LB Havering JSNA 2025
Dying Well Profile

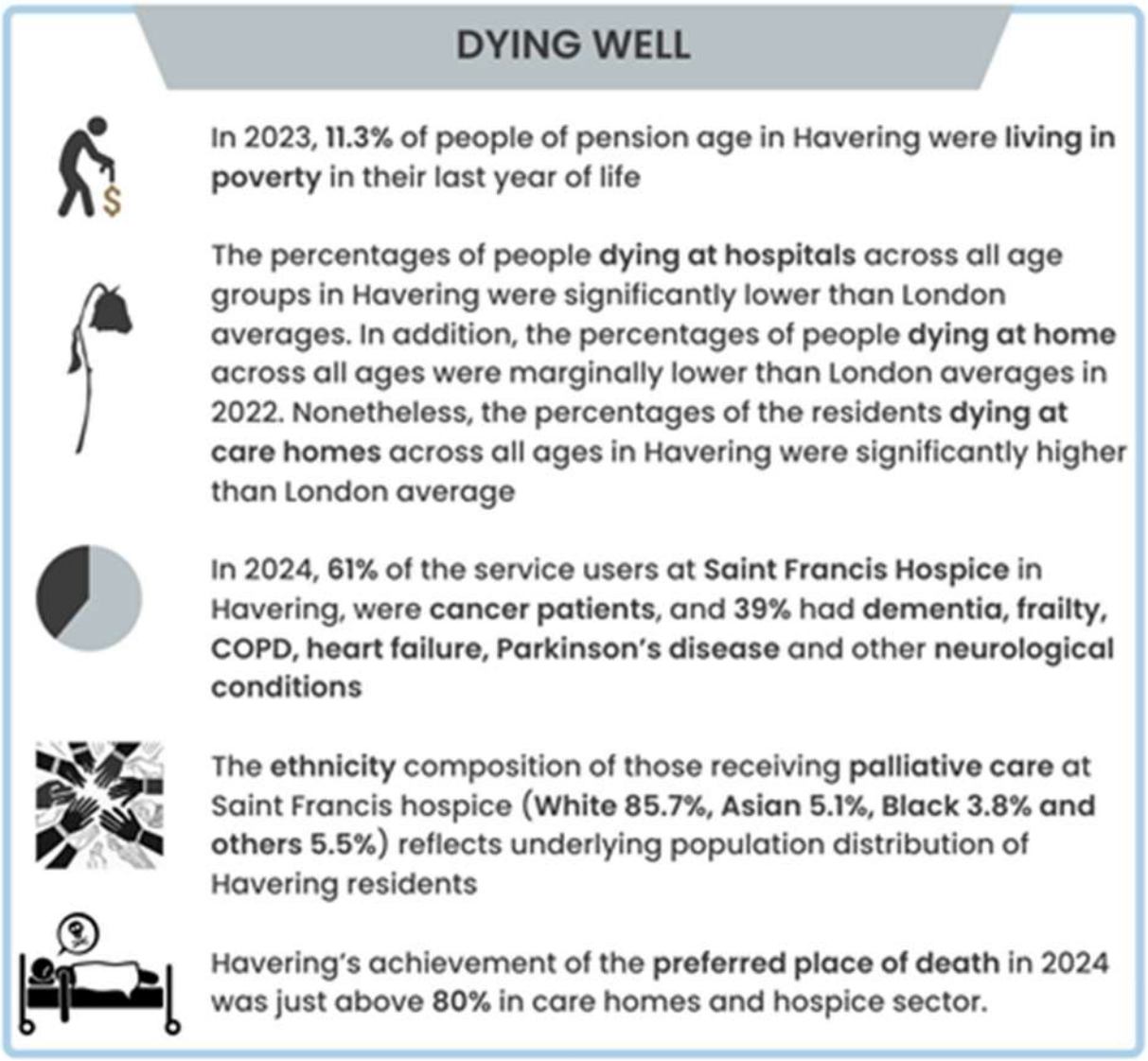
Table of Contents

List of abbreviations

Abbreviation	Full Form
BHR	Barking, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
COPD	Chronic Obstructive Pulmonary Disease
EoL	End of Life
EoLC	End of Life Care
GP	General Practitioner
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
LAS	London Ambulance Service
MDT	Multi-disciplinary team
NEL	North East London
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PPD	Preferred Place of Death
UCP	Urgent Care Plan

