Housing Services
Resident Engagement Strategy (2022 - 2025)

Equality & Health Impact Assessment (EqHIA)

Document control

Title of activity:	EQHIA - Resident Engagement strategy
Lead officer:	Philip Dewar
Approved by:	Patrick Odling-Smee, Director of Housing
Date completed:	2 December 2021
Date for review:	2 December 2022

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

1. About this strategy

1	**Title of strategy**	Resident Engagement strategy	
2	**Description of strategy**	To assess the impact of this policy on all Havering Housing Services residents; in particular residents that may struggle to engage with the service as a result of a protected characteristic; i.e., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.	
3	**Scope of strategy**	Housing Services will seek to ensure that this strategy is, at all times, implemented in a manner that is fair to all sections of the local community. Accordingly, equalities records will be kept and monitored to ensure all accommodation is allocated fairly. This policy will be reviewed annually to ensure it is not operated in any way that could discriminate or disadvantage against any particular group of people. All personal information provided to Housing Services will be kept confidential and treated with respect at all times.	
4a	**Are you updating an existing, or introducing a new, strategy?**	New	
4b	**Does this strategy have the potential to impact upon people with a protected characteristic?**	Yes	
4c	**Does the strategy have the potential to impact upon any factors that determine people's health and wellbeing?**	Yes	

Completed by:	Philip Dewar - Strategy & Policy Officer
Date:	2 December 2021

2. How will this policy impact on people?

Background/context:

Havering Housing Services have over 12000 tenants and leaseholders to manage and support, all of which have their own views which need to be heard to ensure that Havering Housing Services is meeting their demands and needs. This is in combination with the white paper, the Charter for Social Housing.

On 17 November 2020, the then MHCLG (Ministry of Housing Communities and Local Government) published the charter for social housing residents, setting out what every social housing resident should be able to expect. It makes it clear that effective and authentic tenant engagement is expected and widely recognised as the only way to ensure tenant experiences are embedded across policies, plans and services.

1. To be safe in your home
2. To know how your landlord is performing
3. To have your complaints dealt with promptly and fairly
4. To be treated with respect
5. To have your voice heard by your landlord
6. To have a good quality home and neighbourhood to live in
7. To be supported to take your first step to home ownership

A key priority for housing services is to deliver services in a resident and solution focused way, providing ease of access, responsiveness with engagement opportunities tailored to meet resident circumstances. As a result the following aims were developed for the strategy:

- *To develop a collaborative resident engagement culture within Housing*
- *To engage and involve residents to help us improve services*
- *To deliver a right first time service*
- *To embrace digital communication and engagement.*

Covid-19:
The effect of the Covid-19 pandemic cannot be ignored during the preparation of this assessment.

There is evidence indicating that people with protected characteristics in the UK have been disproportionately affected by Covid-19, directly and indirectly. Examples include a study carried at the peak of the pandemic which showed Black Asian Minority Ethnic (BAME) groups who constitute approximately 14% of the population accounted for 34% of critically ill Covid-19 patients and a similar percentage of all Covid-19 cases (Race Equality Foundation UK, 2020).

Age – specifically the over-60s – and those with a pre-existing medical condition are also considered to be particularly vulnerable to Covid-19.

In order to effectively assess and mitigate potential Covid-19 impact inequalities, a separate equality impact assessment focusing on the nine protected characteristics defined in the Equality Act has been prepared.

Who will be affected by the activity?
This policy will impact on all tenants and leaseholders of Havering Housing services.

Protected Characteristic - Age: Consider the full range of age groups		
Please tick (✓) the relevant box:		This strategy will provide for a wider range of accessible routes for all age groups to find out about influencing services, funding, training, projects, events and activities. There are already projects targeting elderly residents, young people and families. For instance the event days held across five different areas of Havering the summer, with activities for all ages and support in completing the online consultation, with paper copies available As the website and written materials are reviewed, the use of plain English and easy to read style will continue to be used. By supporting the development of digital channels, all age groups will be able to more easily access information on services, influence service improvements and be more aware of support available to individuals. Younger households known for not engaging and development of this channels will enable more opportunity to change this. As highlighted in the consultation, concerns were raised in relation to the elderly and it has been proposed that support is sought in this regard from younger residents and local college students to support this. Written and face to face channels will remain available and promoted. Additionally almost half of the respondents to the consultation were over the age of 55.
Positive	✓	
Neutral		
Negative		
Evidence: The population of Havering is relatively old in comparison with the rest of London. As well as growing, the age profile of the Havering population is also projected to change with proportionally greater growth amongst older age groups. According to the ONS 2018		

Mid-Year Population Estimates the number of people aged 85 and above living in Havering will increase by 2.4K (31%) from 7.6K in 2018 to 9.9K by 2030.

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
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 one of the oldest populations 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%**).

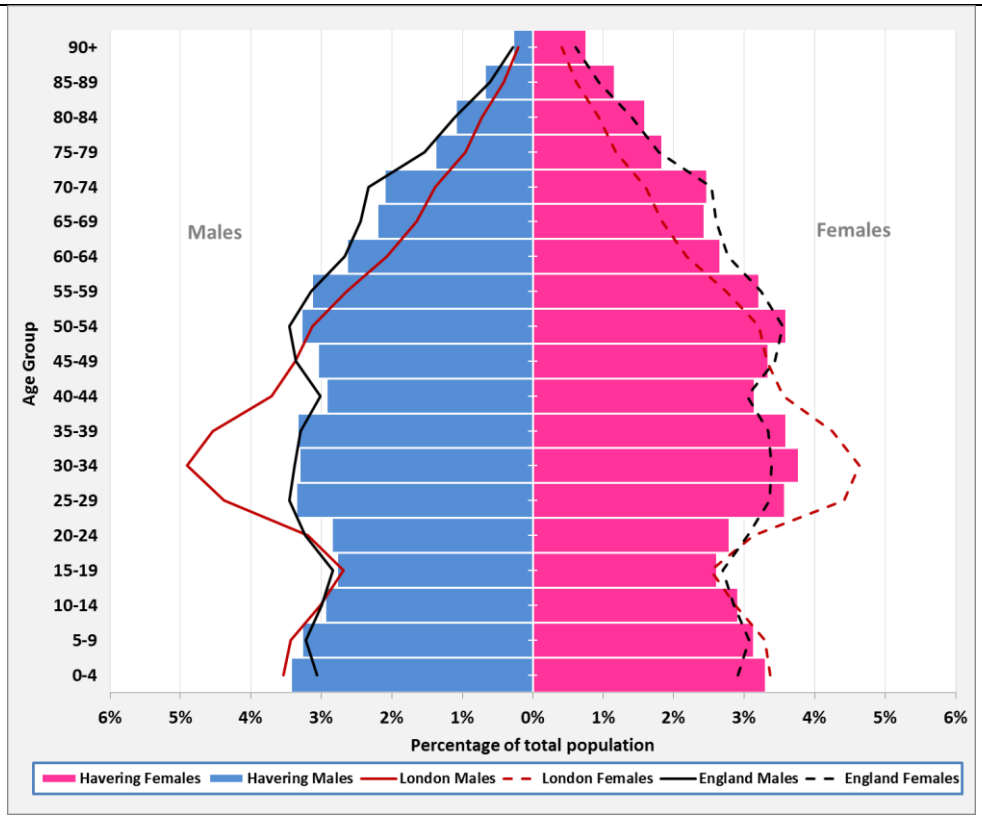
There is a nationally recognised shortage of housing options for older people. One UK study found that 58% of people aged over 60 would consider moving at some point in the future.

