

Prevention of Homelessness & Rough Sleeping Strategy 2020 - 2025

Equality Impact Assessment (EIA)

Document control

Title of activity:	Prevention of Homelessness & Rough Sleeping Strategy 2020 - 2025
Lead officer:	Darren Alexander, Assistant Director Housing Demand
Approved by:	Vernal Scott, Corporate Diversity Advisor
Author:	James Delaney, Housing Strategy & Policy Officer
Date completed:	20/05/2020
Scheduled date for review:	June, 2021

Please note that the Corporate Policy & Diversity and Public Health teams require at least **5 working days** to provide advice on EqHIAs.

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

Please note that EqHIAs are **public** documents and must be made available on the Council's [EqHIA webpage](#).

Please submit the completed form via e-mail to EqHIA@havering.gov.uk thank you.

1. Equality & Health Impact Assessment Checklist

Please complete the following checklist to determine whether or not you will need to complete an EqHIA and ensure you keep this section for your audit trail. If you have any questions, please contact EqHIA@havering.gov.uk for advice from either the Corporate Diversity or Public Health teams. Please refer to the Guidance in Appendix 1 on how to complete this form.

About your activity

1	Title of activity	Prevention of Homelessness & Rough Sleeping Strategy 2020 - 2025		
2	Type of activity	Strategy		
3	Scope of activity	The Havering Prevention of Homelessness & Rough Sleeping Strategy 2020 - 2025 and action plan, developed and led by Havering Council, to help reduce and prevent homelessness within the borough.		
4a	Are you changing, introducing a new, or removing a service, policy, strategy or function?	Yes	If the answer to <u>any</u> of these questions is 'YES', please continue to question 5 .	If the answer to <u>all</u> of the questions (4a, 4b & 4c) is 'NO', please go to question 6 .
4b	Does this activity have the potential to impact (either positively or negatively) upon people (9 protected characteristics)?	Yes		
4c	Does the activity have the potential to impact (either positively or negatively) upon any factors which determine people's health and wellbeing?	Yes		
5	If you answered YES:	Please complete the EqHIA in Section 2 of this document. Please see Appendix 1 for Guidance.		
6	If you answered NO:	N/a		

Completed by:	James Delaney, Housing Strategy & Policy Officer
Date:	16/04/2020

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

Background/context:

As a local housing authority, Havering Council has a statutory duty to publish and deliver a Homelessness Prevention and Rough Sleeping Strategy.

Previously, the Council's Homelessness Strategy (which incorporated a section on rough sleeping) was embedded as a sub strategy within the wider Housing Strategy for the Borough.

With the introduction of the Homelessness Reduction Act (HRA) 2017, the Council is now required to have a separate, stand-alone strategy dedicated to tackling homelessness and rough sleeping. The HRA presents the biggest change to homelessness legislation in 40 years including new duties to prevent and relieve homelessness.

Havering's new Prevention of Homelessness & Rough Sleeping Strategy 2020 – 2025 has developed actions to ensure the provision of support to people who were previously not entitled to help. It will also help prevent people from becoming homeless in the first place by intervening earlier and encouraging other public sector bodies to actively assist in identifying and referring those who are at risk of becoming homeless.

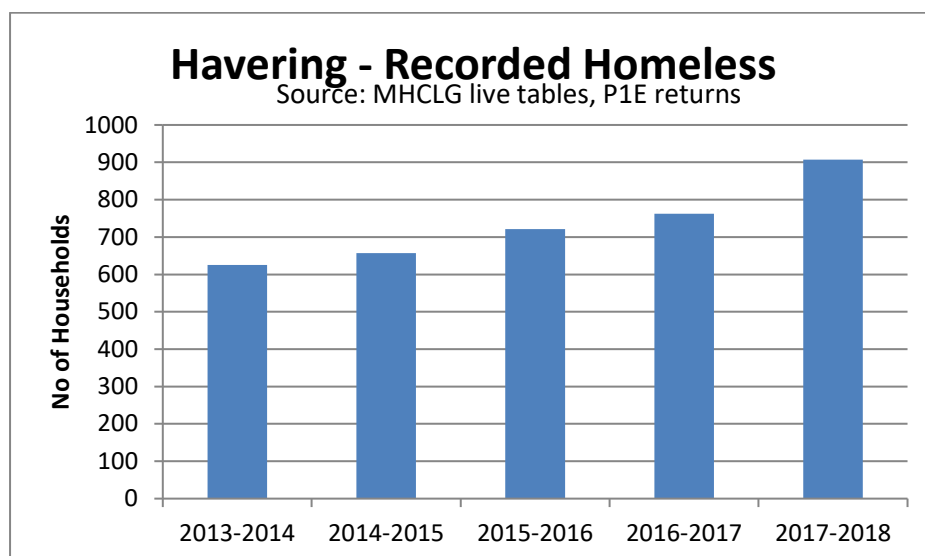
Our strategy aligns with the Housing First principles that see housing as a human right with no prior conditions around 'housing readiness' before someone can be offered a home. Secure housing is seen as a necessary step, not a final reward, and a foundation from which other issues can be addressed. Housing First is a ground breaking as it provides housing 'first', as a matter of right, rather than 'last' or as a reward.

Rough sleeping prevention is a key element of the Strategy with our objective to end rough sleeping in Havering by 2022. In December 2019, Havering were successful in securing a RSI Grant award of £221k to aid this. This initiative will drive the complex needs agenda with an offer of accommodation to every person found to be sleeping rough on the same day they are discovered.

The strategy will develop the partnership with Local Authority, NHS and Third Sector partners to develop joint working protocols to ensure early and effective interventions for those at risk of homelessness with complex and multiple needs. Intensive support will be offered to tackle challenging mental health and substance misuse addictions; we will support probation colleagues to help people who leave prisons off the streets by connecting them to their support network where possible and helping to find stable and secure accommodation.

The Strategy aims to reduce the use of temporary accommodation but where necessary it will provide psychologically informed environments supporting the emotional and psychological needs of the individuals using them to ensure it is an effective route into long term suitable accommodation.