6. Dying Well

6.1 Infographic Summary



6.2 Key Findings & Recommendations

Key findings

- In 2022, 11.3% of Havering residents of pension age were in poverty in their last year of life.
- Havering's 75+ population is 93.5% White but this proportion is changing with continued inward migration from other London boroughs.
- Havering's proportion of adults aged 66 years and over **living alone** (12.7%) is similar to England average but higher than London average (9.1%).
- In 2021, the percentage of people providing **unpaid care** in Havering (9.2%) was higher than the London average (7.7%)
- The percentages of people **dying at hospitals** across most age groups in Havering were lower than London averages in 2023. Nonetheless, the percentages of the residents **dying at care homes** across most ages in Havering were significantly higher than London average. A significantly higher proportion of care home deaths compared to London averages may indicate good availability of care home placements, the availability of specialist palliative care advice and end-of-life care support in care home settings.
- The percentage of Havering patients who died at **hospices** for age groups **under 75 years was higher** than London and England averages.
- In 2024, 61% of the Havering service users at Saint Francis Hospice were cancer patients, and 39% had dementia, frailty, COPD, heart failure, Parkinson's disease and other neurological conditions.
- The **ethnicity composition** of Havering patients receiving palliative care at Saint Francis hospice (White 85.7%, Asian 5.1%, Black 3.8 and others 5.5%) reflects underlying population distribution of Havering residents aged 70-74 years (White 99.2%, Asian 4.5%, Black 1.7% and other 1.7%).
- Havering's achievement of the **preferred place of death** was just above 80% in care homes and hospice sector in 2024.

Recommendations:

- The council, ICB and partners should adequately support residents to ensure the last stages of their lifes happen in the best possible circumstances, receiving the right help at the right time from the right people, and place.
- The council, ICB and partners should enhance home based end of life care by increasing training for care givers and community services on managing end of life symptoms effectively
- NEL ICB should increase the use of urgent care plan (UCP) and ensure that UCPs are well integrated with primary care, secondary care and ambulance records.
- Local commissioners and providers of palliative and end of life care should apply NICE guidance NG142 in the context of local and national priorities for funding and in light of their duties to have due regard to the need to eliminate unlawful discrimination and to reduce health inequalities.
- The council, ICB and partners should strengthen end-of-life care to increase the proportion of people who are supported to die with dignity in their usual place of residence or a preferred place of death.
- The council, ICB and partners should ensure timely access to end-of-life medications by working with community pharmacies.
- The council, ICB and partners should work towards increasing capacity and resources for hospice care to meet the demand for hospice care among those under 75 years of age

6.3 Introduction

Wellbeing matters for everyone at all stages of life, and the end of life is no exception. Adequately addressing the needs of patients at the end of life and their relatives is pivotal in preventing unnecessary suffering and optimising their quality of life. The borough's need for palliative care will continue to grow as a result of the ageing of populations and the rising burden of diseases.

If someone has an illness that cannot be cured, palliative care makes them as comfortable as possible by managing their pain and other distressing symptoms. It also involves psychological, social and spiritual support for them and their family or carers. This is called a holistic approach, because it deals with them as a "whole" person, not just their illness or symptoms. Early delivery of palliative care reduces unnecessary hospital admissions and the use of health services.

People are considered to be approaching the end of life when they are likely to die within the next 12 months, although this is not always possible to predict. This includes people whose death is imminent, as well as people who:

- have an advanced incurable illness, such as cancer, dementia or motor neurone disease
- are generally very frail and have co-existing conditions that mean they are expected to die within 12 months
- have existing conditions if they are at risk of dying from a sudden crisis in their condition
- have a life-threatening acute condition caused by a sudden catastrophic event, such as an accident or stroke

End of life care should help them to live as well as possible and to die with dignity. The people providing their care should ask them about their wishes and preferences and take these into account as they work with them to plan their care. They should also support their family, carers or other people who are important to you. They have the right to express their wishes about where they would like to receive care and where they want to die. They can receive end of life care at home, in a care home, hospice or be cared for in hospital, depending on their needs and preference.