Good quality housing is well-recognised as a key factor in promoting health and wellbeing and supporting independent living, and by providing more integrated services with internal and external partners .

There are an estimated 1.2 million chronically lonely older people in the UK.

The prevalence of dementia nationally amongst over 65s is 4.4% in Havering, compared with 4.33% in England as a whole.

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



Data source: ONS 2018 Mid-year population estimates.

Younger people are finding it increasingly difficult to get on the housing ladder, having to remain longer with parents or in expensive private rented accommodation. In 2006/07 18% of households aged 16-34 were owner occupiers, falling to 9% in 2016/17. Around a third of households in the private rented sector are headed by a 25-34 year old.

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

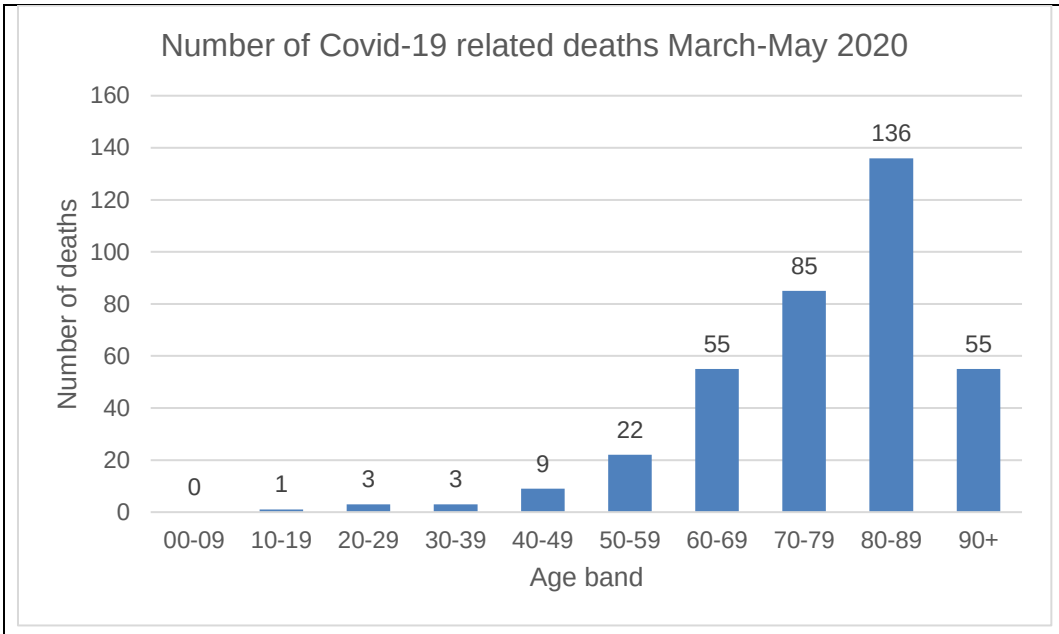
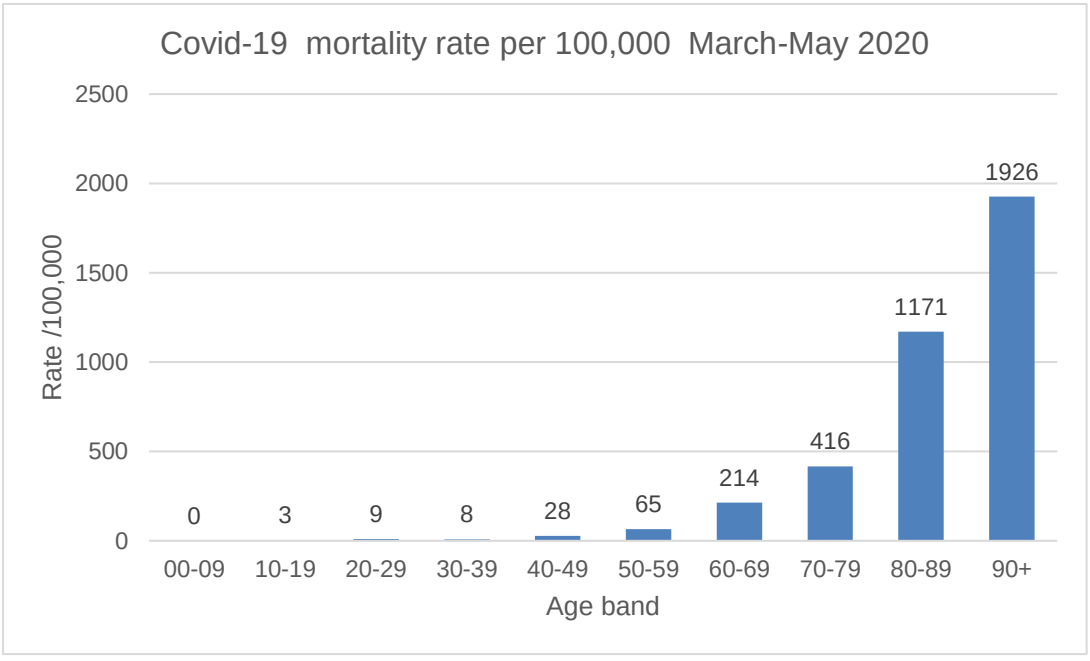


Figure 3: Covid-19 related mortality rate per 100,000 population by age in Havering as of 28/05/2020



Sources used:

- This is Havering 2019/20 version 4.4, Public Health Intelligence
- ONS 2018 Mid-year Population Estimates
- PHE Dementia Profile: Sep 2017
- Havering Deaths Registrar

Protected Characteristic - Disability: Consider the full range of disabilities; including physical mental, sensory and progressive conditions

Please tick (✓) the relevant box:		**Overall impact: Positive**
Positive	✓	*This strategy will continue to build on good practice by ensuring that residents with any physical or mental impairment have access to the services and the opportunity to influence this through the type of engagement that they prefer. Work may lead to specialist resident groups, such as for residents with disabilities and this will be completed in partnership with HAD and other agencies.* *Premises in our management and used for engagement work have regular checks conducted, such as the sapphire community centre, with clear signs using inclusive language and appropriate images. There is an underfloor induction loop for people with hearing difficulties. Travel can also be provided for formal meetings. Provision of information in large print is offered and assistance can be provided to travel to and from meetings.*
Neutral		
Negative		

Evidence:

ONS Annual Population Survey (Jan 2014-Dec 2014) data suggests that around 18% of working age people living in Havering have disclosed that they have a disability or long term illness. This is a lower proportion to national figure of 22%.