In line with the national trend, homelessness in Havering is rising year-on-year:



Whilst the borough may have the lowest rate of homelessness within the East London sub-region, Havering Housing Services recorded 760 cases of statutory homelessness last year, representing a 22% increase in the four years to 31 March 2017:

	TOTALS		People in TA	Rough Sleepers
Newham	4,533	26.8%	4,457	76
Barking & Dagenham	1,844	10.9%	1,844	0
Waltham Forest	2,343	13.9%	2,299	44
Hackney	2,918	17.3%	2,900	18
Tower Hamlets	2,135	12.6%	2,114	21
Redbridge	2,373	14.0%	2,308	65
Havering	760	4.5%	738	22
TOTALS	16,906	100.0%	16,660	246

In 2017-18, the figure rose by 19% compared to the previous period. However, these are recorded homelessness figures. Some sections of the homeless population - such as those who live in squats, sleep on someone's floor, 'sofa surf' with friends or sleep rough in concealed locations - do not present themselves to the Council. Consequently they are not recorded in official statistics, thus the Borough's true homeless figure is likely to have been higher than 760 households*.

* In the context of homelessness, the term 'household' refers to a 'domestic unit' and can be applied equally to individuals and larger such as families.

The significant shortage of housing stock, major reforms to the benefits system and the rapidly changing demographic & socio-economic profiles of the borough are key drivers in fuelling the continuing growth in homelessness and additional pressure on the Council to source suitable housing.

The pressure has become more acute with the arrival of the Homelessness Reduction Act 2017 (the 'Act') which places new duties on local authorities to assist the homeless and, now, also those threatened with homelessness, regardless of 'priority need' or intentionality.

The Act also requires that services are designed to meet the needs of vulnerable people who are at increased risk of becoming homeless. These include (but not limited to);

- * care leavers
- * people leaving prison
- * people who have left the regular armed forces
- * victims of domestic abuse
- * people leaving hospital, and
- * people suffering from a mental illness or impairment.

The Council will work with each eligible applicant to produce and agree a personalised support plan to ensure that the specific needs of the applicant are addressed.

This strategy closely adheres to the statutory guidelines issued by the Ministry of Housing, Communities and Local Government, in relation to the Act and the Rough Sleepers green paper (published in August 2018). This strategy has been developed by Havering Council, but it is owned by the Havering Homelessness Forum to set out how the membership will work together to reduce and prevent homelessness in the borough over the next four years. The key benefits this strategy will deliver to all affected people are:

- Focused collaborative working with a diverse range of local and national organisations, specialist experts, service users and their representative bodies in order to develop effective, lasting solutions for the service user
- The development of agreed personalised plans, tailored to the specific needs of the service user
- Increased focus on early intervention measures to help prevent homelessness happening in the first place
- Improved accessibility to the right advice and information in a way that can be clearly understood by the recipient

The purpose of this Equality Impact Assessment (EIA) is to help ensure that this strategy supports the Forum's commitment to equality and diversity (E&D); meets its statutory obligations in regard to E&D and demonstrates how all sections of the local community will benefit in some way from the implementation of this strategy.

Who will be affected by the activity?

Homeless people and those threatened with homelessness.

Protected Characteristic - Age:

*Please tick (✓)
the relevant box:*

Positive

Neutral

Negative

Overall impact: Neutral

The Homelessness Reduction Act (2017) stipulates that all eligible* people, regardless of priority need and intentionality, are entitled to advice and meaningful support with finding suitable, settled accommodation.

The development of agreed personalised housing plans will go some way to help ensure that any special requirements in relation to the age of the applicant are appropriately addressed at the outset.

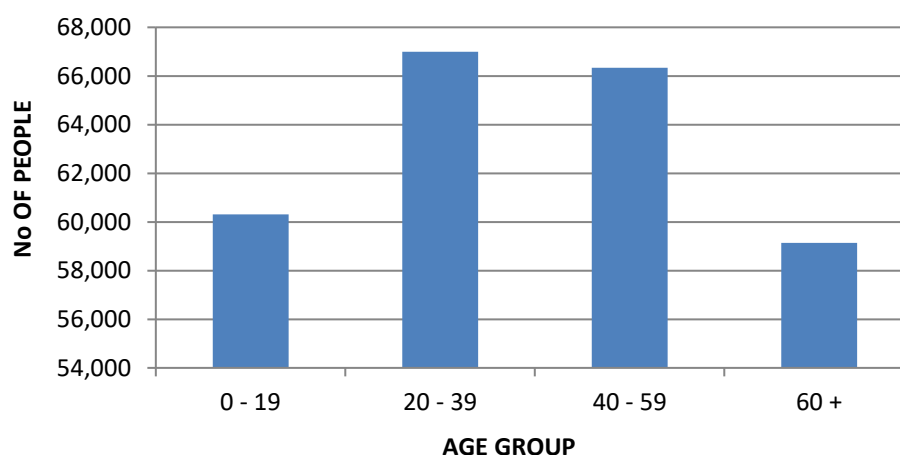
Evidence:

Declining mortality rates mean higher life expectancies. A newborn male baby in the UK today can expect to live for 79.2 years and a girl to 82.9 years, with 22.6% of newborn boys and 28.3% of newborn girls projected to live to 100 years old¹.

- Havering has the oldest population in London with a median age of 40 years, as recorded in the 2011 census.
- The life expectancy at age 65 years in Havering is 19 years for males and 21.7 years for females. The life expectancy at birth for people living in Havering is 80.2 years for males and 83.9 years for females.
- From 2011 to 2016, Havering experienced the largest net inflow of children across all London boroughs. 4,580 children settled in the borough from another part of the United Kingdom during that five-year period.
- It is projected that the largest increases in population up to 2033 will occur in the following age brackets; children (0-17 years), and older people age groups (65 years and above).

¹ Article: 'Living longer; how our population is changing and why it matters' (Office for National Statistics, August 2018)

HAVERING - BY AGE GROUP



2

- The bulk of Havering's population is aged between 20 and 59 years old. This is the age range where the vast majority of homelessness cases are most likely to be found.
- Havering's growing youth population is the age group where cases of 'hidden homelessness (i.e. unrecorded instances of homelessness) are most likely to be found.
- Havering's 60+ population comprise mostly of settled homeowners. Consequently, instances of homelessness in this age group are negligible.

The Havering population is estimated to be 257,810 (ONS, 2018). The table below gives a breakdown by five year age bands and gender.

