SSA EQUALITY IMPACT AND NEEDS ANALYSIS

Directorate	Adult Social Care and Public Health
Service Area	Public Health
Service/policy/function being assessed	Joint Local Health and Wellbeing Strategy
Which borough (s) does the service/policy apply to	Wandsworth
Staff involved in developing this EINA	Shannon Katiyo Riya Verma
Date approved by Directorate Equality Group (if applicable)	N/A
Date approved by Policy and Review Manager All EINAs must be signed off by the Policy and Review Manager	26/07/23
Date submitted to Directors' Board	To be confirmed (September)

1. Summary

Introduction

The Joint Local Health and Wellbeing Strategy (JLHWS) is the Health and Wellbeing Board's five-year plan setting out how the local authority, NHS, and other partners including the voluntary and community sector will work together jointly to meet the health and wellbeing needs of Wandsworth residents. This plan addresses the health and wellbeing needs of residents identified in the refreshed Joint Strategic Needs Assessment for Wandsworth (JSNA), published in 2022.

This strategy follows a life course approach which recognises a wide range of factors influencing mental and physical health and wellbeing which often cluster in the population at different life stages. The priority areas are grouped into three life stages i.e., Start Well, Live Well and Age Well.

Following the publication of the JSNA in 2022, a series of prioritisation seminars were held; one focusing on children and young people 'Start Well', and another focus on working aged adults and older people, titled 'Live Well', and 'Age Well, respectively' to help decide on which priorities would be the focus of the strategy. The priorities identified were agreed by the Health and Wellbeing Board.

'Start Well' identifies the main priorities as self-harm and mental health, obesity, immunisations, and A&E attendances or hospital admissions caused by unintentional and deliberate injury.

'Live well' identifies the main priorities as immunisations, a range of long-term conditions, cancer screening uptake, and the impacts of air quality & climate change on health. Priorities were also identified around mental health & suicide prevention, and health behaviours such as smoking, alcohol, physical activity, and healthy eating.

'Age well' identifies the main priorities as Falls, Dementia, and Social isolation.

Changes proposed – The changes that will arise from implementation of the strategy are based on the following actions:

START WELL

Self-harm and mental health

- A strategy to prevent mental disorders and improve community resilience.
- Ensure that all schools and colleges have access to Mental Health Support Teams
- Consolidate whole school approaches to improve the mental health and well-being of children and young people.
- Establish the I Thrive integrated, person-centred, and needs-led approach to delivering mental health services for children and young people across the system.
- Promote the self-harm and suicide prevention toolkits to schools, parents, children and young people and frontline staff to support a reduction in self-harm and suicide among children and young people

Childhood obesity

- Research shows that Breastfeeding and healthy weaning is an important start to sustaining health weight.
- Offer places on A Family Weight Management Programme for these identified as overweight or obese by the NCMP.
- Work with leisure and environment partners to encourage more use of open spaces, playgrounds, and sporting activities.

Childhood immunisations

- Improved community engagement to address inequalities. E.g.,
    - To develop outreach programmes based on joint working with public health, Healthwatch, and voluntary sector and community groups, to support hard-to-reach groups to get vaccinated (tackling health inequalities)
    - Using population health management approach to understand groups with lower uptake.
- To improve access to immunisation services
- To innovate and flex the system to improve uptake.
    - e.g., centralised call centre for all immunisations
- To improve access to better quality data to better identify gaps.

A&E attendances, and hospital admissions caused by unintentional and deliberate injury.

- Maintain 0-5 Healthy Child Programme: reducing accidents and minor illnesses is one of the six high impact areas and includes:
    - Contact and liaison with parents following admission to A&E, where safeguarding risks may be identified.
    - Evidence-based accident prevention information and guidance within child health clinics / reviews.
    - Bespoke safety sessions with care leavers who are also parents.
    - Delivery of safety sessions for parents with children aged under 6 months
- Improve understanding of data at a local level including top 10 A&E attendances and/or primary admissions to hospital within the defined age brackets.
- Explore need to re-establish access to safety equipment for vulnerable families.
- Interagency training on the prevention of accidents & safer sleep messages e.g., Make Every Contact Count (MECC) module.
- Explore the provision of first aid training for parents at Children's Centres.
- Expand UNICEF Baby Friendly Initiative to Children's Centres.