In 2021, NHS England published a national framework for local action (2021-2026)[1] with 6 ambitions for Palliative and End of Life Care:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

[1] https://www.england.nhs.uk/wp-content/uploads/2022/02/ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf

6.4 Wider Determinants of Health

In 2022, 11.3% of Havering residents of pension age were in poverty in their last year of life. Poverty makes dying well harder. Havering's 75+ population is currently 93.5% White but this proportion is changing with continued inward migration from other London boroughs (Table 18). In a study carried out by Marie Curie, they found that, overall, palliative and end of life care provision for ethnic minority groups was often inadequate.[2] Therefore, raising awareness across communities and provision of culturally sensitive care will be crucial in meeting the diverse needs of the Havering population.

Robust knowledge of these services, and the range of other supports available, is therefore key to ensuring households and families impacted by terminal illnesses are able to access care and support when and where they need it. In death literate communities, people can talk openly about death and dying. This helps to increase engagement with palliative care services and also leads people to feel more capable of sharing their end of life wishes.[3]

Table 18: Havering population 65 years and above by age and ethnicity, 2021

Ethnicity	Age 65 to 69 years	Age 70 to 74 years	Age 75 to 79 years	Age 80 to 84 years	Age 85 and over
Asian	6.20%	4.51%	3.46%	3.21%	2.01%
Black	3.24%	1.70%	1.89%	1.90%	1.38%
Mixed	0.56%	0.54%	0.48%	0.39%	0.36%
Other ethnic group	1.63%	1.11%	0.69%	0.70%	0.49%
White	88.4%	92.2%	93.5%	93.8%	95.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: ONS Census, 2021

Service Gaps / Unmet Needs

Occasionally, residents with complex need e.g., drugs and alcohol use, rough sleeping or mental health condition have died without end of life care and referred to safeguarding for review. It is also important that end of life care services adequately cater for those with learning disability or autistic spectrum disorder.

Recommendation

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people, and place.

[2] https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/june-2013/palliative-and-end-of-life-care-for-black-asian-and-minority-ethnic-groups-in-the-uk.pdf
[3] https://www.mariecurie.org.uk/document/creating-a-death-literate-society-ni-2022

6.5 Places & Communities

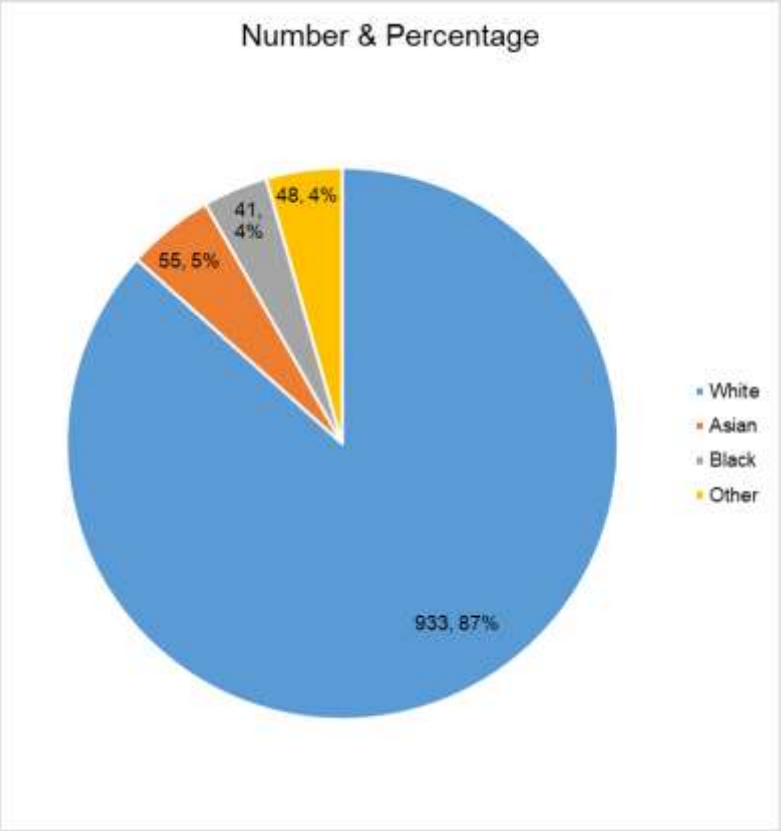
We need to build communities which are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways, where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss.