Age Band (Years)	Male	Female	Persons
00-04	8,850	8,520	17,370
05-09	8,429	8,081	16,510
10-14	7,595	7,503	15,098
15-19	7,166	6,743	13,909
20-24	7,351	7,198	14,549
25-29	8,642	9,220	17,862
30-34	8,526	9,742	18,268
35-39	8,614	9,268	17,882
40-44	7,542	8,125	15,667
45-49	7,868	8,624	16,492
50-54	8,460	9,279	17,739
55-59	8,072	8,290	16,362
60-64	6,806	6,860	13,666
65-69	5,696	6,272	11,968
70-74	5,417	6,379	11,796

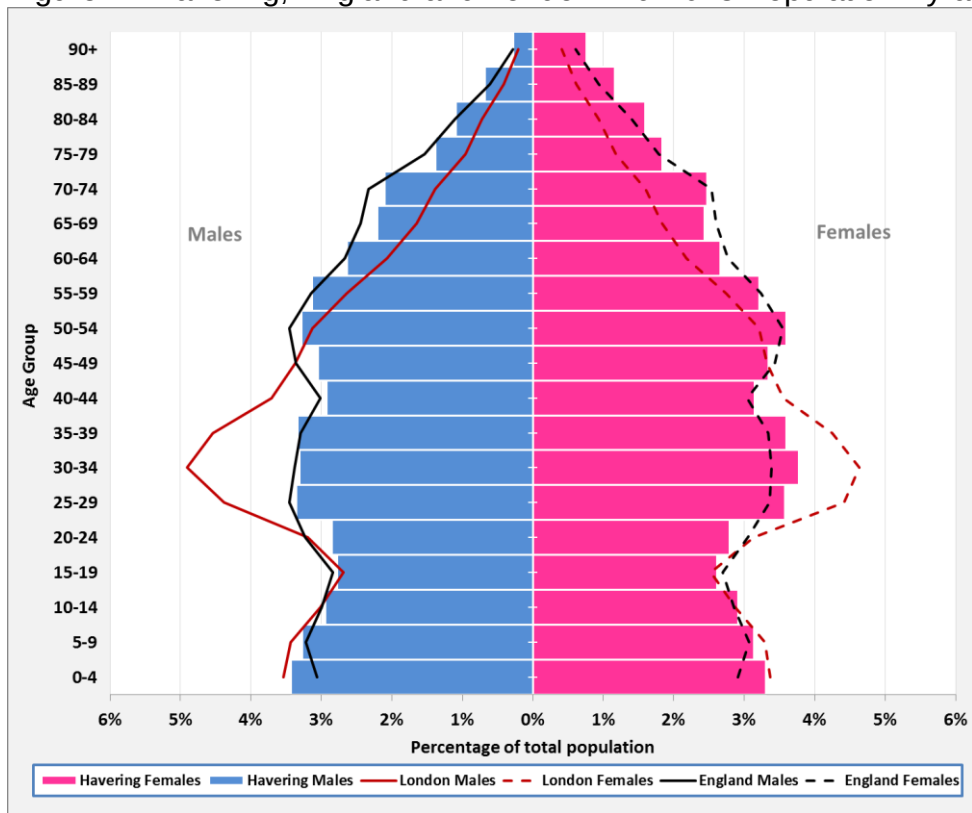
² 'This Is Havering, 2018' London Borough of Havering Public Health Service

75-79	3,561	4,741	8,302
80-84	2,817	4,121	6,938
85-89	1,747	3,000	4,747
90+	719	1,966	2,685
All Ages	123,878	133,932	257,810

Havering has the oldest population in London with a median age of 39 years. There are approximately 60,102 persons aged 65 and over in Havering. This is more than a fifth of the whole population (23.3%).

Figure 1 below shows a much older age structure for the population of Havering compared to London but similar to England.

Figure 1 : Havering, England and London Mid-2018 Population Pyramid



Data source: ONS 2018 Mid-year population estimates.

Increasing age is a major risk factor for developing severe complications and death from COVID-19. Other factors, including various co-morbidities are also important and these are more common in older people. People aged over 60 and especially those aged over 65 are at significantly higher risk of severe disease, requiring respiratory support, and death from Covid-19 than younger age groups.

Figure 2 and 3 show that there have been relatively more Covid-19 related deaths among older people as compared to other age groups.