- Consider public health targeted accident prevention campaigns, informed by local data.

LIVE WELL
Adult Immunisations

To improve community engagement to address inequalities by:

- Developing outreach programmes based on joint working with public health, Healthwatch, and voluntary sector and community groups, to support hard-to-reach groups to get vaccinated (tackling health inequalities)
- Using population health management approach to understand groups with lower uptake.

To improve access and increase uptake to immunisation services through innovation of the system:

- e.g., creating a centralised call centre for all immunisations

To improve access to better quality data to better identify gaps.

Bowel Cancer Screening

- To target underserved populations and health inequalities by engaging with established programmes such as the Homeless Health Offer.
- To educate the eligible cohort, highlighting the importance of screening To provide communication in a variety of languages and formats to increase accessibility (this also links with addressing health inequalities)
- To engage with the voluntary sector, faith groups and via primary care to promote cancer screening.

Cervical cancer screening

- **Addressing health inequalities**-targeting underserved populations and those less likely to take up services (example: utilising the Homeless Health Offer)
- **Health education** -e.g., highlighting the importance of screening amongst eligible cohort, e.g., the role of school health in communicating messages around screening.
- **Community engagement and comms**. -Engaging with women through primary care services to promote cancer screening, engaging with faith groups. Provide communication in a variety of languages and formats to increase accessibility (also links with addressing health inequalities)
- **Improving access**: Opportunistically offering cervical screening through sexual health clinics (there is an NHSE/CLCH offer currently being developed). Also, potential to offer opportunistically via other sites.

Breast Cancer screening

- To target underserved populations to address health inequalities by engaging with established programmes such as the Homeless Health Offer.
- To improve health education of eligible cohort, highlighting the importance of screening,
- To provide communication in a variety of languages and formats to increase accessibility (also links with addressing health inequalities)

- **To engage with** women, faith groups and primary care to promote cancer screening. Opportunistically offer cervical screening through sexual health clinics to improve access using the NHSE/CLCH offer currently being developed.

Type 2 Diabetes

- **Focus on prevention:**
- Raising awareness and improving patient engagement with structured education programmes such as NDPP and decathlon - particularly among sub-groups of the population at increased risk of developing diabetes.
- Ensure there is adequate provision of health promotion interventions such as weight management programmes, smoking cessation and healthy eating.
- **Find the missing thousands:**
- Identification and assessment of people at high risk of diabetes through the NHS Health checks and community health clinics.
- **Treat the missing hundreds:**
- Enabling enhanced and improved access to high quality information, treatment and care for people living with Diabetes, through patient education and self-management, medication, review and management of the three treatment targets (blood pressure, cholesterol and blood glucose).
- Upskilling clinicians, diabetes champions and the wider primary and community care workforce such as health coaches, clinical pharmacists, link workers and social prescribers to provide high-quality, person focused care and support to individuals with established disease or at risk of developing diabetes.
- Ensuring patients have access to specialist care such as specialist foot teams and ophthalmology
- **Close the variation gaps:**
- Implementation of the quality improvement framework to support underperforming practices to improve their achievement of the three treatment targets - to reduce variation across the borough.
- **Improve our enabling assets:**
- Strengthening Primary Care Networks as a vehicle for delivering collaborative working amongst front-line staff.
- Improving engagement and dynamic relationships with local communities to understand and address local health education needs.

Cardiovascular disease

Actions plans focus on closing the gap between the expected prevalence and diagnosis and treatment of patients with Hypertension, Atrial Fibrillation, raised cholesterol and Chronic Heart Disease.

- **Prevention**
- Ensure there is adequate provision of health promotion interventions such as weight management programmes, smoking cessation, and healthy eating
- Establish a local CVD Decathlon programme
- Identify opportunities to improve healthy lifestyle advice through Making Every Contact Count (MECC)

- **Identification**

- Increase uptake of Community Health Checks (outside healthcare settings)
- Expand and increase the scope of the BP@Home programme
- Identify opportunities to increase uptake of BP & ABPM checks via the Community Pharmacy Hypertension Case Finding Service (BPCS)
- Improve the model and increase delivery of holistic health checks in faith and community settings
- Use Core20PLUS5 data to target preventative strategies to support the most deprived and vulnerable communities
- Upskill ARRS roles (health & wellbeing coaches / social prescribing link workers and pharmacists)

