50's Forum
- St Francis Hospice
- Dr Maurice Sanomi/ Dr Uzma Haque
- Havering Carers Hub
- Carers
- Havering dementia operational working group (system wide)



Through these groups it became clear that what was needed and could be put in place reasonably quickly, was a one page summary of information sheet at the point of diagnosis giving information about the support that is available in Havering.

What is Dementia?

Dementia is the broad term used to describe a number of different conditions affecting the brain that will trigger the decline of brain functioning over a period of time. Here are the most common types of dementia.



Dementia data nationally

Dementia – The National Picture

The number of people with dementia is expected to increase to one million in the UK this year, 1.6m by 2040 and two million by 2051. There will be over 200,000 diagnoses this year, equated to one in six people over 80 live with dementia and 1:79 of the total population. (source Alzheimer's UK).

National data also suggests that:

- 1 in 4 acute beds have a patient with dementia
- Readmissions - 25% for those with dementia to non-dementia of 17%
- 35% increase in ED presentations in people with dementia in the last 5 years
- Average length of stay for admissions of people with dementia is three times that of admissions for people without dementia.
- A significant number of admissions from care homes have an underlying condition of dementia.

The pandemic has had a considerable impact on people living with dementia with acute hospitals reporting more behaviour incidents in Emergency Departments, care homes requesting 1-1s and local carers advising they have and are still struggling with their care responsibilities due to increased agitation and challenging behaviour of the cared for and having to offer 24-hour care with services suspended during COVID with no breaks.

Acute Admission and Dementia

Most of the dementia related admissions are due to lack of intervention at the right time leading into crisis. With proper support to carers, care home and the nursing home staff and crucially being responsive when needed, this will reduce Emergency Department presentation and ultimately non-elective bed use. It is also much better for the patient to remain at home as stays in an acute bed have a very negative impact of those dementia including increased confusion, distress agitation and delirium and as stated earlier this ultimately leads to a longer length stay. This leads to a decline in functioning and independence when the patient returns home.

What the data tells us about dementia in Havering

Prevalence Data

There are an estimated 3,121 people 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%

Havering's rate is currently 56.3%

Havering

Havering has the largest older population in North East London and one of the largest in Greater London, with more than 18% of the population over 65.

Havering has an over 80's population of just under 15,000 people, with potentially around 2,500 with dementia, diagnosed or undiagnosed (based on 1:6 national ratio). Dementia diagnosis rate in Havering is also below the national standard.

In Havering additionally, medical reviews for all patients diagnosed with dementia, which is a gold standard practice, are not taking place as standard and need to be improved.

Early Onset/Younger Dementia

There has also been an increase in early onset of dementia presentations. With both cases, either early onset or age related, if there is early diagnosis and post-diagnostic support people and their carers can manage their condition well.

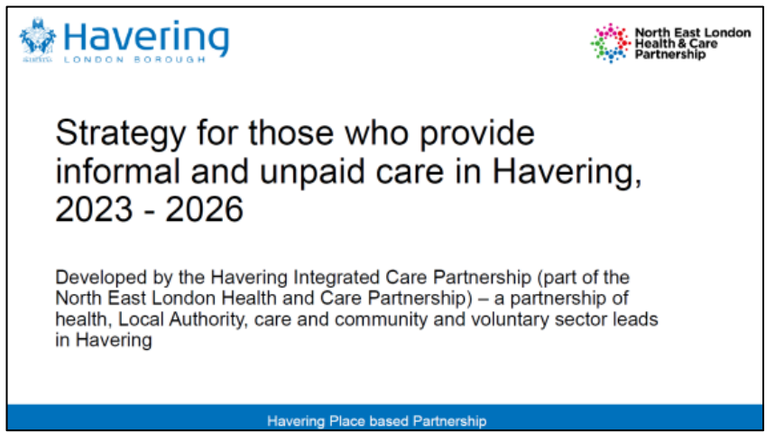
Memory clinic referrals

The memory service has seen an increase in demand from 2019 from 550 referrals to current referral rates (Sept 2021 figures) approximately 90-100 per month, showing year end forecast of 1000 referrals.

Why are Carers so important?

Carers play a vital role in supporting the people with dementia, particularly as they become increasingly reliant on their caregivers throughout the course of the disease. It is therefore crucially important to ensure that support also meets the needs of the caregiver to support their health and wellbeing.

For paid /professional carers, achieving the aims and objectives of this strategy is likely to require re-examination of the financial investment in dementia care; how we jointly develop the quality and capacity of care providers in Havering, and a review of the quality and cost effectiveness of current pathways of care, including respite care.