The estimated number of people in Havering aged 18-64 living with moderate physical disabilities was 11,592 in 2015 – a rate of 7,779 per 100,000 population aged 18-64 years.

This rate is one of the highest among London local authorities. It is statistically similar to England but significantly higher than the London average (see Figure 1).

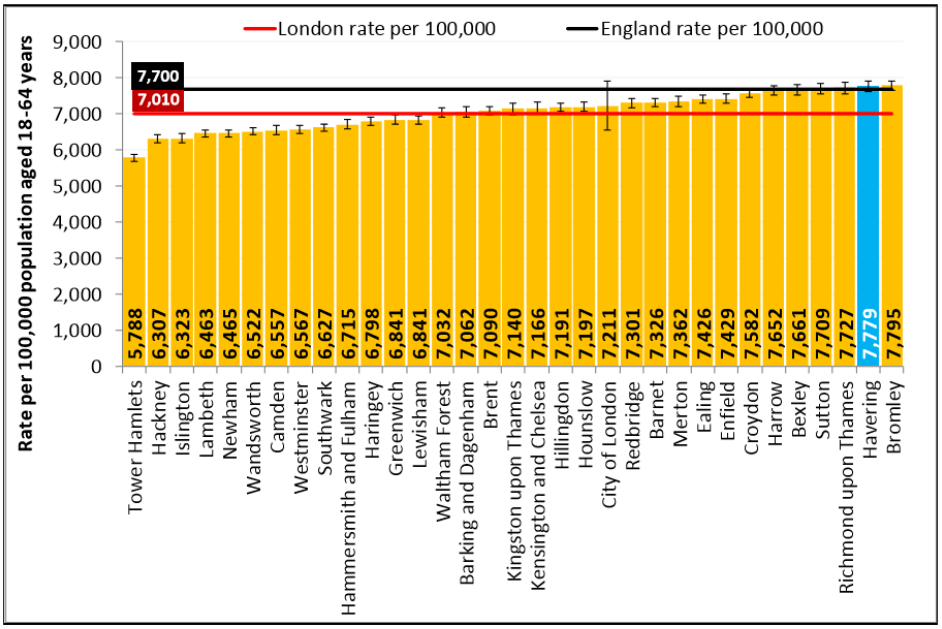


Figure 1: Estimated moderate physical disability rate per 100,000, persons aged 18-64 years, in Havering and other London boroughs, London and England, 2015

Of those who reported a disability, 24 per cent nationally reported a mental health impairment in 2016/17, up from 20 per cent in 2014/15. Mental health impairments were most prevalent amongst working age adults.

This is also reflected locally, with partners reporting an increase in the number of service users with mental health issues over recent years. For example: increasing numbers of rough sleepers with mental health problems, many of whom also have alcohol and substance misuse issues; and an increase in numbers of older people with dementia.

Mobility was the most prevalent impairment reported nationally.

There is a nationally recognised shortage of housing for people with disabilities. For example: around 2% of the UK population are wheelchair users, yet 84% of homes in England do not allow someone using a wheelchair to get to and through the front door without difficulty. Around 15% of households containing at least one wheelchair user feel that their current home is not suitable for their needs, and needs adaptations.

Appropriate housing adaptions and/or access to supported housing options can enable vulnerable residents to live independently for longer and facilitate timely discharge from hospital.

In 2011 around 26% of individuals living in social housing in Havering, had a long-term health problem or disability. This is similar to the national figure of 28% and nationally 50% of households in the social rented sector include someone with a long term illness or disability.

Mobility issues are most prevalent amongst those of state pension age.10

People in families with disabled members are more likely to be in poverty than those with no disabled person in the family. 11

Nationally, 8% of hate crime offences recorded during 2017/18 were disability related.12

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

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

Poverty, unemployment, homelessness, relationship breakdown etc. predispose to mental health problems. With additional training, public facing housing staff in a wide range of services and in the community can encourage people experiencing disadvantage and personal problems to seek help, as well as identify and intervene where there is greater risk identified.

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 non-disabled 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).

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

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/
Family Resources Survey 2016/17
Disability in the United Kingdom 2016 – Papworth Trust
Census 2011
English Housing Survey 2016/17
Family Resources Survey 2016/17
JRF Poverty rates in families with a disabled person
Hate Crime England & Wales 2017/18 statistical bulletin

Protected Characteristic - Sex/gender: Consider both men and women		
Please tick (✓) the relevant box:		**Overall impact: Neutral** *The strategy provides a wider choice for all genders, recognising time limitations of residents and ability to access engagement opportunities. For example providing both day time and evening meeting to ensure residents can find the best time for them to meet.* *Digital inclusion will be promoted regardless of gender.*
Positive		
Neutral	✓	
Negative		

Evidence:

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

AGE BAND (YEARS)	MALE	FEMALE	PERSONS
0-4	8,273	7,893	16,166
5-9	7,720	7,450	15,170
10-14	7,021	6,863	13,884
15-19	7,485	7,244	14,729
20-24	7,616	7,414	15,030
25-29	8,119	8,877	16,996
30-34	7,974	8,734	16,708
35-39	7,504	8,247	15,751
40-44	7,554	8,040	15,594
45-49	8,297	9,108	17,405
50-54	8,423	9,094	17,517
55-59	7,779	7,647	15,426
60-64	6,248	6,602	12,850
65-69	6,423	7,049	13,472
70-74	4,460	5,377	9,837
75-79	3,654	4,892	8,546
80-84	2,791	4,209	7,000
85-89	1,608	2,946	4,554
90+	687	1,763	2,450
All Ages	**119,636**	**129,449**	**249,085**

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

There remains a gender pay gap with women tending to earn less than men, and women are more likely than men to live in poverty. As a result, women are more likely to be eligible for social housing: 58% of social rented homes nationally are headed by a female Household Reference Person.

Lone parent households are also more likely to be headed by women, again many of whom are on low incomes. For example; 24% of social housing households in England are lone parent households.

Women are also considerably more likely to suffer from mental health issues. For example, nationally, around 1 in 5 women aged 18-64 reported symptoms of a common mental health disorder in 2014, compared with around 1 in 9 men; and 10% of women reported severe symptoms, compared with 6% of men.

Women are more likely to have experienced domestic abuse than men (7.5% compared with 4.3% across England and Wales in 2017).