- **Optimisation**
- Optimise care and treatment of people with hypertension in primary care using the UCLP proactive care frameworks
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score >20% on lipid lowering therapies
- Optimise the use of DOAC therapy in people with AF to reduce the risk of stroke
- Increase access to Cardiac Rehabilitation

- **Decrease variation**
- Support primary care to reduce variation between practices across the borough

Air quality

- To work collaboratively as a health and social care system in achieving reductions in air pollution emissions.
- To implement the new borough Air Quality Action Plan (following the recommendations from the Citizen's Assembly) and Climate Change Strategy to help tackle local sources of air pollution.
- To adopt and implement the new borough Local Spatial Plan to ensure new developments in the borough help to limit and reduce local sources of air pollution.
- To work collaboratively with the partners including NHS bodies, local pharmacies, and voluntary sector organisations to help raise awareness of health and air quality co-benefits and to highlight the impact of air pollution on vulnerable groups.

Climate Change

- To work collaboratively as a health and social care system in achieving Net Zero targets and in reducing emissions.
- To implement the Climate Change Strategy to help tackle impact of climate change.
- To adopt and implement the new borough Local Spatial Plan to ensure new developments in the borough help to limit carbon emissions.
- To work collaboratively with the partners including NHS bodies, local pharmacies, and voluntary sector organisations to help raise awareness of health and climate change co-benefits and to highlight the impact of climate change on vulnerable groups.
- All partners to develop adverse/extreme weather and health plans (heat/cold/drought/flood) as an adaptation measure to help minimise the risks to peoples' health.

Physical activity and healthy eating

Ensure these proposed actions are included in the forthcoming Leisure, Sport, and Physical Activity Strategy

- Target and support inactive adults to become more active.
- Identify barriers to participation and reduce them where possible.
- Create pathways for inactive adults to take small steps or 'doses' of physical activity
- Promote the benefits of physical activity to Wandsworth adults – specifically targeting those groups who are the least physically active and improve signposting to opportunities to be physically active
- Create an on-line physical activity offer for those who are unable to leave home
- Promote the benefits of informal physical activity in parks and open spaces
- Work with organisations who are supporting food insecurity to promote the benefits of healthy eating and consider providing a community recipe resource
- Promote the benefits of healthy eating when adults take their first step to join the physical activity ladder

Alcohol

- Monitor the number of new alcohol licences, licence renewals and change applications in Wandsworth by creating a pathway for reviewing applications received. Pathway will review on and off licence requests and make recommendations based on local data linked to crime, hospital admissions, surrounding premises, road traffic incidents and complaints.
- Keep people engaged in treatment after release from prison by increase rates of successful engagement in drug treatment for adults within three weeks of prison discharge (adult)
- Improve engagement of people before they leave prison by review rates of treatment engagement of those discharged with substance misuse needs and consider the actions needed if rates are below the London/England average (18-24).
- Maintain the oversight of drug related deaths via the quarterly Drug related deaths panel.
- Map the Alcohol Care Team (ACT) provision in the 3 local hospitals (West Middlesex, St George's, and Kingston). Consider the feasibility of adopting the Chelsea and Westminster hospital model locally.
- Consider the next published rates of alcohol related hospital admissions for under 18's from Wandsworth to ascertain if action is required.
- Consider a process/pathway for those young people having an alcohol related hospital admission that do not reach the threshold for specialist treatment.
- Ensuring that all pupils receive a co-ordinated and coherent programme of evidence-based interventions to reduce harm through primary prevention and reduce harm escalation. Ensure there is a specific focus on alcohol related harm in PSHE in mainstream secondary and alternative schools in Wandsworth.
- Conduct and evidence review of effective alcohol interventions in school aged children

Smoking

1. Provide targeted interventions for high-risk groups such as young people, pregnant women, and people with mental health conditions, while maintaining a universal offer.
2. Ensure access to evidence-based smoking cessation services, including Nicotine Replacement Therapy (NRT), such as patches, lozenges, oral spray, nasal spray, gum, sublingual tablets and lozenges, behavioural support, and digital interventions, to support people to quit smoking.
3. Monitor progress towards reducing smoking rates and improving health outcomes through the use of clear and measurable indicators, such as smoking prevalence, quit rates, hospital admissions for smoking-related illnesses, and health inequalities related to smoking.
4. Develop new and strengthen existing smoking cessation pathways across different health organisations and partnerships across NHS Trusts, the local authority and voluntary sector, particularly those aimed at targeted groups and reducing inequalities.
5. Advocate across the ICS the importance of stopping smoking on health outcomes and increase awareness of and visibility of smoking cessation services, pathways and access points with a focus on targeted groups and reducing inequalities.