According to the census 2021, the percentage of people providing unpaid care in Havering (9.2%) was higher than London average of 7.7%.

The proportion of adults aged 66 and over living alone (12.7%) was similar to England average but higher than London average (9.1%).

In 2024, 85% of the service users at Saint Francis Hospice were White reflecting the Havering's older people population characteristics (Figure 61). The hospice is for anyone struggling with an advanced progressive condition, irrespective of faith or ethnic background.

Figure 61: Ethnicity distribution of service users at Saint Francis Hospice in Havering, 2024



Source: Saint Francis Hospice.

The community awareness of services or options for End-of-life-care (EoLC) should be strengthened as well as ensuring consistency of sharing EoLC plans across all care settings. With adequate planning and support people can die with dignity in familiar surroundings; for some people this will mean a care home. The BHR EoLC work stream aim is to acknowledge

a person's wishes and support their end-of-life needs in their preferred place of care and is addressing this challenge across three boroughs. Care Home Support, a rapid response team and 24-hour support line are being implemented and the palliative care capacity is increasing to improve the quality of the end-of-life care.

Place of death (for home, care homes, hospice and hospitals)

The percentages of people dying at hospitals across all age groups were significantly lower than London averages. In addition, the percentages of people dying at home across all ages were marginally lower than London averages in 2022. Nonetheless, the percentages of the residents dying at care homes across all ages were significantly higher than London average. A significantly higher proportion of care home deaths compared to London averages may reflect more availability of care home placements in Havering but could also suggest a need for more robust home care or hospice care alternatives.

The percentages of those who died at hospices for age groups under 75 years in Havering were higher than London and England averages. It is positive that the hospice services are preferred place of death for many under 75s so we can build upon this confidence for broader age groups.

Bereavement support

OrangeLine is a telephone support line (01708 758649) for any local person of any age who may be bereaved, feeling isolated or lonely. OrangeLine helps by:[4]

- Regular telephone calls from specially trained OrangeLine staff and volunteers
- Information and signposting to local services and social groups
- Referrals to local specialist advice centres

Recommendations

- People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people, and place.
- Enhance Home based end of life care by increasing training for care givers and community services on managing end of life symptoms effectively
- To work with community partners to ensure there is no disparities in hospice usage amongst ethnic minorities e.g., outreach work targeting potentially under-represented groups to raise awareness of end of life care options.

6.6 Lifestyle & Behaviours

Awareness and preparation: It is important that people are supported to be able to make the end-of-life arrangements. When someone is approaching end of life, health and care services should ask them:

- Whether they have an advance care directive
- If they've named someone to make decisions about their medical care
- Whether someone knows where their important paperwork is and what their essential online passwords are

[4] https://www.sfh.org.uk/orangeline-helpline

- If they have a current will
- If they have funeral preferences and whether they want to be buried or cremated

Recommendation

Strengthen end-of-life care to increase the proportion of people who are supported to die with dignity in their usual place of residence or a preferred place.

6.7 Integrated Health & Social Care

Each person's journey to death is unique. Some people have a very gradual decline, while others fade away quickly. Different health and social care professionals may be involved in their end of life care, depending on their needs. For example, hospital doctors and nurses, their GP, community nurses, hospice staff and counsellors may all be involved, as well as social care staff, chaplains (of all faiths or none), physiotherapists, occupational therapists or complementary therapists.
Palliative and end of life care: If they have an illness that cannot be cured, palliative care makes them as comfortable as possible by managing their pain and other distressing symptoms. It also involves psychological, social and spiritual support for them and their family or carers. This is called a holistic approach, because it deals with them as a "whole" person, not just their illness or symptoms.

End of life care is a form of palliative care they receive when you're close to the end of life. People are considered to be approaching the end of life when they are likely to die within the next 12 months, although this is not always possible to predict.