Given that the COVID-19 crisis affects men and women in different ways, measures to resolve it must take gender into account. For women and girls, vulnerabilities in the home, on the front lines of health care, and in the labour market must be addressed.

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

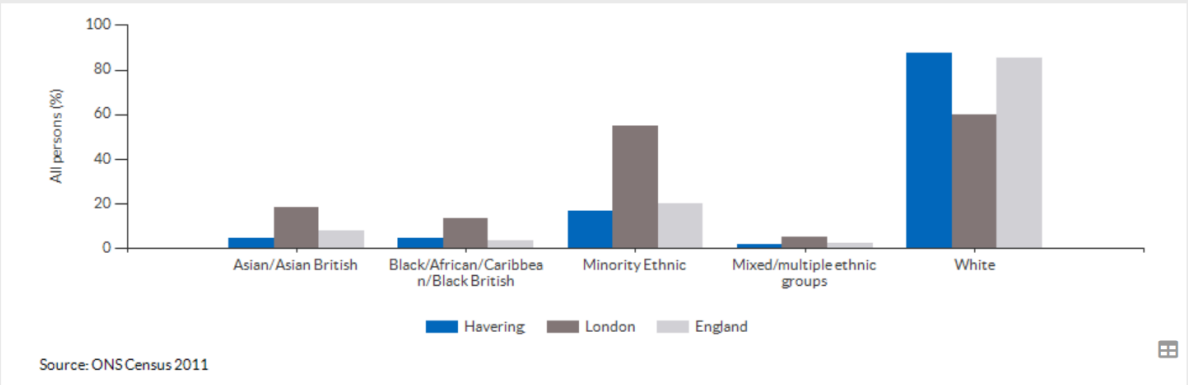
Gender	Number of deaths	Mortality rate/100,000
Female	152	110
Male	217	170

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
ONS 2018 Mid-year population estimates
National Housing Survey Social Housing Report 2016-17
Survey of Health and Wellbeing, England 2014
ONS Domestic abuse in England and Wales: year ending March 2017

Protected Characteristic - Ethnicity/race:		
Please tick (✓) the relevant box:		**Overall impact: Neutral** *This strategy offers to provide a wider range of accessible routes to engage with housing services.* *There is an issue of awareness for all residents and work will be completed with specific community groups to promote involvement. This is highlighted by the promotion of the consultation via the Havering Asian Woman's Association.* *There is potential for those that wre not confident in reading or speaking English to be excluded from the consultation. Steps already available include interpretation and translation. The profile of residents engaging will be monitored and analysed against the profile of residents, with any underrepresentation from different ethnic groups drilled down on to understand the reasons further and ultimately boost participation.* *Cultural difference could also exclude resident form being able to influence service delivery. As above, this will be monitored and work will be completed with the relevant local groups to help develop understanding and awareness for all.* *Ensuring that sufficient support is available for those at greatest risk by developing partnerships with appropriate organisations and identifying residents with vulnerabilities from communities that can be difficult to engage.*
Positive		
Neutral	✓	
Negative		

Havering is one of the most ethnically homogenous places in London, with 83% of its residents recorded as White British in the 2011 census, higher than both London and England (see Figure 1).



	Havering		London		England	
	Count	%	Count	%	Count	%
Asian/Asian British	11,545	4.9	1,511,546	18.5	4,143,403	7.8
Black/African/Caribbean/Black British	11,481	4.8	1,088,640	13.3	1,846,614	3.5
Minority Ethnic - Total	39,617	16.7	4,504,657	55.1	10,733,220	20.2
Mixed/multiple ethnic groups	4,933	2.1	405,279	5	1,192,879	2.3
Other ethnic group	1,324	0.6	281,041	3.4	548,418	1
White	207,949	87.7	4,887,435	59.8	45,281,142	85.4

Figure 1: Population of Havering, London & England by ethnicity. 2011 UK census.

The number of black & minority ethnic group residents in the borough is expected to rise from 18% currently to 22% by 2032.

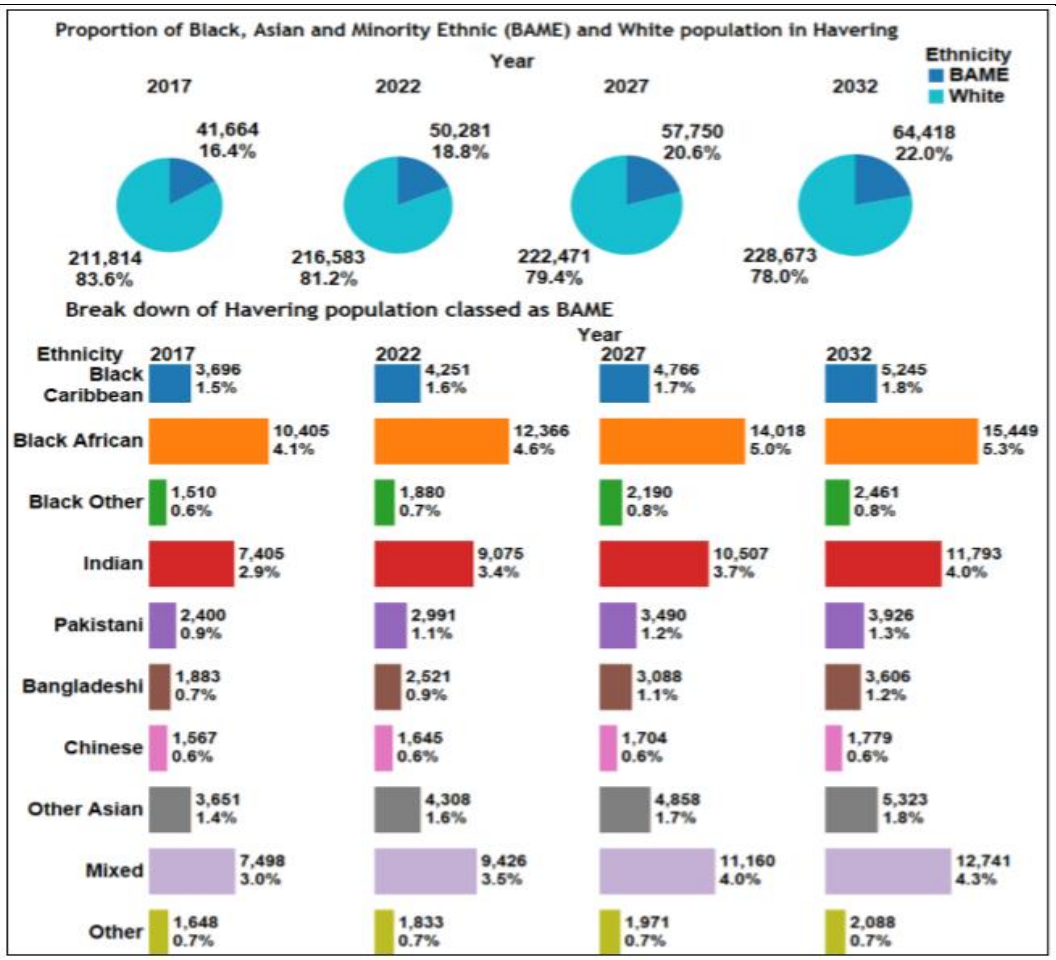


Figure 2: Projected proportion of Havering population by ethnicity

The UK poverty rate is twice as high for black & minority ethnic groups as for white groups.