For informal and unpaid carers, the Havering Strategy for those who provide informal and unpaid care, sets out the significant amount of support and aspirations to improve outcomes. [PowerPoint Presentation (havering.gov.uk)]

It is important that:

- **Carers have access to information, advice and support**
- **Carers have a balanced role in their caring responsibilities and are supported to have time outside of their caring role for their own wellbeing**
- **Carers are able to look after their own health, making sure they get enough sleep and are able to manage stress and anxiety levels**
- **Carers have support networks so they feel less alone**
- **Carers feel reassured about the health and wellbeing of the person(s) cared for, when Carers are not with them**
- **Carers have access to respite care and bereavement support**

Summary of existing Community Support in Havering

Dementia Support	Singing for the Brain	Dementia Music and Social Club	Bring me Sunshine	Dementia Cafés	Havering Dementia Action Alliance	Alzheimer's Society
Carers Support	Havering Dementia Carers Support Group	Peabody – help with form filling and blue badge applications	Tapestry – Day Care Centres and hot meal service	Alzheimer's Society helplines/courses	Dementia Advisers	Havering Carers hub
Pre and Post Diagnostic Support	GPs	BHRUT Dementia and Delirium Team/blue wrist band/This is Me/blue butterfly	NELFT Memory Service	Admiral nurses	Carers Assessments	
Community Activities	Links to solicitors for power of attorney	Queen's Theatre for Down Memory Lane, dementia choir and dementia friendly performances	Leisure activities that cater for people with dementia	Dementia Friendly Awareness sessions	Dementia Friendly retail outlets	Carers forum (all carers); carers register and assessments

The aspirations within this strategy will be achieved through focusing five key priorities:

Preventing Well Information which focuses on prevention of dementia, early intervention and support

Diagnosing Well Access to a timely diagnosis with pre-diagnostic and post-diagnostic support

Supporting Well Prevention of crisis and supporting people with dementia, their families and communities

Living Well Improving the quality of personalised care and support planning for people with dementia

Dying Well Including planning for the end of life, as well as bereavement support

ACTION PLAN: Preventing Well (1)

Aspiration	Interventions	Outcome
We aim to minimise the risk of people developing dementia	▪ Work with Public Health through Health Champions and Primary Care Networks, to inform and encourage people to understand health risks leading to healthier lives ideally through exercise and lifestyle changes ▪ High LDL cholesterol and vision loss are now risk factors for dementia, which may broaden the scope for the 'at risk' target cohorts and we will work proactively with the public and health service to raise awareness ▪ Utilise the Joy Directory of services and Havering Partnership website to promote wellbeing and healthy lifestyle choices, as well as connecting people to services that support wellbeing and mitigate key risk factors ▪ Through the Havering Wellbeing village events, support the BHRUT audiology team to go out into communities and increase the number of people who have access to hearing tests, and support those with hearing loss, as this is a key risk factor for developing dementia	Reduce people's risk of developing Dementia and improve the dementia diagnosis in Havering

Note: *There are delivery risks associated with elements of the Strategy which are reliant on the use of non-statutory services e.g. Local Area Coordination and Havering Volunteer Centre. This could affect several actions in the plans.*

ACTION PLAN: Preventing Well (2)

Aspiration	Interventions	Outcome
We will provide training and education on Dementia Prevention to appropriate Health and Social Care staff and voluntary sector	▪ Joint working with LBH, Havering Place Based Partnership, BHRUT and NELFT to identify training opportunities – both through sharing training courses and identifying opportunities to improve engagement and support prevention ▪ Train Social Prescribers, Local Area Coordinators, Health Champions and others in connecting roles to identify the risk factors of dementia and promote healthier lives connecting more people to wider wellbeing services, and in particular to link local people into services that combat loneliness and social isolation which is a key risk factor for dementia ▪ Social care staff have access to online dementia awareness training as part of their induction, through the Dementia Friends website www.dementiafriends.org.uk	Through expanding access to knowledge, education and training on Dementia risks we aim to reduce risk of developing Dementia and improve quality of life
We will promote exercise, activity and better lifestyle across our Havering Community	▪ Co production with Havering Dementia Action Alliance and Everyone Active Sports and Leisure to develop appropriate services and to promote Veterans/Masters sport. ▪ Work with Social Prescribers, Care Coordinators, Health Champions and other roles that connect people to support, enabled by the Joy Directory of services, to link people into wider wellbeing support to help them to maintain active lifestyles ▪ Joint working with Voluntary Sector to promote activities	Fitter and more active Havering Community and reducing the risk of dementia. Promoting 55+ activity and sport.