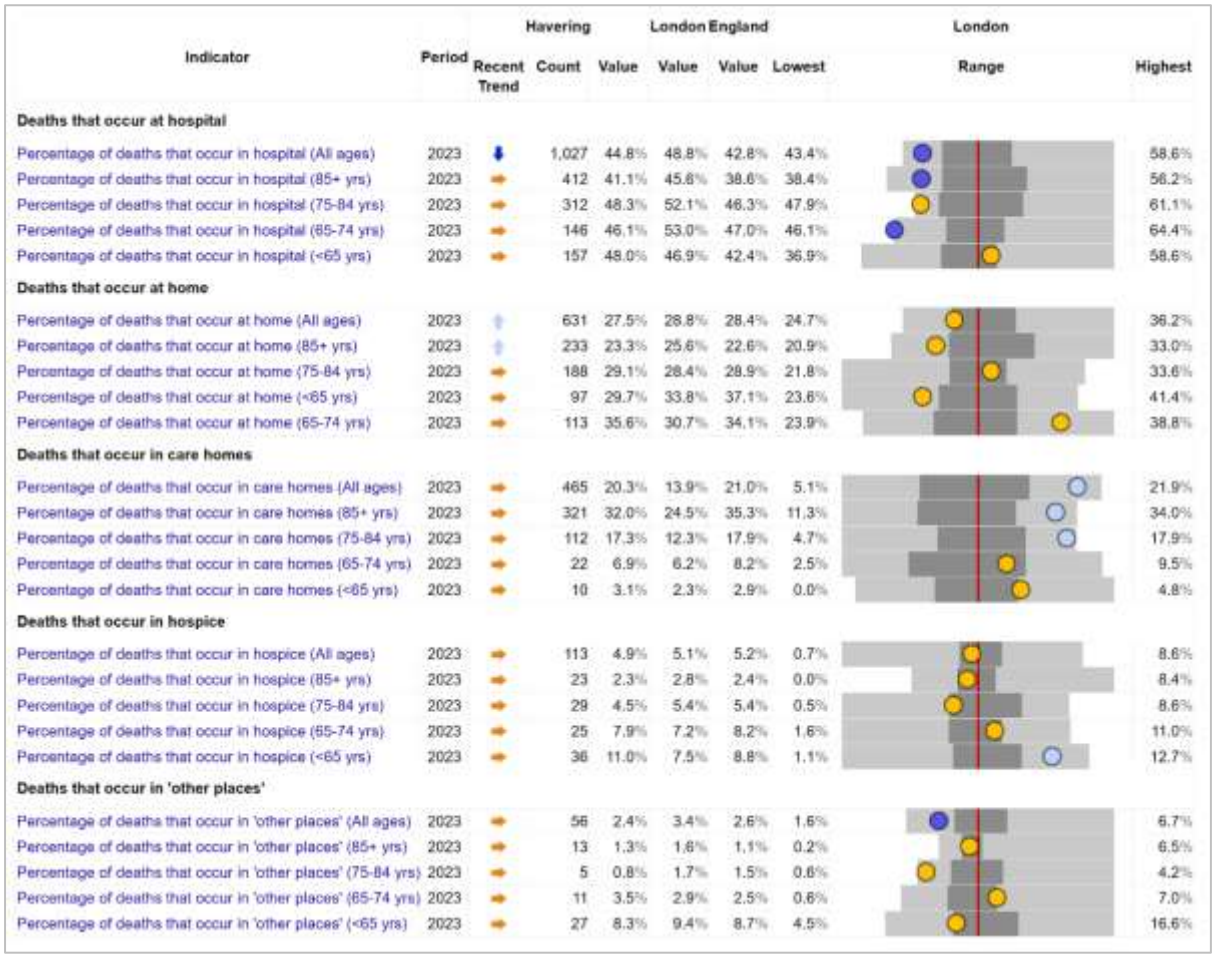
Both palliative care and end of life care could be given at home, care homes and specialist palliative care provider depending on the individual situation and choice. The providers work alongside GPs, community nurses, social care, voluntary care sector organisation and hospital specialists to help manage pain and other difficult symptoms, with an aim for comfort, as much independence as possible, and the best possible quality of life. Hospice services support those on the frontline and those in crisis with complex issues related to end of life care. We need to ensure timely access to services for people facing advanced illness.