Nationally, ethnic minority groups are more likely than white British households to spend a high proportion of income on rent, regardless of whether they live in social or private rented housing.

However, the housing they live in tends to be of lower quality, especially among households of Pakistani origin, and overcrowding is more common, particularly among households of Bangladeshi origin.

76% of hate crimes in 2017/18 were recorded as race hate crimes.

People from black & minority ethnic groups are less likely to engage with mental health services other than at a time of crisis. People of African/Caribbean descent are over-represented at all levels of the psychiatric process; in particular they are more likely to be treated as inpatients, be sectioned or access mental health services via a criminal justice system pathway.

Recent analysis by the ONS has shown that the risk of death from Covid-19 among some ethnic groups is significantly higher than that of those of White ethnicity. When taking into account age in the analysis, Black males are 4.2 times more likely to die from a COVID-19-related death and Black females are 4.3 times more likely than White ethnicity males and females.

People of Bangladeshi and Pakistani, Indian, and Mixed ethnicities also have a raised risk of death involving COVID-19 compared with those of White ethnicity. After taking account of age and other socio-demographic characteristics and measures of self-reported health and disability, the risk of a COVID-19-related death for males and females of Black 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 COVID-19-related death than White males when age and other socio-demographic characteristics and measures of self-reported health and disability were taken into account; for females, the figure was 1.6 times more likely. These results show that the difference between ethnic groups in COVID-19 mortality is partly a result of socio-economic disadvantage and other circumstances.

An analysis of latest Havering's deaths data shows that out of 369 deaths reported between march and May this year 29 were of persons from ethnic minority groups. Earlier studies examining hospital admissions also indicated that people from BAME backgrounds constitute approximately 14% of the population but account for 34% of critically ill Covid-19 patients and a similar percentage of all Covid-19 cases.

Evidence shows that particular BAME sub groups have higher rates of long term conditions associated with COVID19 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 where they are at 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 large part to their concentration in the restaurant sector, and Pakistani nearly three times as likely, due in part to their concentration in taxi driving. Overall there are approximately 10,520 men and 1,530 women in Havering from BAME who work in sectors affected by lock down.

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 - Religion/faith:		
Please tick (✓) the relevant box:		**Overall impact: Neutral** *There will be a wider range of accessible routes to find out about engaging with housing services.* *Lack of understanding could exclude tenants from being able to influence service delivery, particularly if engagement opportunities that require a resident's presence clash with a religious celebration. Work will continue with our partners to maximize the engagement opportunities for all and minimize any barriers present. The profile of resident engaging will be monitored against the profile of all our residents and develop methods of participation that encourage residents from underrepresented groups to get involved.* *Individual tenants and leaseholders will be able to directly influence service delivery through a channel that best suits them.*
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 seek support from their religious community.
- Important dates on the religious calendar may be unable to happen
- People who follow a religion may be worried about whether they will be able to honour the funeral customs of their faith due to COVID-19.
- Due to the national restrictions in place to minimise the infection rate of COVID-19, it may not be possible to carry out some traditional practices.

- Marriages and other important civic ceremonies have tight restrictions, which may cause upset and anxiety.

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 & Gender reassignment:		
Please tick (✓) the relevant box:		**Overall impact: Neutral**
Positive		*There will be a wider range of accessible routes to find out about engaging with housing services.*
Neutral	✓	*Efforts will be made to link with local community groups with Havering residents involved to further promote these opportunities.*
Negative		*The option will always be available to inform Housing Services of gender reassignment and sexual orientation, however this will remain optional*

Transgender people are particularly likely to experience discrimination and be victims of hate crime; it is estimated that 2 in 5 trans people nationally have experienced a hate crime or incident because of their gender identity in the last 12 months.13

Transgender hate crime accounted for 2% of hate crimes recorded nationally in 2017/18.

People who are lesbian, gay, bisexual and trans (LGBT) have increased levels of common mental health problems.

Through our Strategy we are committed to tackling anti-social behaviour to promote health and wellbeing.

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 disproportionally vulnerable to COVID-19 infection.

Sources used:

Stonewall website: https://www.stonewall.org.uk/lgbt-britain-hate-crime-and-discrimination
Hate Crime England & Wales 2017/18 statistical bulletin
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 - Marriage/civil partnership:		
Please tick (✓) the relevant box:		**Overall impact: Neutral** *There will be a wider range of accessible routes to find out about engaging with housing services.*
Positive		
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 - Pregnancy, maternity and paternity:		
Please tick (✓) the relevant box:		**Overall impact: Neutral**
Positive		*There will be a wider range of accessible routes to find out about engaging with housing services.*
Neutral	✓	*The consultation showed that, whilst the least significant barrier to engagement overall was childcare, this correlated with households who identified as having child care responsibilities for dependent children. Low level forms or engagement will be available to residents to get there opinion across, such as community days with activities for children, text surveys and online consultations. For higher level involvement, such as focus groups that require meetings faces to face, flexibility will be offered with the times of these. Other options are also being explored in relation to tapping in to mother and tots groups in Havering and combining with a focus group subject.*
Negative		

Evidence:

There were about 3,400 births to women resident in Havering in 2018.

The fertility rate in Havering (68/1000 women aged 15-44) is higher than the London (62.9) and national average (64.2).

Fertility rates in Havering appear to have now plateaued having increased steadily over the last decade. Notwithstanding any further changes in fertility rates, the number of pregnancies in Havering is likely to increase further in line with increases in the number of residents of childbearing age.

About 8,200 babies are born at Queens Hospital per year, making it one of the largest single site maternity units in the country.

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:

BHR CCG 2018
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

Socio-economic status: Consider those who are from low income or financially excluded backgrounds		
Please tick (✓) the relevant box:		**Overall impact: Positive**
Positive	✓	*There will be a wider range of accessible routes to find out about engaging with housing services. This will include more flexible types of engagement as well as times to engage, in particular to attract young working families who may not be able to join during working hours and a cohort that need to have there voices heard.*
Neutral		
Negative		

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).