Mental Health and Suicide Prevention

In addition to the Wandsworth Suicide Prevention and Self-Harm Strategy which highlights specific actions:

1. Prevention – Raising awareness, signposting residents to support services/offers
2. Tackling inequality – Reduce stigma particularly for LGBT, Ethnic minorities, men, carers population groups
3. Holistic approach to individuals and families and empowering our communities - Engagement campaigns to raise awareness of resources, services, offers offered and accessible to community groups individuals and families
4. 'Place' Integration – Using a targeted approach, allocate local resource to support the geographic and areas and resident cohorts of greatest need

AGE WELL

Falls

- Revise membership of the falls task & finish group, to ensure representation from services in the pathway and a collaborative approach.
- Revise falls prevention and rehabilitation pathways, to ensure clarity of inclusion and exclusion criteria, so that patients are seen by the appropriate service sooner
- Organise pop-up assessment clinics, which will form part of the wider community engagement strategy
- Develop a stronger community presence of falls services, enhancing the publics knowledge on falls prevention
- Care home work with UCR falls pickup services, embedding falls acoustic monitoring into care homes, working with care homes that have increased falls rates or no-pickup policies in place.
- Understanding the numbers of people who are admitted as an emergency for less than 1 day/ Same Day Emergency Care as a proportion of those people being admitted for a fall and working with the Wandsworth community providers to consider alternative pathways away from Hospital.

- Utilising population health management data from hospitals and community providers to ensure that falls recovery services are accessible for the Wandsworth population.

Dementia

General

1. **Establish Dementia Working Group:** to implement objectives in the Strategy
2. **Data & policy:** work with local partners to ensure local dementia data is up-to-date, accurate and accessible to all partners, that national and local policy is reflected in the work going forward, and that partners in the Wandsworth system can utilise this data to understand and address variations in the diagnosis rate by population cohort.

Prevention

3. **Build on the 'Think Brain Health Campaign'** dementia awareness training public health offer, linking to the prevention framework, targeting those identifying themselves as Black, Asian and Mixed ethnicity
4. **Dementia Friendly Wandsworth:** Review learning from 'Dementia Friendly London' and work with partners to create plan for Wandsworth
5. **Link with Live Well priorities:** helping to reduce modifiable risk factors for dementia

Diagnosis

1. **Dementia diagnosis:** Ensure rates remain high, with a particular focus on identifying people in care homes; ensure local support available and easily accessed to help the person and their family post diagnosis.

Dementia Care & Support and & End-of-Life care

2. **Undertake Pathway work:** address gaps, duplications, make improvements and create consistent approach.
3. **Information booklet:** explore opportunity to update booklet in attached link https://www.wandsworth.gov.uk/media/9566/dementia_services_in_wandsworth.pdf
4. **Universal Care Plan (UCP):** ensure every person diagnosed with dementia has a UCP and the person's needs at the end of their lives are addressed fully
5. **Carer respite:** explore opportunities to ensure good access to short breaks for unpaid carers
6. **Young Onset Dementia:** understand current needs and most suitable solutions, and develop a plan.
7. **Care Homes:** support and utilise learning from range of work on dementia being undertaken in Care Homes
8. **Training:** ensure good training opportunities exist for staff working with people with dementia

Social isolation

- Develop skills, resource and knowledge sharing across the system.
- Develop a mechanism to address gaps in data and identify gaps/issues that contribute to social isolation.
- Map transport systems to indemnify how to better link people with social opportunities and places.
- Build/invest in 'Social Capital' and the use of local networks and community assets to increase resilience.
- Identify gaps/issues that contribute to social isolation.
- Use digital technology to reduce social Isolation.

- Factor in outcomes of Voluntary Sector Needs Assessment regarding addressing social isolation and loneliness.