NICE Guidance NG142 (https://www.nice.org.uk/guidance/ng142) covers organising and delivering end of life care services, which provide care and support in the final weeks and months of life (or for some conditions, years), and the planning and preparation for this. It includes recommendations on:

- Identifying adults who may be approaching the end of their life
- Holistic needs assessment
- Supporting carers and providing information
- Reviewing current treatment
- Advance care planning and reviewing people’s needs
- Communication between services, providing multi-practitioner care and care coordination
- Transferring people between care settings and providing out-of-hours care.

The percentages of people dying at hospitals across most age groups in Havering were significantly lower than London averages. Nonetheless, the percentages of the residents dying at care homes across most ages in Havering were significantly higher than London average. A significantly higher proportion of care home deaths compared to London averages may indicate good availability of care home placements. (Fig. 62)

Figure 62: Place of death in Havering, 2023.



Indicator	Period	Havering			London	England		London	
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
Deaths that occur at hospital									
Percentage of deaths that occur in hospital (All ages)	2023	↓	1,027	44.8%	48.8%	42.8%	43.4%		58.6%
Percentage of deaths that occur in hospital (85+ yrs)	2023	→	412	41.1%	45.6%	38.6%	38.4%		56.2%
Percentage of deaths that occur in hospital (75-84 yrs)	2023	→	312	48.3%	52.1%	46.3%	47.9%		61.1%
Percentage of deaths that occur in hospital (65-74 yrs)	2023	→	146	46.1%	53.0%	47.0%	46.1%		64.4%
Percentage of deaths that occur in hospital (<65 yrs)	2023	→	157	48.0%	46.9%	42.4%	36.9%		58.6%
Deaths that occur at home									
Percentage of deaths that occur at home (All ages)	2023	↑	631	27.5%	28.8%	28.4%	24.7%		36.2%
Percentage of deaths that occur at home (85+ yrs)	2023	↑	233	23.3%	25.6%	22.6%	20.9%		33.0%
Percentage of deaths that occur at home (75-84 yrs)	2023	→	188	29.1%	28.4%	28.9%	21.8%		33.6%
Percentage of deaths that occur at home (<65 yrs)	2023	→	97	29.7%	33.8%	37.1%	23.6%		41.4%
Percentage of deaths that occur at home (65-74 yrs)	2023	→	113	35.6%	30.7%	34.1%	23.9%		38.8%
Deaths that occur in care homes									
Percentage of deaths that occur in care homes (All ages)	2023	→	465	20.3%	13.9%	21.0%	5.1%		21.9%
Percentage of deaths that occur in care homes (85+ yrs)	2023	→	321	32.0%	24.5%	35.3%	11.3%		34.0%
Percentage of deaths that occur in care homes (75-84 yrs)	2023	→	112	17.3%	12.3%	17.9%	4.7%		17.9%
Percentage of deaths that occur in care homes (65-74 yrs)	2023	→	22	6.9%	6.2%	8.2%	2.5%		9.5%
Percentage of deaths that occur in care homes (<65 yrs)	2023	→	10	3.1%	2.3%	2.9%	0.0%		4.8%
Deaths that occur in hospice									
Percentage of deaths that occur in hospice (All ages)	2023	→	113	4.9%	5.1%	5.2%	0.7%		8.6%
Percentage of deaths that occur in hospice (85+ yrs)	2023	→	23	2.3%	2.8%	2.4%	0.0%		8.4%
Percentage of deaths that occur in hospice (75-84 yrs)	2023	→	29	4.5%	5.4%	5.4%	0.5%		8.6%
Percentage of deaths that occur in hospice (65-74 yrs)	2023	→	25	7.9%	7.2%	8.2%	1.6%		11.0%
Percentage of deaths that occur in hospice (<65 yrs)	2023	→	36	11.0%	7.5%	8.8%	1.1%		12.7%
Deaths that occur in 'other places'									
Percentage of deaths that occur in 'other places' (All ages)	2023	→	56	2.4%	3.4%	2.6%	1.6%		6.7%
Percentage of deaths that occur in 'other places' (85+ yrs)	2023	→	13	1.3%	1.6%	1.1%	0.2%		6.5%
Percentage of deaths that occur in 'other places' (75-84 yrs)	2023	→	5	0.8%	1.7%	1.5%	0.6%		4.2%
Percentage of deaths that occur in 'other places' (65-74 yrs)	2023	→	11	3.5%	2.9%	2.5%	0.6%		7.0%
Percentage of deaths that occur in 'other places' (<65 yrs)	2023	→	27	8.3%	9.4%	8.7%	4.5%		16.6%