ACTION PLAN: Diagnosing Well (1)

Aspiration	Intervention	Outcome
We will enable access to timely, accurate diagnosis, and once diagnosis has taken place, ensure that a care plan is developed, and that a review takes place within the first year **We will ensure that 'at risk' groups are reviewed annually given the increased risk of early onset dementia, e.g. people with a learning disability or Downs Syndrome**	▪ LBH, Havering Place Based Partnership and NELFT will work in partnership to develop more joined up care, and seamless pathways for local people, for example, closer links between those going through the memory service, and Social Prescribers / Local Area Coordinators, and use of the Joy Directory, to those diagnosed, and their carers into wider support ▪ Work to address the backlog of referrals and waiting lists for hospital and GP referrals and treatment and improve accurate recording of diagnosis. ▪ Work with PCNs to ensure that there are yearly health checks from 55+ for at risk groups that include consideration of dementia risk factors, and that discussion takes place with those aged 55+ via the Health checks of those risk factors, what to look out for, and helpful lifestyle changes that can be made	▪ Improve Havering dementia diagnosis rate from bottom quartile to top quartile ▪ Improve carers and cared for outcomes and care experience. ▪ Improve quality of service. ▪ Increase number of people with LD and Downs Syndrome who receive health checks

ACTION PLAN: Diagnosing Well (2)

Aspiration	Intervention	Outcome
Ensure that people have access to early intervention advice, support, training and education	▪ Work with the Carers Hub to ensure that Carer and cared for information, advice and training programmes are provided alongside diagnostic services, with staff at the memory clinic trained to either use the Joy directory themselves, or refer on to Social Prescribers and Local Area Coordinators to ensure that there is full support available. We will ensure that we get the right messages in the right way across our populations including faith groups. ▪ Havering Dementia Alliance to increase number of Dementia Champions by working with the VCSE, Volunteer Centre, and other groups to promote this across the borough	▪ Better carer understanding of dementia, issues, support and advice. ▪ Improve carers and cared for experience and quality of life ▪ Reduce/remove the stigma associated with dementia
Greater links to be made on digital records between a person, and their informal/unpaid carer	▪ Develop a single digital health and care record which identifies and notifies carer and cared for to services – Explore use of the 'this is me' document across the borough for those with dementia ▪ As set out in the Havering Carers strategy and action plan, increase the number of Carers for those with dementia who are identified as a carer with local services and their GP so that they receive the support that they need, when they need it	▪ Increase the number of registered carers both with the carers hub, and coded as a carer with their GP practice ▪ Improved qualitative outcomes around continuity of care and a reduction in the number of times people report they have to repeat their story

ACTION PLAN: Supporting Well (1)

Aspiration	Intervention	Outcome
We will improve the support to people with dementia and their families following a dementia diagnosis	▪ LBH, Havering Place Based Partnership and NELFT will work together to improve the pathway following diagnosis – the memory clinic will be trained on use of the Joy directory and will also link those diagnosed into wider support services such as Social prescribing and Local Area Coordination to ensure that local people are linked into wider wellbeing support ▪ Utilisation of the Blue Band scheme at BHRUT (in partnership with LAS and Local Care Homes) to support those with dementia to be recognised and supported throughout their journey to ensure that attendance and admission to hospital are seamless and not disruptive to the person with dementia's routine as possible. ▪ Utilisation of 'this is me' document within hospital and in other areas to prevent people with dementia and their carers from having to repeat their stories and preferences, and ensure that they're treated in a way that prevents exacerbation of their condition ▪ Explore implementation of the Herbert Protocol with local police to support those with dementia who may wander or get lost, to ensure that they are identified and supported back to their usual place of residence as quickly and seamlessly as possible	▪ To provide better support for people on their dementia journey, supporting carers and helping to ensure that people with dementia are able to live full lives and remain where they wish to live

ACTION PLAN: Supporting Well (2)