The Key findings of the EINA are that:

Summary on areas of under-representation/over-representation

Positive impacts

The Strategy sets out the priorities for the borough which are evidence-based so that improvements can be made to existing services, so that new services can be commissioned, or action can be taken to improve the public's health and reduce unfair and avoidable differences in people's health outcomes. It also provides an opportunity for the local authority to embed health improvement and prevention in all policy and decision making.
The Health and Wellbeing board agreed that any actions proposed should be guided by a set of five principles that are at the core of the strategy and embedded across all priority areas. The agreed principles are as follows:

1. **Tackling inequality:** We are committed to providing the most support to those who need it the most, and to work towards creating a fairer and more equal community. There are several groups within our community who have poorer health outcomes due to health inequalities which are avoidable and unfair, and we will ensure they are prioritised within our strategy. We recognise that the wider determinants of health, including income, employment, housing, and transport, are the most important drivers for health. Keeping them at the centre of our strategy will ensure we make health everyone's business. We will work closely with a wide range of stakeholders to address the wider determinants, reduce inequalities, and improve health.

2. **Focus on prevention:** We want to promote positive health and wellbeing by delivering an evidence-based approach to prevention through embedding the Council's Prevention Framework within the JLHWS. This will include helping to make the healthy choice the easy choice supporting a tailored approach to prevention; connecting with policies and initiatives to enable prevention work to be sustainable; and creating supportive communities and health promoting environments.

3. **Empowering our communities:** Communities are at the heart of everything we do, and we need to work with and empower our communities to produce positive, sustainable benefits for our residents. This strategy wants to add social value to our communities and ensure that the actions we take enable them to continue to improve their local communities after our initiatives are complete.

4. **Holistic approach to individuals and families:** By considering individuals holistically and supporting families through their life course, we will ensure that no group gets left behind. We will make sure that we have considered the needs of each group at different stages of life and identify areas where we can improve health at each part of the life course, particularly transition periods which can present the most challenging times. We will ensure individuals are considered within their wider social context to ensure we are offering effective support that looks beyond a diagnosis and is personalised to the individual. This includes identifying carers and ensuring they have access to adequate support.

5. **Place integration:** The new JLHWS provides a footprint which is owned and driven by all organisations working across the borough's health and care system, with a view to coordinate activity and bring about system wide change in response to the needs of our residents. We recognise that there are existing partnerships and strategies in place which will contribute to the success of the JLHWS. We will not seek to duplicate the work being done by existing strategies, but aim to recognise, coordinate, streamline and support a well-connected system working together to improve the health and wellbeing of our communities.

Negative impacts:

While a health and wellbeing strategy by design should not have any negative impact on the outcomes for any group in the population, there are several priority areas where data is not available to understand the impact on people with protected characteristics. This may result in a missed opportunity to address inequalities they may experience arising from the actions in the strategy.

2. Evidence gathering and engagement

a. What evidence has been used for this assessment? For example, national data, local data via DataRich or DataWand

Evidence	Source
Evidence of Need, Services Available, and Effective Interventions.	Wandsworth Joint Strategic Needs Assessment (detailed data sources are included for each priority area)

b. Who have you engaged and consulted with as part of your assessment?

Individuals/Groups	Consultation/Engagement results	Date	What changed as a result of the consultation
Start Well Prioritisation Seminar Invitees included: All Council Directorates Clinical Vice Chair and GP Borough Lead – SWL ICB Cabinet members Locality Executive Director and Team – SWL ICB SWL and St Georges Mental Health NHS Trust Wandsworth Care Alliance	The group considered the issues arising from the Joint Strategic Needs Assessment and used an evidence-based prioritisation framework to agree the issues that would be considered in the strategy. The priorisation framework considered the following: • Level of need and size of population affected • Comparative benchmark • Severity • Trend • Early intervention implications	26 July 2022	The Start Well seminar agreed that all the issues put forward for consideration would be prioritised in the refreshed strategy