Source: OHID

To facilitate home based end of life care, it is crucial to provide effective training for care givers and community services on managing end of life symptoms, and to ensure that urgent care plans are well integrated with primary care and hospital records/LAS enabling seamless care transitions and timely access to services. Moreover, we must work with community pharmacies to ensure timely access to end of life medications particularly for those opting for home based care.

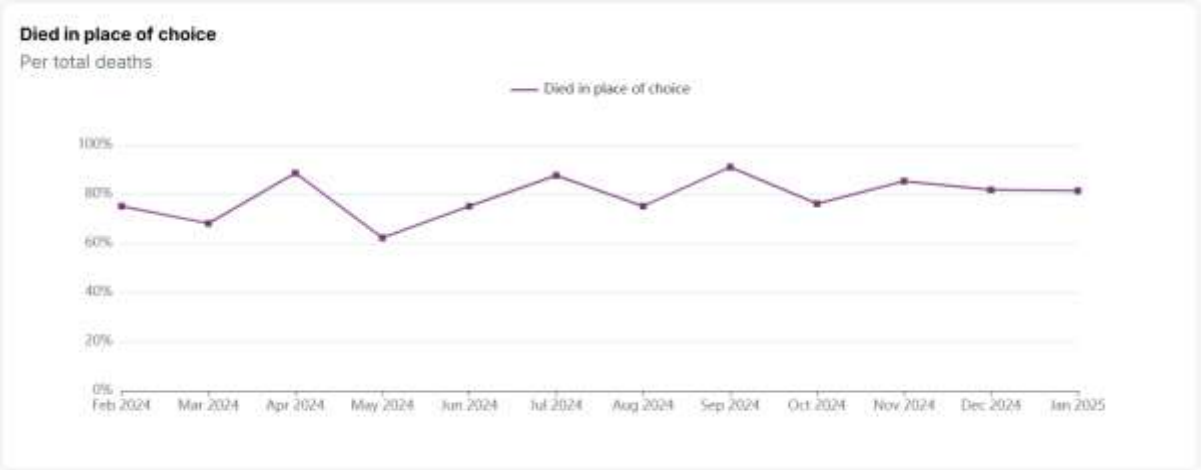
Place of death and preferred place of death

Helping someone to be cared for and die in their preferred place, avoiding intensive hospital treatment are all crucial palliative considerations.[5] To improve dying at the preferred place of death, we should regularly analyse place of death against preferred place and transform services to match patient preferences also ensuring this information is included in urgent care plans. There should be regularly reviewed including an update of patients' preferred place of death throughout their care journey. A key quality metric could be a report on the