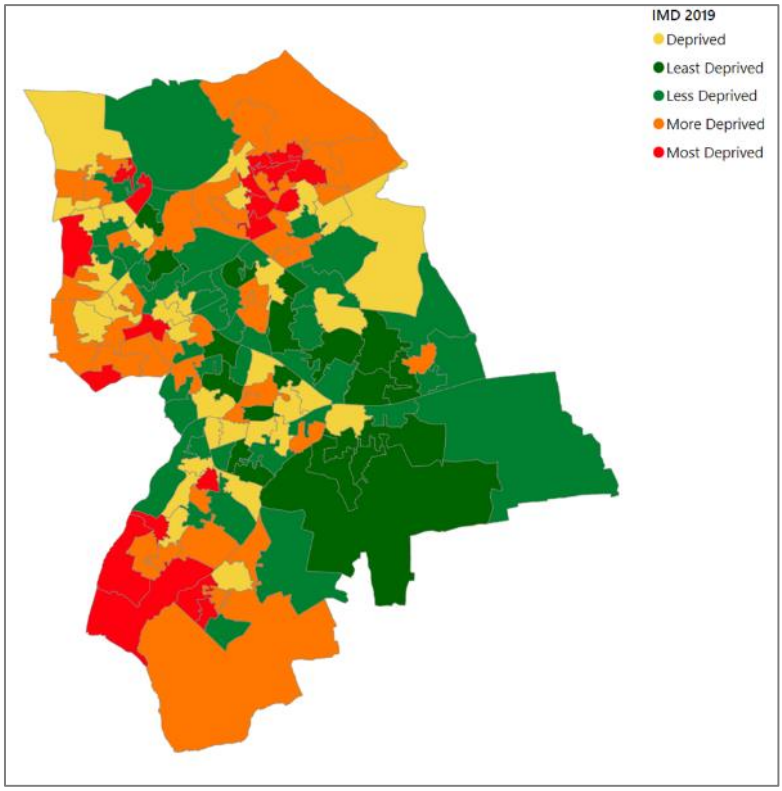
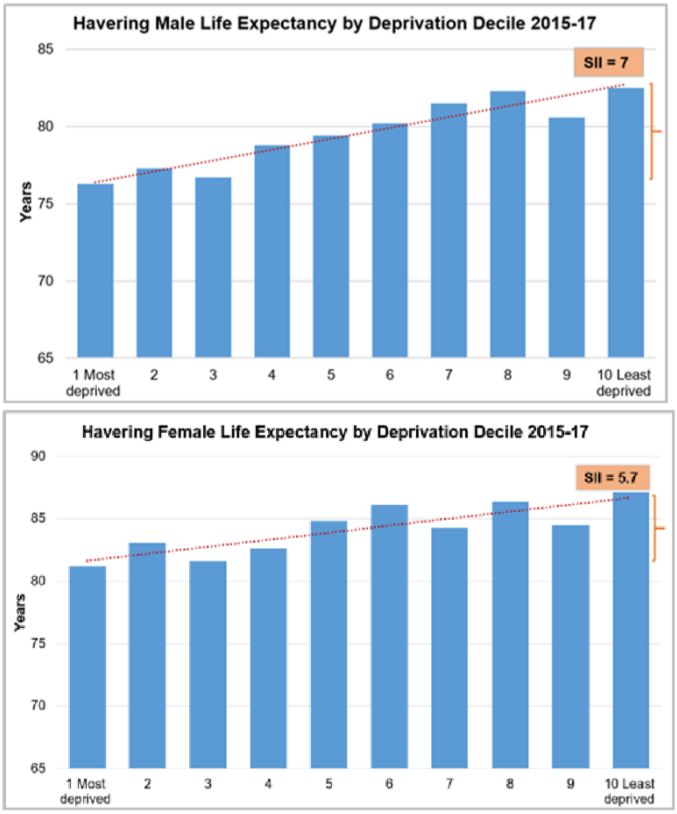


Figure 1: Depivation Quintiles based on the Income Deprivation Affecting Children Index (IDACI), Havering LSOAs.

There is a significant social gradient in life expectancy such that residents living in the most disadvantaged decile of the borough have a significantly lower life expectancy (7 years for men and 5.7 years for women) than peers in the least deprived decile.7 As well as lower life expectancy, people living in disadvantage have proportionally less healthy life expectancy than less disadvantaged peers.



Figures 2 & 3. Havering Life expectancy by Deprivation Decile, 2015-17

For males, life expectancy at birth ranges from 76.6 years in the most deprived decile to 84.5 years in the least deprived decile (difference of 7.9 years). This is greater than the gap seen across London (difference of 6.7 years).

For females, life expectancy at birth ranges from 81.1 years in the most deprived decile to 86.6 years in the least deprived decile (difference of 5.5 years). This is greater than the gap seen across London (difference of 4.4 years).

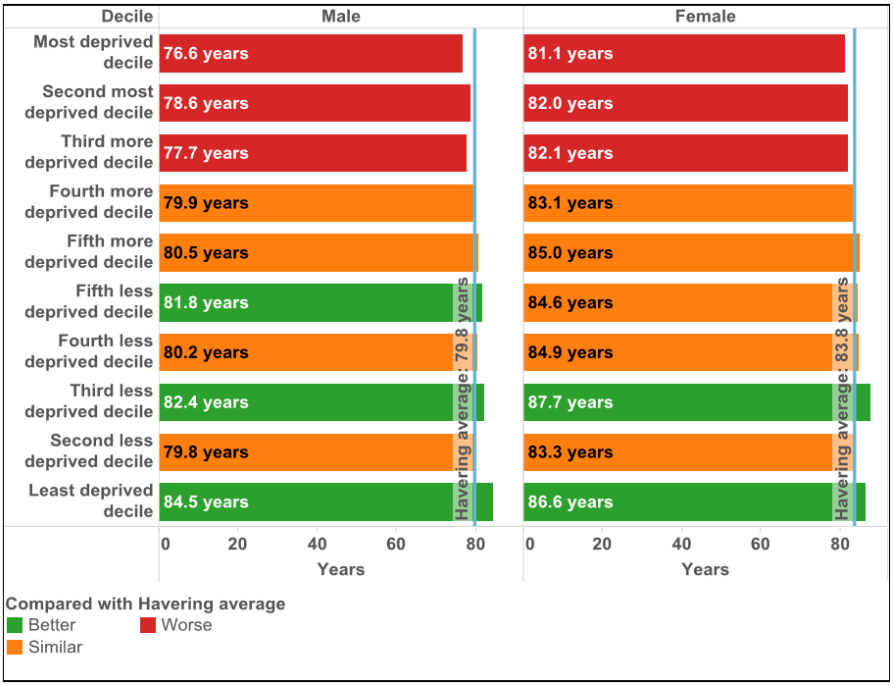


Figure 4: Life expectancy at birth by local deprivation decile with Havering average, by gender, 2012-14

Median annual household income in Havering (£36.7K) is well above that for England (£30.6K) – but below the London figure (£39.1K). Although incomes in Havering are not particularly high for London, the proportion of adults that are income deprived is relatively low. Nonetheless more than 1 in 10 adults in LBH are income deprived.