Figure 2: Number of Covid-19 related deaths by age in Havering as of 28/05/2020

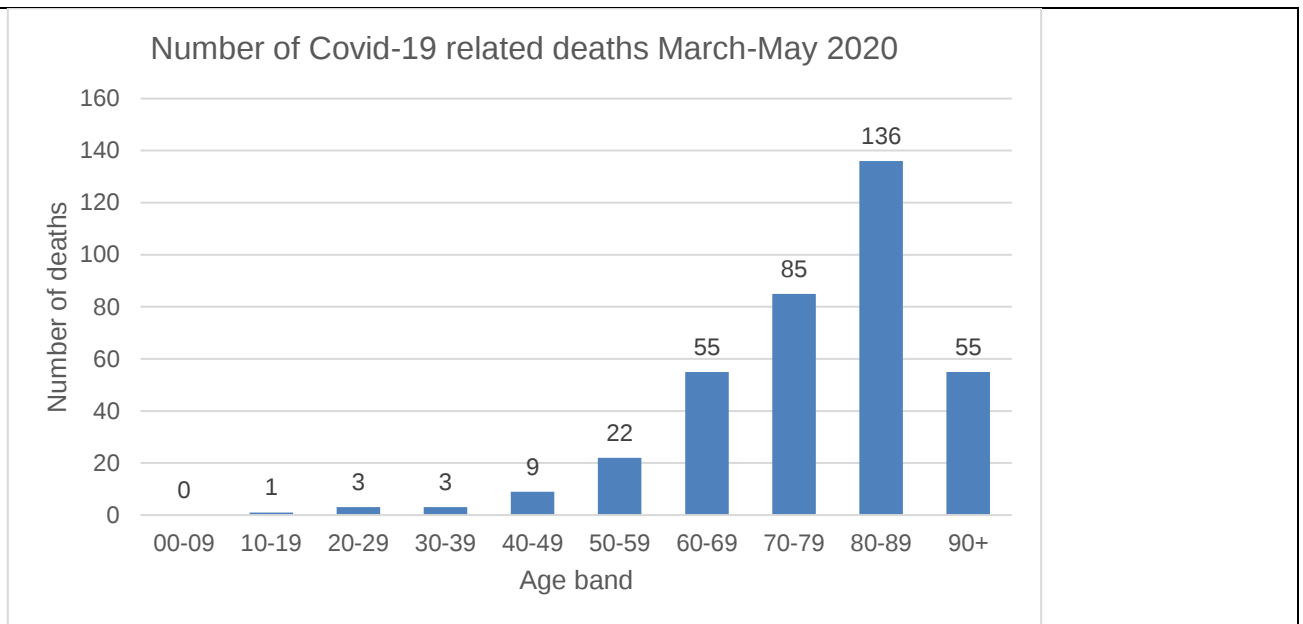
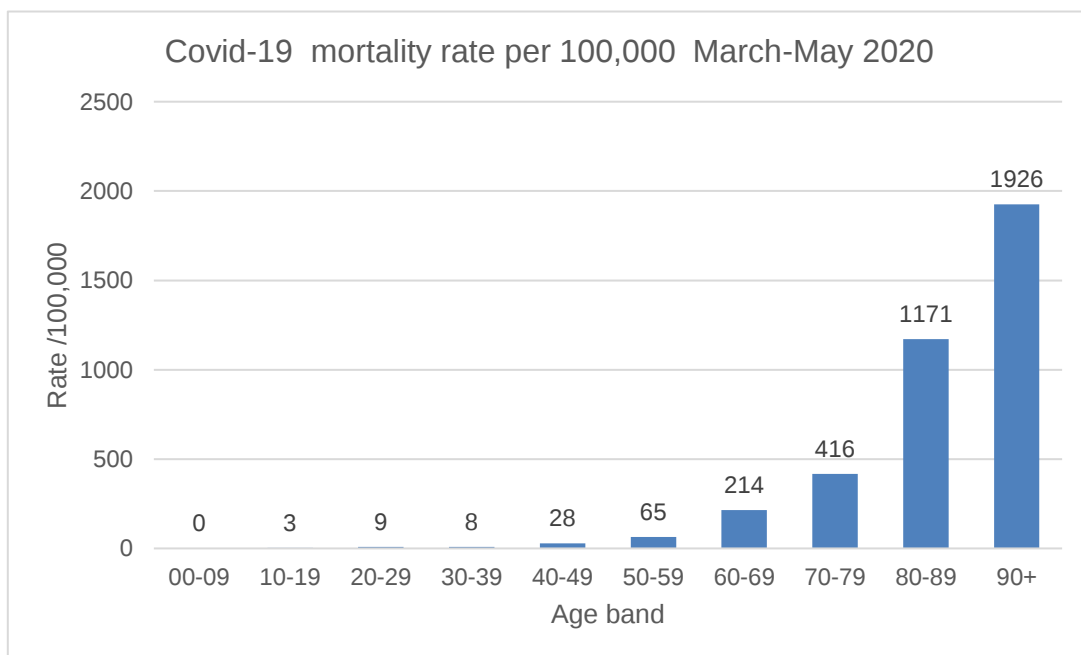


Figure 3: Covid-19 related mortality rate per 100,000 population by age in Havering as of 28/05/2020



Sources used:

- This is Havering 2019/20 version 4.4, Public Health Intelligence
- ONS 2018 Mid-year Population Estimates
- Havering Deaths Registrar

Protected Characteristic - Disability:	
<i>Please tick (✓) the relevant box:</i>	Overall impact: Neutral
Positive	The Homelessness Reduction Act (2017) stipulates that all eligible* people, regardless of priority need and intentionality, are entitled to advice and meaningful support with finding suitable, settled accommodation. The development of agreed personalised housing plans will help to ensure that any special requirements in relation to an applicant's disability are appropriately addressed at the outset. We will be working with the individual or their designated representative to ensure their ease of access to facilities, resources and support. Physical Disability: Access to facilities and use of resources will be reviewed and, if necessary, improved. Advice and information will be made available via a number of additional communication channels including Braille, audio recordings and BSL which will be offered to the individual and/or their representative. Mental Disability and those with learning difficulties: Working closely with the service user and/or their representative, we will seek to develop a bespoke approach to addressing the specific needs of the individual. Special attention will be given to help ensure the individual's awareness and understanding of the support that is available. For example, the approach may require the development of tools such as 'easy read' or pictorial versions of informational literature. Such items will be offered to the individual and/or their representative. For the definition of 'eligible', please see section 2 (background/context)
Neutral	
Negative	

Evidence:

- In 2017, 3,506 adults (aged 18-64 years) were estimated to be living with serious physical disabilities in Havering.
- The estimated rate of serious physical disabilities in Havering (2,323 per 100,000 population aged 18-64 years) is similar to England but significantly higher than London average. It is one of the highest rates within London local authorities (see Figure 22). One of the key reasons for this is likely to be due

to the relatively older population in Havering compared to other London boroughs.

Please note: Rate per 100,000 calculation uses mid 2016 population³.

Tables 1-4 show the prevalence of various disabilities in Havering (POPPI & PANSI 2020)

Table 1: Number of people aged 18-64 with disabilities in Havering by age band, 2020

Age band	Number with learning disability	Number with Impaired mobility	Number with serious visual impairment	Number with moderate or severe, or profound hearing impairment
18-24	519	192	12	347
25-34	911	366	24	791
35-44	882	1,790	23	1,652
45-54	792	1,685	22	4,271
55-64	721	4,438	21	8,143
18-64	3,824	8,471	102	15,204

Table 2: Number of people aged 18-64 with mental health problems in Havering, 2020

Mental health problem	Number
Common mental disorder	29,906
Borderline personality disorder	3,796
Antisocial personality disorder	5,184
Psychotic disorder	1,100
Two or more psychiatric disorders	11,327

Table 3: Number of people aged 65 & over with disabilities in Havering, 2020

Age band	Number with learning disability	Number with moderate hearing loss	Number with Severe hearing loss	Number with learning disability	Number with moderate or severe visual impairment
	2020	2020	2020	2020	
65-74	531	11,492	742	531	1,366
75-84	318	11,552	1,668	318	
85+	148	7,444	1,777	148	
65 & Over	997	30,488	4,187	997	
75 and over					2,902

³ 1 This is Havering 2018

2 Projecting Adult Needs and Service Information System (PANSI, 2017) and Mid-year population estimates 2016

3 Office for National Statistics (ONS)

Table 4: Number of people aged 65 & over unable to manage at least one mobility activity on their own in Havering, 2020

Age band	Number
65-69	1,023
70-74	1,642
75-79	1,506
80-84	1,740
85 and over	3,410
65 and over	9,321

Emerging research on the impact of COVID-19 shows that the coronavirus pandemic has increased psychological distress both in the general population and among high-risk groups. Behaviours such as physical distancing, as well as their social and economic impacts, are worsening mental health consequences. Research on the psychological impact of mass trauma (e.g., natural disasters, flu outbreaks) suggests that the pandemic might particularly harm the mental health of marginalized populations who have less access to socioeconomic resources and supportive social networks (Galea S, 2020).