[5] https://www.england.nhs.uk/blog/its-emotional-lets-talk-about-dying/

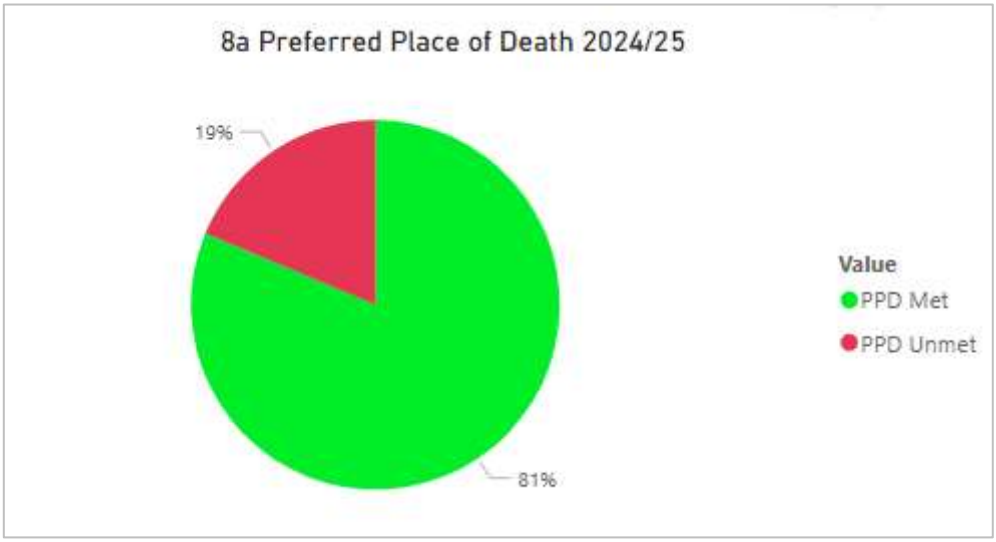
percentage of individuals achieving their preferred place of death. Although there is no publicly available data, data provided by Saint Francis Hospice shows that over 80% of those who died in care homes were recorded as “died in place of choice” in 2024 (Fig. 63). Similarly, 81% of those who died at Saint Francis Hospice were recorded to be deaths at preferred place of death up to Q3 2024/25.

Figure 63: Percentage of deaths documented as preferred place of death among those who passed in nursing homes in Havering Feb 2024 to Jan 2025.



Source: Carepulse

Figure 64: Percentage of deaths documented as preferred place of death among those who passed at Saint Francis Hospice.



Source: Saint Francis Hospice, Havering, 2025.

The percentages of those who died at hospices for age groups under 75 years were higher than London and England averages. Nonetheless, people had to make decision to be in the hospice for their place of choice for death.

To meet the demand for hospice care among under 75s, we should strengthen the capacity and awareness for hospice care. We need to partner collaboration to provide enhanced bereavement support for families and care givers.

Saint Francis Hospice is a major provider of both of these services. Higher referrals were seen in December, January, May and June. Referral sources were mainly from the hospitals, followed by GP, district nurses and self- referrals. They also provide support on hospital wards.

Although there is no central register for all adults who need palliative care or end of life care, and the reasons for requiring palliative care, the largest provider Saint Francis Hospice in Havering reported that in 2024, 61% of the service users were cancer patients, and 39% had dementia, frailty, COPD, heart failure, Parkinson's disease and other neurological conditions. Year-on-year, the hospice is helping with a broader range of advanced illnesses that need palliative care.

It is crucial that death does not come unexpected and after an emergency hospital admission. Proactive care planning can reduce emergency admission at end of life and by better identification of earlier palliative care needs. This could be achieved through GP and MDT training on identifying deterioration of those likely to die within 12 months and initiating EoL discussions early. Community pharmacies could be included in EoLC multi-disciplinary teams (MDTs) to improve medication management and symptoms control. The success could be measured by the reduction on the percentage of older people dying within 7-days of emergency hospital admissions.

Service Gaps / Unmet Needs

Residents with liver failure who have complex issues (rough sleeping, substance misuse, mental health condition, lack of family and social support) could die without a planned end of life care.

Recommendations

Local commissioners and providers of palliative and end of life care should:

- Apply NICE guidance NG142 in the context of local and national priorities for funding and in light of their duties to have due regard to the need to eliminate unlawful discrimination and to reduce health inequalities.
- Work towards improving early access to available community palliative care support services to prevent avoidable hospital admissions;
- Increase the use of urgent care plan (UCP) in EoLC, especially within the community setting, to improve multi-agency communication and prevent avoidable hospital admissions;
- Ensure that urgent care plans are well integrated with primary care and hospital records/LAS enabling seamless care transitions and timely access to services;
- Regularly update place of death against preferred place and information is included in urgent care plans;
- Develop mechanisms to regularly review and update patients preferred place of death to match the demand and supply;
- Include community pharmacies in MDT EoLC teams to improve medication management and symptoms control; and to ensure timely access to end-of-life medications by working with community pharmacies;
- Increase capacity and resources for hospice care to meet the demand for hospice care among those under 75 years of age; and to collaborate with the hospices to provide enhanced bereavement support for families and care givers.
- Facilitate care providers to report on the percentage of individuals achieving their preferred place of death and those dying within 7 days of an emergency admission.