Healthwatch Wandsworth Central London Community HealthCare Trust ENABLE St Georges University Hospital NHS Trust Silver Lined Horizons Burntwood School Southfields Academy	• Scale of inequality • Economic cost of the issue **A full report is available**		
Live Well, and Age Well Prioritisation Seminar Invitees included: Council Directorates Cabinet Members Age UK SWL ICB Locality Leads Wandsworth Care Alliance GP Primary Care Leads Local Pharmaceutical Committee Alzheimer's Society Battersea HealthCare St Georges University Hospital NHS Trust South London and Maudsley NHS Mental Health Trust MIND	The group considered the issues arising from the Joint Strategic Needs Assessment and used an evidence based prioritisation framework to agree the issues that would be considered in the strategy. The priorisation framework considered the following: • Level of need and size of population affected • Comparative benchmark • Severity • Trend • Early intervention implications • Scale of inequality • Economic cost of the issue **A full report is available**	29 June 2022	Using a scoring matrix, the Live Well, and Age Well Prioritisation Seminar agreed to prioritise several issues. Some issues were not agreed for prioritisation.
Wandsworth Place Committee Membership includes Local Authority SWL ICS Richmond Locality Kingston Hospital NHS Trust Chelsea and Westminster NHS Hospital Trust Wandsworth Care Alliance Healthwatch Wandsworth	The Wandsworth Place Committee was presented with the draft strategy and asked for feedback on the process and content of the strategy, including seeking an agreement in principle committing to deliver the actions in the strategy.	5 July 2023	The Committee asked for more information on the engagement of carers with the Strategy.

Central London Community Health NHS Trust Epsom and St Helier University Hospital NHS Trust Southwest London and St Georges NHS Mental Health Trust			

3. **Analysis of need was based on information in the refreshed Wandsworth Joint Strategic Needs Assessment** and DataWand.

Protected group	Findings
Age	The table below shows the population age structure for Wandsworth. Wandsworth has one of the youngest populations in the country and by 2029, the boroughs population will rise to 373,000 with the biggest increase within the 20-39 year old age group. 1 in 10 residents are 65 years old or older, by 2031 this population age group will increase by 26%. Age Group (5 Year) ▲ | Wandsworth | Inner London | London | Population 0 to 4 | 6.00% | 5.42% | 5.98% | 19,631 5 to 9 | 5.47% | 5.10% | 5.90% | 17,903 10 to 14 | 5.26% | 5.21% | 6.03% | 17,193 15 to 19 | 4.52% | 5.06% | 5.57% | 14,767 20 to 24 | 5.21% | 6.50% | 5.65% | 17,047 25 to 29 | 11.53% | 10.94% | 8.53% | 37,712 30 to 34 | 11.60% | 11.37% | 9.20% | 37,931 35 to 39 | 10.70% | 9.86% | 8.67% | 34,989 40 to 44 | 8.43% | 8.04% | 7.89% | 27,563 45 to 49 | 6.44% | 6.49% | 6.73% | 21,071 50 to 54 | 5.76% | 5.98% | 6.37% | 18,849 55 to 59 | 5.03% | 5.42% | 5.91% | 16,457 60 to 64 | 3.84% | 4.27% | 4.83% | 12,542 65 to 69 | 3.00% | 3.24% | 3.76% | 9,797 70 to 74 | 2.54% | 2.55% | 3.11% | 8,321 75 to 79 | 1.98% | 1.93% | 2.47% | 6,474 80 to 84 | 1.38% | 1.30% | 1.66% | 4,519 85+ | 1.30% | 1.31% | 1.73% | 4,243 There are various risks which place children and young people at a heightened risk of multiple and sustained childhood mental health difficulties. These include being a victim of abuse, poor

	housing, poverty, parental separation, financial crisis, parents with poor mental health, and experiencing traumatic events.
	
	Other children and young people at risk of suffering from a mental health condition are those who identify as LGBTQ+, looked after children and those in the youth justice system.
	
	Nearly three quarters of children with a mental health condition also have a physical health condition or developmental problem. Mental ill health has a significant burden on children and young people in the UK, yet mental health issues are least likely to be identified in this age group.
	
	In the UK there are substantial unmet needs in services for young people with mental ill health, especially for those who are most vulnerable.
	
	Some vulnerable groups in the community rely on herd immunity to protect them from infectious diseases as they cannot be safely vaccinated. These include newborn babies, those with certain conditions such as immune deficiencies, and the elderly.
	
	Groups that are vulnerable to poor air quality include older adults over 65, young children.
	
	People who most likely to be physically inactive are:
	• Older adults
	• Adults and children are twice as likely not to be active enough for good health if they have:
	  ○ Physical disability
	  ○ Longer term health conditions such as diabetes or cardiovascular disease
	  ○ Multiple Comorbidities
	• Adults and children who have problems with weight management – men's engagement in weight loss programmes is low.