There are unique stressors and challenges that could worsen mental health for people with disabilities during the COVID-19 crisis. Research on past pandemics shows that disabled people find it harder to access critical medical supplies which can become even more challenging as resources become scarce (Goldmann E, 2014).

Some people with disabilities report higher levels of social isolation than their nondisabled counterparts. They may experience intensified feelings of loneliness in response to physical distancing measures. Social isolation and loneliness have been associated with increases in heart disease, dementia and other health problems. Furthermore, policies around rationing of medical care can intensify discriminatory attitudes towards disabled individuals during times of crisis. This can understandably worsen anxiety about getting sick and needing to seek medical care (Galea S, 2020).

Sources used:

Galea, S., Merchant, R. M., Lurie N. (2020). The mental health consequences of COVID-19 and physical distancing: The need for prevention and early intervention. *JAMA Intern Med*. Published online April 10, 2020. <https://doi.org/10.1001/jamainternmed.2020.1562>

Goldmann, E., & Galea, S. (2014). Mental health consequences of disasters, *Annual Review of Public Health*, 35, 169-183 <https://doi.org/10.1146/annurev-publhealth-032013-182435>

Lai, J., Ma, S., Wang, Y, et al. (2020). Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Network Open*. 3(3):e203976. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2763229>

Projecting Older People Population Information: <https://www.poppi.org.uk/index.php>

Projecting Adults Needs and Services Information: <https://www.pansi.org.uk/>

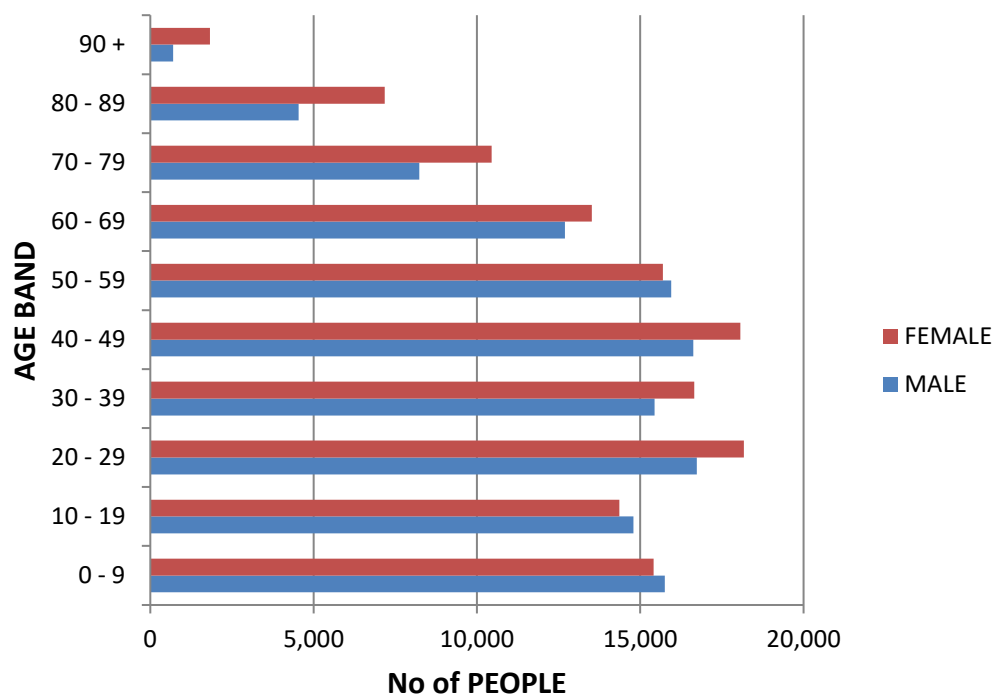
Protected Characteristic - Sex/gender:		
Please tick (✓) the relevant box:		Overall impact: Neutral
Positive	☐	The Homelessness Reduction Act 2017 brings a new and very positive benefit to both male and female genders, with the emphasis on equality of treatment. Whilst the ratio of the male to female population is fairly even at around 50:50, previous legislation afforded 'priority need' to pregnant women and those with dependent children thus excluding the housing needs of single men and women. Under the new Act, all eligible* people regardless of priority need or intentionality are entitled to advice, information and meaningful support with finding suitable, settled accommodation. For the definition of 'eligible', please see section 2 (background/context)
Neutral	☒	
Negative	☐	

Evidence:

MALE		FEMALE		TOTAL
121,456	48.0%	131,327	52.0%	252,783

HAVERING POPULATION

- BY GENDER AND AGE BAND



There are approximately 123,878 men (48%) and 133,932 women (52%) resident in Havering.

Women bear most of the responsibility for holding societies together, be it at home, in health care, at school, or in caring for the elderly. In most cases women perform these tasks without pay. Yet even when the work is carried out by professionals, those professions tend to be dominated by women, and they tend to pay less than male-dominated professions (World Economic Forum, 2020).

Evidence shows that domestic, sexual, and gender-based violence increases during crises and disasters. Under conditions of quarantine or stay-at-home measures, women and children who live with violent and controlling men are exposed to considerably greater danger (URBACT, 2020).

Evidence also shows women rely more on public transport than men - to get to work, visit a doctor or do the grocery shopping. This puts women at greater risk of coming into contact with the virus. In many places public transport has been reduced or even shut down, but low-paid retail and care workers still need to travel (World Economic Forum, 2020).

The availability of essential sexual and reproductive health services may also be challenging during the crisis due to redirected resources and clinic closures/reduced operating hours. This can be a cause of anxiety and additional health risks for pregnant women who may as a result delay seeking help (URBACT, 2020).

In the UK men have been disproportionately affected by Covid-19 related mortality as compared to women. A recent report by ONS (May 2020) shows there were 41,220 deaths registered in England and Wales of which 23,108 were men and 18,112 women.

Men with COVID-19 in the UK (excluding Scotland) are three times more likely to be in critical care and to receive respiratory support. The reasons for the excess mortality burden on men are not yet fully understood. But the emerging consensus is that a mix of biological and behavioural factors are involved. These include smoking, excessive alcohol consumption and underlying health conditions (RSPH, 2020).