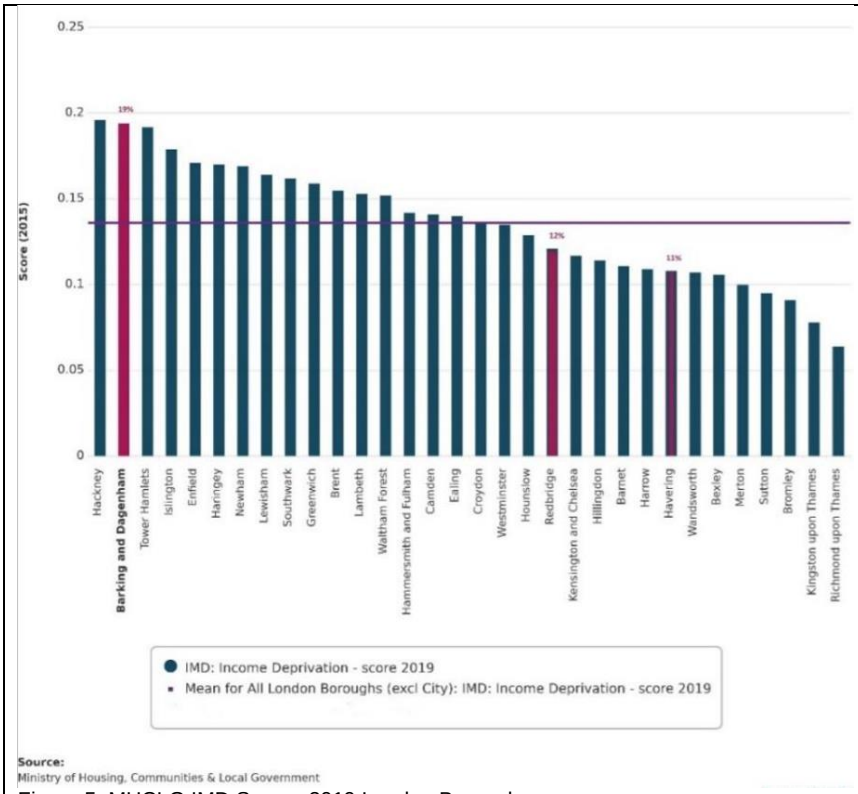


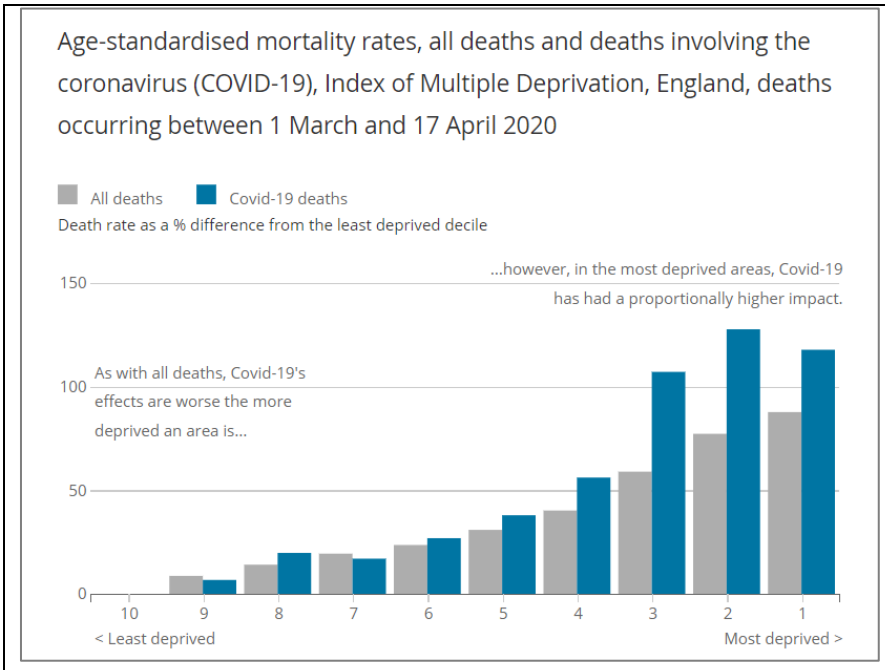
Figure 5: MHCLG IMD Scores 2019 London Boroughs

Homelessness directly impacts on the health of children and young people e.g. children in temporary accommodation have poorer social networks and higher rates of mental health problems. In addition, homelessness can interfere with a child's studies further affecting their life chances in the longer term. Rates of family homelessness in Havering (2.5/1000 households) is slightly higher than the national average (1.7/1000 households).

People who sleep on the streets have particularly complex social issues and are at high risk of both substance misuse and mental health problems and effective care requires specialist input for both problems. Locally, the percentage of people receiving treatment for substance misuse and in concurrent contact from mental health services is lower than England as a whole.

PHE estimate that 1 in 10 excess winter deaths are directly attributable to fuel poverty and that 1 in 10 households in Havering are affected by fuel poverty (9.9%).

Nationally COVID-19 has had a proportionally higher impact on the most deprived areas. Figure 6 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



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.

It is expected that the Housing strategy will have a positive impact for the borough and its residents as the Housing Strategy commits to significant amount of Regeneration of homes, communities, businesses and improvements to infrastructure that will offer opportunity to local people.

Sources used:

This is Havering 2019/20 v4.4, Public Health Intelligence
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april
Indices of Multiple Deprivation, 2019 (IMD, 2019); Department for Communities and Local Government (DCLG).
Public Health England
MHCLG – IMD - Income Deprivation - score - measures the proportion of the population experiencing deprivation relating to low income. The definition of low income used includes both those people who are out-of-work, and those who are in work but who have low earnings (and who satisfy the respective means test).
Public Health Outcomes Framework (PHOF - 0.1ii. Life expectancy at birth); Public Health England (PHE); Produced by Public Health Intelligence. Published on February 2016

Multigenerational Households:		
Please tick (✓) all the relevant boxes that apply:		**Overall impact: Neutral** *There will be a wider range of accessible routes to find out about engaging with housing services.* **Do you consider that a more in-depth HIA is required as a result of this brief assessment?** **Yes** **No ✓**
Positive		
Neutral	✓	
Negative		

Evidence:

Multigenerational households are defined as homes where there are two or more generations of the same family living together, often consisting of elderly parents and one or more adult children (over the age of 25).Nearly 7% of UK households are multigenerational, which is roughly equivalent to 1.8 million households. The number of multigenerational households in the UK has been increasing, driven by greater numbers of adult children (aged 25 or over) living in the parental homes.

Four out of five multigenerational households in the UK are White British, although some ethnic groups (predominantly Asian families) are more likely than White British people to live in multigenerational households.