Disability	The tables below show the proportion of the population in Wandsworth with a health problem or disability overall, and in 5-year age bands. Around 10% of the population experience limitations to day-to-day activities due to disability. The groups with the highest proportions are those aged 25 to 34 years of age reflecting the population age structure of the borough.

Health Problem/Disability	Population
Day-to-day activities not limited	89.32%
Day-to-day activities limited	10.68%

Age	Population
0 to 4	7.18%
5 to 9	4.83%
10 to 14	4.15%
15 to 19	3.81%
20 to 24	7.49%
25 to 29	15.52%
30 to 34	13.73%
35 to 39	9.69%
40 to 44	7.37%
45 to 49	5.90%
50 to 54	4.60%
55 to 59	3.71%

Children with learning disabilities are more likely to be overweight or obese.

Unpublished flu data from the Southwest London Health Insights Dashboard suggests that the following groups are likely to have lower levels of coverage or are underrepresented within the vaccinated relative to the demographic composition of the borough: Individuals living with serious mental illness, diabetes, Musculo Skeletal system conditions were the furthest from coverage target for at risk groups in terms of total numbers. Individuals living with learning disability and asthma showed proportionally low levels of coverage relative to the total eligible with the respective conditions.

Women with learning disabilities are less likely to participate in cervical screening (IRR 0.54 compared to those without learning disabilities)

Disability: Women reporting any disability are less likely to participate in bowel screening (RR 0.75 compared to those without disabilities) – this is particularly the case for those with disabilities relating to self-care or vision, or for those with 3 or more disabilities – people with learning disabilities are also less likely to participate in bowel screening (IRR 0.86 compared to those without learning disabilities).

Groups that are vulnerable to poor air quality include people with pre-existing or chronic medical conditions.

People who most likely to be physically inactive are: Disabled people or those with a long-term health condition (45%) than those without (66%)

	Adults with learning disabilities experience a higher rate of injuries and falls compared to the general population
Sex	The table below shows the sex distribution of the Wandsworth Population. The borough's population is made up of 52% females and 48% males, and both are projected to increase by 13% each (approx. 22,000) by 2029.The proportion of women and men are roughly equal across the life-course age-bands until later in life. As women experience longer life expectancy than men, 84.2 years in females versus 80.6 years in males, by the time people are aged 75 years and over, one starts to see a shift in balance between the proportion of both genders (59% female, 41% male). Sex / Population Female 170,345 Male 156,665 Analysis undertaken on screening programme inequalities; national inequalities insights are highlighted across deprivation, ethnicity, disability, age and sex: Women in the most deprived groups (most deprived quintile) are less likely to attend cervical screening (odds ratio (OR) 0.91 to 0.94 when compared to the least deprived quintile) yet are more likely to have high-risk HPV, and a higher risk of being diagnosed with/dying from cervical cancer. Women in the most deprived groups are generally less likely to participate in breast screening (relative risk (RR) 0.89 for the most deprived groups compared to the least deprived) but are more likely to die from breast cancer. Women from ethnic minority groups are less likely to attend cervical screening compared to White British women (OR 2.20 for White British women compared to ethnic minority women – the disparity is particularly great for certain ethnic minority groups. For example, the likelihood of non-attendance reaches OR 10.69 and OR 12.86 for Indian and Bangladeshi women respectively compared to White British women. There is some evidence that women from ethnic minority groups are less likely to attend breast screening compared to White British women, but estimates vary by study and by minority ethnic group.

People who most likely to be physically inactive are:

- More Females than men in general are inactive – “39% of women aged 16 and over are not active enough to get the full health benefits of sport and physical activity, compared to 35% of men” (Sport London).

The Suicide rate (Male) 2018-20 for Wandsworth is 13.7 per 100,000, which is higher than for women, (Female) 2018-20 for Wandsworth is 3.0 per 100,000.

Data from the English Longitudinal Study on Ageing (ELSA) found that falls occur more commonly in women. Severe pain and chronic disease have also been identified as leading to an increased likelihood of falls for both men and women. Several risk factors have been found which are specific to gender, namely incontinence and frailty in women, and depression, older age, and poor balance in men.