Table 2: Number of Covid-19 related deaths in Havering by gender, March-May 2020

Gender	Number of deaths	Mortality rate/100,000
Female	152	110
Male	217	170

Sources used:

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates>

<https://www.weforum.org/agenda/2020/05/what-the-covid-19-pandemic-tells-us-about-gender-equality/>

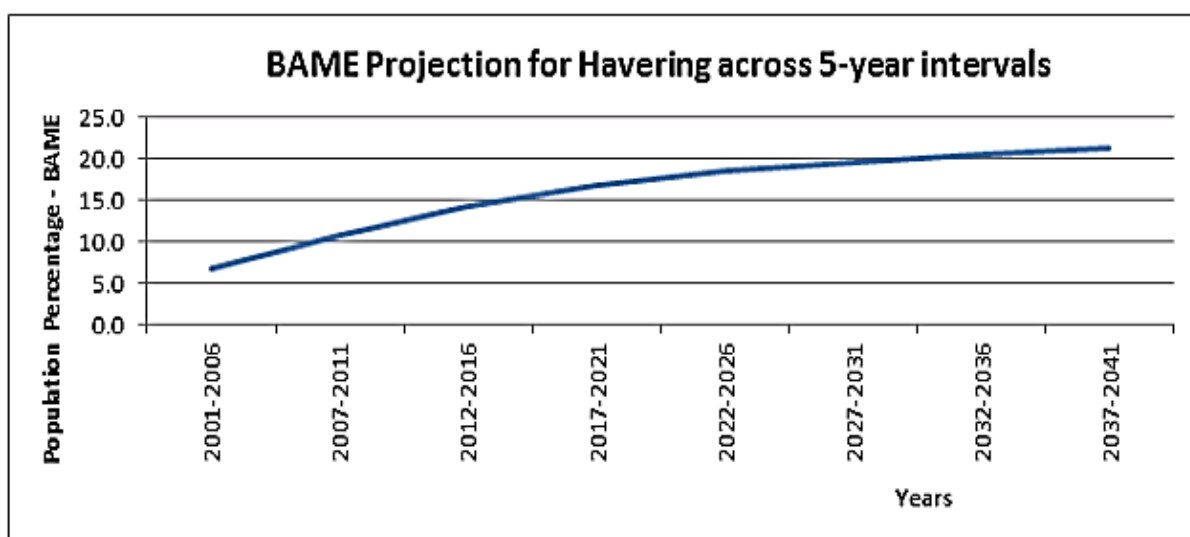
<https://urbact.eu/exploring-gendered-impacts-covid-19>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19roundup/2020-03-26#coviddeaths>
<https://www.rsph.org.uk/about-us/news/covid-19-a-men-s-health-emergency.html>

Protected Characteristic - Ethnicity/race: Consider the impact on different ethnic groups and nationalities		
<i>Please tick (✓) the relevant box:</i>		Overall impact: Neutral
Positive		The new Act requires all eligible* people regardless of priority need, intentionality or ethnicity to be afforded advice, information and meaningful support with finding suitable, settled accommodation.
Neutral	✓	
Negative		As with every other vulnerable group, the Forum will maintain its robust commitment to the principles of equality and diversity, ensuring that the right kind of support is provided. Emphasis will be placed on maintaining two-way understanding throughout, if necessary with support from the individual's representative, an appropriate linguist or via other translation services.
For the definition of 'eligible', please see section 2 (background/context)		

Evidence:

- Havering is one of the most ethnically homogenous boroughs in London, with 83% of its residents recorded as 'White British' in the 2011 census; higher than both London and England.
- However, the ethnically homogenous characteristic of Havering is gradually changing due to its growing cultural diversity.
- The Borough's white population is projected to decrease from the current 84% to 78% in 2032.
- The BME population, notably those from Black African heritage (though many of whom are likely to be British born) is projected to increase from 4.1% in 2017 to 5.3% of the Havering population in 2032



According to the GLA ethnic projections (2020) There are approximately 40,500 (18%) people from Havering, the majority being black Africans (11,700, 4.5%).

Table 2: The GLA ethnic population projections 2020

Ethnic Group	Male	Female	Persons
White British	94,850	101,950	196,810
White Irish	1,320	1,620	2,940
Other White	7,280	7,330	14,610
White & Black Caribbean	1,900	1,840	3,740
White & Black African	710	780	1,490
White & Asian	890	860	1,750
Other Mixed	900	920	1,820
Indian	4,050	4,530	8,590
Pakistani	1,290	1,510	2,810
Bangladeshi	1,190	1,140	2,340
Chinese	610	1,010	1,620
Other Asian	1,980	2,120	4,110
Black African	5,270	6,430	11,700
Black Caribbean	2,090	1,940	4,030
Other Black	790	970	1,760
Arab	290	220	510
Other Ethnic Group	660	570	1,220
Total	126,070	135,740	261,850

Recent analysis by ONS has shown that the risk of death from Covid-19 among some ethnic groups is higher than that of those of White ethnicity. When taking into account age in the analysis, Black males are 4.3 times more likely to die from a COVID-19-related death and Black females are 4.3 times more likely than White ethnic females.

People of Bangladeshi and Pakistani, Indian, and Mixed ethnicities also have a raised risk of death compared with those of White ethnicity. After taking account of age and other socio-demographic factors,

measures of self-reported health and disability, the risk of a COVID-19-related death for males and ethnicity reduces to 1.9 times more likely than those of White ethnicity.

Similarly, males in the Bangladeshi and Pakistani ethnic group were 1.8 times more likely to have a death than White males when age and other socio-demographic characteristics and measures of self-reported disability were taken into account; for females, the figure was 1.6 times more likely. These results suggest that the difference between ethnic groups in COVID-19 mortality is partly a result of socio-economic disadvantage and health inequalities.

An analysis of latest Havering's deaths data shows that out of 369 deaths reported between March and April 2020, 10% were of persons from ethnic minority groups.

Earlier studies examining hospital admissions also indicated that people from BAME backgrounds account for approximately 14% of the population but account for 34% of critically ill Covid-19 patients and a similar proportion of Covid-19 cases.

Evidence shows that particular BAME sub groups have higher rates of long term conditions associated with Covid-19 fatalities, such as high blood pressure and diabetes.

BAME persons are more likely to be key workers and/or work in occupations where they are at a higher risk of exposure (Race Equality Foundation, 2018).

Persons from the BAME community are more likely to be key workers and/or work in occupations with a higher risk of exposure. These include cleaners, public transport (including taxis), shops, and NHS staff.