Older people in multi-generational households are considered to be at a higher risk of Coronavirus infection.The proportion of over-70s in a local authority area who share a household with people of working-age is confirmed to be a significant factor in accounting for the variation in the number of Covid-19 cases across England – even when levels of local deprivation, the time since the area first recorded five cases and an additional, non-specific, "London effect" are taken into account.

Sources used:

https://www.cbre.co.uk/research-and-reports/our-cities/multi-generational-housing
https://www.npi.org.uk/files/2115/8661/6941/20-04-11_Accounting_for_the_variation_in_Covid_cases_across_England.pdf

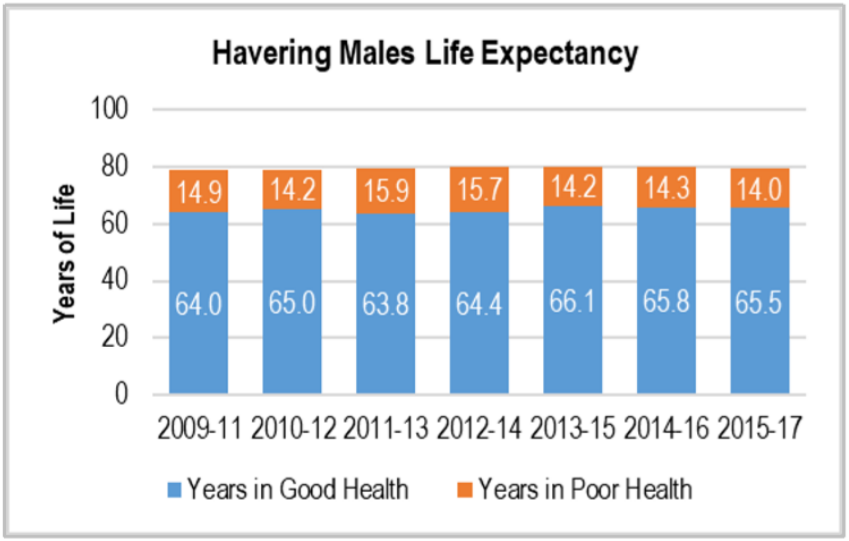
https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Multigenerational-living-An-opportunity-for-UK-house-builders.pdf

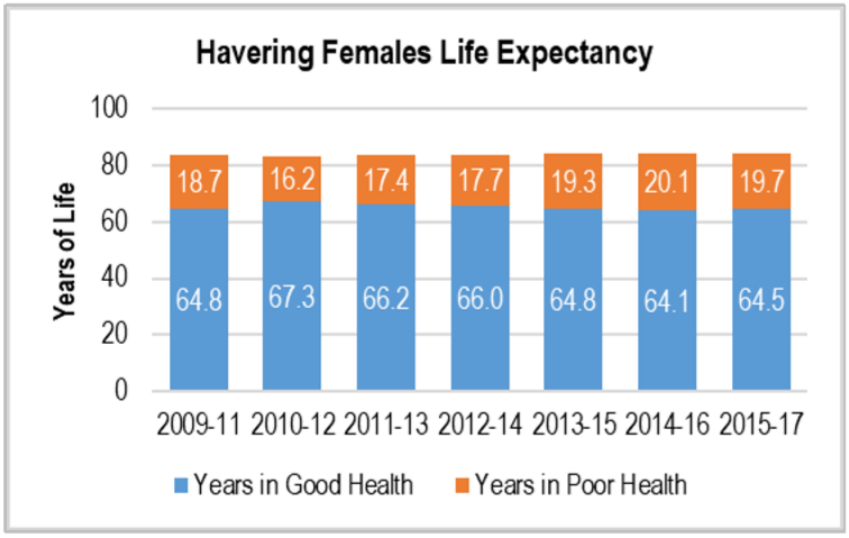
Health & Wellbeing Impact:		
Please tick (✓) all the relevant boxes that apply:		**Overall impact: Neutral** *There will be a wider range of accessible routes to find out about engaging with housing service.*
Positive		
Neutral	✓	**Do you consider that a more in-depth HIA is required as a result of this brief assessment?** Please tick (✓) the relevant box **Yes** **No** ✓
Negative		

Evidence:

Life expectancy in Havering is similar to the national average. As is the case nationally, life expectancy has increased steadily over recent decades but more recently, the rate of improvement has slowed if not stopped entirely.

The additional years of life achieved in recent decades are impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services.





Figures 1 & 2. Havering Life expectancy 2009-11 to 2015-17

Previously obesity was associated with middle age. Now 1 in 10 children are obese by the age 5, rising to 1 in 5 by age 11. Type 2 diabetes is now a disease of childhood and very large numbers of residents will run the increased risk cancers, CVD, MSK etc. associated with excess weight for many more years of life.

The family home is by far the most important community for any child. A secure and loving family is the single best predictor of subsequent life chances and one that other agencies struggle to replicate. Nonetheless there is extensive evidence regarding the impact of negative factors experienced within the family home during childhood on later life. 'Adverse childhood experiences' is one way of describing these negative factors. UK studies have suggested a relationship between these experiences and negative outcomes.

Health and wellbeing behaviours	Social and community impact	Impact on services
Those with 4 ACEs + are:		
2x more likely to have a poor diet	2x more likely to binge drink	2.1 x more likely to have visited their GP in the last 12 months
3x more likely to smoke	7x more likely to be involved in recent violence	2.2 x more likely to have visited A&E in the last 12 months
5x more likely to have had sex under 16 years	11x more likely to have been incarcerated	2.5 x more likely to have stayed a night in hospital
6x more likely to have been pregnant or got someone accidently pregnant under 18	11x more likely to have used heroin or crack	6.6 x more likely to have been diagnosed with an STD

Sources used:
Public Health England
Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population

3. Outcome of the Assessment

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

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

✓	1. The EqHIA identified no significant concerns OR the identified negative concerns have already been addressed		**Proceed with implementation** of your activity
	2. The EqHIA identified some negative impact which still needs to be addressed		**COMPLETE SECTION 4:** **Complete action plan** and finalise the EqHIA
	3. The EqHIA identified some major concerns and showed that it is impossible to diminish negative impacts from the activity to an acceptable or even lawful level		**Stop and remove** the activity or **revise** the activity **thoroughly.** **Complete an EqHIA on the revised proposal.**

4. Action Plan

The real value of completing an EqHIA comes from the 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 address any negative equality and health & wellbeing impacts you have identified in this assessment. Please ensure that your action plan is: more than just a list of proposals and good intentions; 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

Add further rows as necessary

***** You should include details of any future consultations and any actions to be undertaken to mitigate negative impacts

** Monitoring: You should state how the impact (positive or negative) will be monitored; what outcome measures will be used; the known (or likely) data source for outcome measurements; how regularly it will be monitored; and who will be monitoring it (if this is different from the lead officer).

5. Review

Scheduled date of review:
Lead Officer conducting the review:

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