Aspiration	Intervention	Outcome
We will provide timely access to health and social care professional and develop a central point of access for information and guidance for people with dementia and their carers	▪ Work with staff across health and social care to develop more robust and integrated personalised care plans to support the carer and their cared for person, particularly encouraging them to ensure that there is a Herbert Protocol in place where appropriate, and a 'this is me' care plan ▪ Development and launch of the JOY directory as a central point of access for information including technology aids, and wider support services, both health, council, police, community and voluntary sector and faith groups ▪ We will ensure that we raise awareness of the importance of Power of Attorney signposting to advice and guidance on completion	▪ People with dementia and their carers know who to contact, how and when and feel more empowered to manage day to day
Establishing Dementia Ambassadors in all care homes	▪ LBH to work with Havering Care Association and Havering Dementia Action Alliance to implement	▪ To provide leadership in all care homes in dementia care. ▪ Ambassadors to disseminate best practice and innovation to drive up standards of care

ACTION PLAN: Living Well

Aspiration	Intervention	Outcome
We aim to support people with dementia to remain in their own home or where they chose to reside as independently as possible	▪ LBH and Havering Place Based Partnership will use care planning, carer support and remote monitoring services to enable people with dementia to remain in their preferred place of care	▪ To improve the quality of life for people with dementia and their carers
We will develop activities available for people with dementia both with and without their carers, and activities for carers, and ensure that they are made aware of these	▪ We will co-produce a programme of activities, both sport and leisure, working with community partners and representatives from our population who are living with dementia. The plan will need to include consideration of respite to support involvement in activities	▪ To improve independence and quality of life for people living with Dementia ▪ Helping people to keep connected with their community
We will support Havering Care Homes(HCH) to achieve accreditation in training and educating their staff in dementia care	▪ LBH will work with Care Provider Voice, HCH and Grey Matters Learning to target and provide accredited training for Care Home and Home Care staff.	▪ To improve standards of care across Havering while also increasing understanding, compassion and care in care provision.

ACTION PLAN: Dying Well

Aspiration	Intervention	Outcome
We will create safe places and opportunities for people to discuss their advance care plan and end of life wishes. **We will provide training and education for carers on the dying process and help and support in keeping the person in their preferred place of death.**	▪ Working with health, social care and voluntary services to increase the number and quality of Urgent Care Plans (UCPs) that are developed with people with dementia and their carers. ▪ We will use “Dying Matters Week” to facilitate and promote discussion and planning, and the Hospices to provide training and education.	▪ To enable people with dementia to prepare through advance care planning to die in the place of their choice with the right support. ▪ To facilitate a “ good death” ▪ To support carers in understanding the dying process, who to call and when.
We will ensure that appropriate and accessible bereavement support is in place	▪ LBH and Havering Place Based Partnership to review current bereavement offer and looks for opportunities to improve this	▪ To provide support for those with dementia and caring for people with dementia to cope with and understand loss and bereavement . ▪ To enable the carers to understand and manage their grief
We will ensure that proactive and timely services are provided at end of life	▪ LBH and Havering Place Based Partnership to review services that provide support to a dying person. We will ensure that the fast track process operates as quickly as possible to facilitate support for people with dementia to be in their preferred place of death	▪ To enable people to die in their preferred place of death. ▪ Supporting carers in the most difficult times to achieve preferred place of death

Future Aspirations

Yearly checks for people with dementia aged 65+

Respite care to be more accessible and flexible - to reduce carer load and prevent burnout and improve quality of life for carer and cared for

Implementation of the Herbert protocol

Namaste - LBH to look at opportunities to provide training in Namaste Care for Care Home providers

Improved signage in public places – exits, toilets

Commission services appropriate for early onset dementia

Key Outcomes

The key outcomes that we want to see are:

- more people have increased say and control over their dementia diagnosis and are diagnosed early enough that they can take as full a part as possible in their own care planning
- more people get earlier access to good quality, person-centred post-diagnostic support in a way that meets their needs and circumstances
- more people with dementia are enabled to live well and safely at home or in a homely setting for as long as they and their family wish with dignity and respect
- more people get timely access to good quality palliative and end of life care during the process of diagnosis and through all parts of the care journey; the critical input of family carers is encouraged and facilitated, and carers' own needs are recognised and addressed
- people with dementia's right to good quality, dignified, safe and therapeutic
- treatment, care and support is recognised and facilitated equally in all care settings – at home, in care homes or in acute or specialist NHS facilities which are flexible and tailor made
- there are more dementia-friendly and dementia-enabled communities, organisations, institutions and initiatives

Glossary of Abbreviations

ASC	Adult Social Care
B&D	Barking and Dagenham
BHRUT	Barking, Havering & Redbridge University Hospital Trust
ED	Emergency Department
GP	General Practitioner
IT	Information Technology
LBH	London Borough of Havering
NELFT	North East London Foundation Trust
UCP	Universal Care Plan