Bangladeshi men are four times as likely to work in shut-down sectors as white British men, due in part to their concentration in the restaurant sector, and Pakistani nearly three times as likely, due in part to their concentration in driving. Overall there are approximately 10,520 men and 1,530 women in Havering from BAME who are affected by lock down.

In short, people from ethnic minority groups are more likely to have underlying health conditions that make them more vulnerable to the virus, work in roles where they are exposed to it and live in conditions in which it is more likely to spread.

Sources used:

Havering Deaths Registrar

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales>

<https://raceequalityfoundation.org.uk/health-care/coronavirus-information-and-resources/>

<https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article>

<https://www.icnarc.org/>

<https://data.london.gov.uk/dataset/ethnic-group-population-projections>

Protected Characteristic - Religion/faith		
Please tick (✓) the relevant box:		Overall impact: Neutral The Homelessness Reduction Act came into effect in 2018. There is insufficient evidential information at this time as to whether this protected characteristic will be positive or negative. It is currently envisaged that there will be neutral impact. This assumption will be reviewed on an annual basis or sooner if evidence becomes available.
Positive		
Neutral	✓	
Negative		

Evidence:

Most recent available data (Census 2011) shows the majority of Havering residents are Christians

Table 7: Religion and Belief 2011 Census, Havering

Faith	Number	%
Christian	155,597	65.6%
Buddhist	760	0.3%
Hindu	2,963	1.2%
Jewish	1,159	0.5%
Muslim	4,829	2.0%
Sikh	1,928	0.8%
Other Religion	648	0.3%
No Religion	53,549	22.6%
No Response	15,799	6.7%
Totals	237,232	100%

Anecdotal evidence has listed some of the likely Covid-19 effects on religion as follows:

- The suspension of religious services means that people are unable to worship collectively or their faith community.
- Important dates on the faith calendar, such as Easter Sunday and Ramadan 2020, when faith communities come together to fast, pray or eat together, are unable to happen, causing great strain for people.
- People of faith may be worried about whether they will be able to honour the funeral customs of those who lose a loved one to COVID-19.
- Due to the national restrictions in place to minimise the infection rate of COVID-19, it may not be possible to honour some traditions.
- Marriages and other important civic ceremonies have tight restrictions, which may cause upsets.

Sources used:

<https://www.shoutoutuk.org/2020/04/24/religion-in-a-time-of-covid-19/>
<https://www.ons.gov.uk/census/2011census>

Protected Characteristic - Sexual orientation

Please tick (✓) the relevant box:

Positive

☐

Neutral

☒

Negative

☐
Overall impact: Neutral

The Homelessness Reduction Act came into effect in April 2018, thus there is insufficient evidential information at this time as to whether the impact on this protected characteristic will be positive or negative.

It is currently envisaged that there will be neutral impact at the least. This assumption will be reviewed on an annual basis or sooner if data

		becomes available.
Evidence: Although there is no evidence to suggest that LGBT people are inherently more likely to contract COVID-19 than other groups, a number of factors exist which may result in people from LGBT communities being more at risk of infection than the general population. These include the following factors: LGBT communities are disproportionately impacted by HIV. Without the right treatment, a compromised immune system is more susceptible to the effects of COVID-19. Those people living with HIV who do not know their status or are not accessing treatment are therefore of particular concern. LGBT people are more likely to smoke than the general population. Smoking has been linked as a factor that is 'highly likely' to increase the risk of coronavirus pneumonia. LGBT communities may be more reluctant to access healthcare due to fears of encountering LGBTphobia. This may result in people with COVID-19 symptoms avoiding advice or care once these develop. LGBT people are less likely to be active enough to benefit from the protective factors of exercise - resulting in a higher prevalence of long term conditions. Both of these have been linked as risk factors leading to people getting more seriously ill from COVID-19. LGBT people are more likely to be homeless meaning that many may be unable to self-isolate effectively & may not have what they need if they do fall ill. These factors mean that LGBT communities run the risk of being disproportionately vulnerable to COVID-19 infection.		
Sources used: https://lgbt.foundation/coronavirus/impact https://www.gov.uk/government/publications/coronavirus-and-the-human-rights-of-lgbti-people-equal-rights-coalition-statement/equal-rights-coalitions-erc-statement-on-coronavirus-covid-19-and-the-human-rights-of-lgbti-persons		

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: Neutral

Positive		The Homelessness Reduction Act came into effect in April 2018, thus there is insufficient evidential information at this time as to whether the impact on this protected characteristic will be positive or negative. It is currently envisaged that there will be neutral impact at the least. This assumption will be reviewed on an annual basis or sooner if data becomes available.
Neutral	✓	
Negative		
Evidence: The Equality Act 2010 says employees must not be discriminated against in employment for being married or in a civil partnership. In the Equality Act marriage and civil partnership means someone who is legally married or in a civil partnership. Marriage can either be between a man and a woman, or between partners of the same sex. Civil partnership is between partners of the same sex. Marriages and registration of civil partnerships in the UK are currently suspended due to the COVID-19 pandemic.		
Sources used: https://www.equalityhumanrights.com/en/advice-and-guidance/marriage-and-civil-partnership-discrimination		

Protected Characteristic - Marriage/civil partnership: Consider people in a marriage or civil partnership		
Please tick (✓) the relevant box:		Overall impact: Neutral The Homelessness Reduction Act came into effect in April 2018, thus there is insufficient evidential information at this time as to whether the impact on this protected characteristic will be positive or negative. It is currently envisaged that there will be neutral impact at the least. This assumption will be reviewed on an annual basis or sooner if data becomes available.
Positive		
Neutral	✓	
Negative		
Evidence: Pregnancy, maternity and paternity rights should not change during the pandemic period. Guidance to all employers has been issued on dos and don'ts and can be accessed here: https://www.equalityhumanrights.com/en/advice-and-guidance/coronavirus-covid-19-guidance-employers-your-duties-pregnancy-and-maternity All available evidence suggests that pregnant women are at no greater risk of becoming seriously unwell than other healthy adults if they develop Covid-19. The large majority of pregnant women experience only mild or moderate cold/flu-like symptoms.		
Sources used:		

<https://www.equalityhumanrights.com/en/advice-and-guidance/coronavirus-covid-19-guidance-employers-your-duties-pregnancy-and-maternity>
<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy/#general>

Protected Characteristic - Pregnancy, maternity and paternity

Please tick (✓) the relevant box:

Positive

Neutral

Negative

☐
☒
☐

Overall impact: Neutral

The Homelessness Reduction Act came into effect in April 2018, thus there is insufficient evidential information at this time as to whether the impact on this protected characteristic will be positive or negative.

It is currently envisaged that there will be neutral impact at the least. This assumption will be reviewed on an annual basis or sooner if data becomes available.

Evidence: No meaningful evidence is available at this time. It is hoped that such evidence will become available by the time this EIA is due for review/renewal.

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 use the Health and Wellbeing Impact Tool in Appendix 2 to help you answer this question.

Please tick (✓) all the relevant boxes that apply:

Positive

Neutral

Negative

☒
☐
☐

Overall impact: Positive

The impact should be positive, as Chapter 17 of the Homelessness Reduction Act deals with suitability of accommodation, which takes in environmental considerations. With specific regard to Health and Wellbeing, the following should also be noted:

Section 210(1) of the Housing Act (1996) requires a housing authority to have regard to the following provisions when assessing the suitability of accommodation for an applicant:

1. (a) Parts 9 and 10 of the Housing Act 1985 (the '1985 Act') (slum clearance and overcrowding); and,
2. (b) Parts 1 to 4 of the Housing Act 2004 (the '2004 Act') (housing conditions, licensing of houses in multiple occupation, selective licensing of other residential accommodation, additional control provisions in relation to residential accommodation).

Do you consider that a more in-depth HIA is required as a result of this brief assessment? Please tick (✓) the relevant box

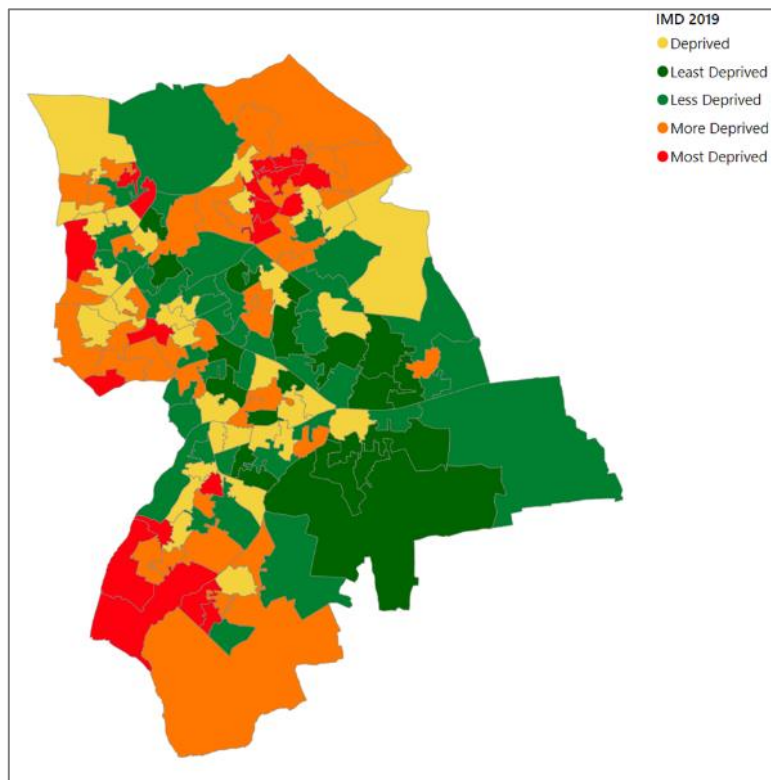
Yes

No ☒

Evidence:

Although Havering is among the least deprived boroughs in London, over 8,000 children are estimated to live in poverty. The map below shows deprivation patterns in Havering based on the IMD 2019 child poverty index by Lower Super Output Areas (LSOAs).

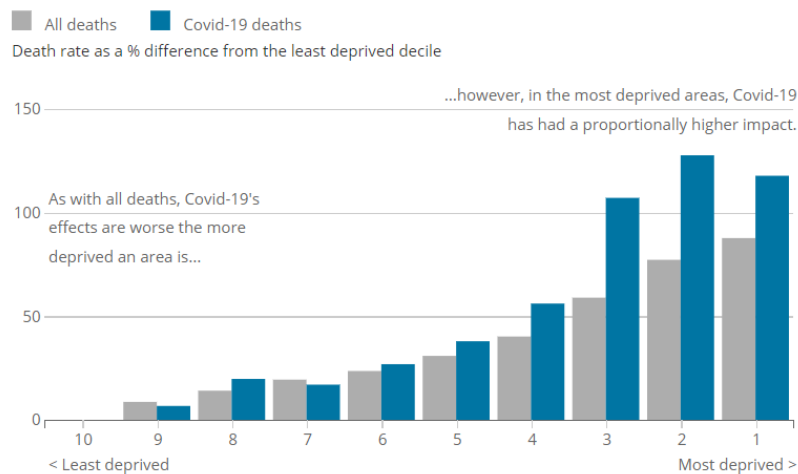
Figure 1: Deprivation Quintiles based on the Income Deprivation Affecting Children Index (IDACI), Havering LSOAs.



Nationally COVID-19 has had a proportionally higher impact on the most deprived areas. Figure 5 shows age-standardised mortality rates, all deaths and Covid-19 related deaths by deprivation deciles for the period between 1 March and 17 April 2020

Figure 2

Age-standardised mortality rates, all deaths and deaths involving the coronavirus (COVID-19), Index of Multiple Deprivation, England, deaths occurring between 1 March and 17 April 2020



The chart shows that the rate for the least deprived area was 25.3 deaths per 100,000 population and the rate in the most deprived area was 55.1 deaths per 100,000 population; this is 118% higher than the least deprived area. In the least deprived area (decile 10), the age-standardised mortality rate for all deaths was 122.1 deaths per 100,000 population. In the most deprived area (decile one), the age-standardised mortality rate for all deaths was 88% higher than that of the least deprived, at 229.2 deaths per 100,000 population.

Sources used:

This is Havering 2019/20 v4.4, Public Health Intelligence

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolveingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april>

Indices of Multiple Deprivation, 2019 (IMD, 2019); Department for Communities and Local Government (DCLG).

3. Review

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

Review: This EIA will be reviewed annually, or as and when new legislation or relevant influential data that may impact on the EIA arrives.

Scheduled date of review: August, 2021

Lead Officer conducting the review: Darren Alexander, Assistant Director
Housing Demand

Please submit the completed form via e-mail to EqHIA@haverling.gov.uk