Gender reassignment

The table below shows census findings on Gender Identity in Wandsworth. There were no specific findings in relation to the priority areas**.**

Gender Identity

Interactive map: 2021 Census Data Atlas| Gender Identity

- **First time Census has collected data on gender identity**. The question was voluntary and only asked of people aged 16+ (n=273, 565).
- 254,037 (92.86%) said their gender identity was the same as their sex registered at birth, higher than London and England.
- In total, **1,691 (0.62%) Wandsworth residents indicated a change in gender identity** with 713 (0.26%) stating their gender identity was different to that of birth but did not provide a write in response to what they identified with.
- Of the 1,690 residents who indicated a change in gender identity, there was an even split between males and females. 3 in 5 were aged under 44 years of age.
- Locally, 347 identified as trans woman and 304 identified as trans man; the proportions were lower to that of London but higher than England.
- 182 Wandsworth residents identified as non-binary. This proportion of the population was lower than the London but higher than England averages.
- In England, 16-24 were most likely age group to have said their gender identity was different from their sex registered at birth and proportion declined in older age groups.

	Wandsworth	Inner London	London	England
Gender identity the same as sex registered at birth	92.86% (n=254,037)	90.81%	91.21%	93.4
Not answered	6.52% (n=17,831)	8.20%	7.88%	5.9
Gender identity different from sex registered at birth but no specific identity given	0.26% (n=713)	0.47%	0.46%	0.2
Trans woman	0.13% (n=347)	0.17%	0.16%	0.1
Trans man	0.11% (n=304)	0.15%	0.16%	0.1
Non-binary	0.07% (n=182)	0.12%	0.08%	0.0
All other gender identities	0.05% (145)	0.07%	0.05%	0.0

Marriage and civil partnership

The tables below show marital status overall, and categorised by age. There were no specific findings in relation to the priority areas.

Marital Status	Population
Single (never married or never registered a same-sex civil partnership)	54.21%
Married	32.59%
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	6.46%
Widowed or surviving partner from a same-sex civil partnership	3.69%
Separated (but still legally married or still legally in a same-sex civil partnership)	2.47%
In a registered same-sex civil partnership	0.59%

	<table><tr><th>Age</th><th>Population</th></tr><tr><td>16 to 24</td><td>13.23%</td></tr><tr><td>25 to 34</td><td>34.75%</td></tr><tr><td>35 to 49</td><td>27.41%</td></tr><tr><td>50 to 64</td><td>14.10%</td></tr><tr><td>65+</td><td>10.51%</td></tr></table>
Pregnancy and maternity	The General Fertility Rate for Wandsworth in 2021 was 44.5%. This is the rate of Live births in the respective calendar year divided by female 15-44 per (1,000 population). Fertility is dropping across UK and the developed world, and this trend is also reflected locally in recent years. About half the children born in Wandsworth are born to mothers born outside the UK. Pregnant women are vulnerable to poor air quality. They are also a target group for several priority areas including smoking, alcohol, healthy eating, physical activity and immunisations.
Race/ethnicity	The table below shows the ethnic groups in Wandsworth. Wandsworth is an ethnically diverse Borough when compared to England, however, compared to London and Inner London, Wandsworth has much higher proportion of White British population. <table><tr><th>ethnicity</th><th>Population</th></tr><tr><td>White</td><td>69.92%</td></tr><tr><td>Black</td><td>10.77%</td></tr><tr><td>Asian</td><td>10.23%</td></tr><tr><td>Mixed</td><td>6.30%</td></tr><tr><td>Other</td><td>2.78%</td></tr></table> **Table 2: Ethnicity Breakdown, Numbers and Percentage, 2019, Wandsworth, Inner London, and London** <table><tr><th>Ethnicity</th><th>Wandsworth n</th><th>Wandsworth %</th><th>Inner London %</th><th>London %</th></tr><tr><td>**White**</td><td>230621</td><td>70.2</td><td>56.9</td><td>56.6</td></tr><tr><td>***White British***</td><td>157737</td><td>48</td><td>34.7</td><td>39</td></tr><tr><td>***White Irish***</td><td>9484</td><td>2.9</td><td>2.3</td><td>2</td></tr><tr><td>***White Other***</td><td>63400</td><td>19.3</td><td>19.9</td><td>15.6</td></tr><tr><td>**BAME**</td><td>98209</td><td>29.9</td><td>43.1</td><td>43.3</td></tr><tr><td>***Black Caribbean***</td><td>11802</td><td>3.6</td><td>4.5</td><td>3.8</td></tr><tr><td>***Black African***</td><td>16999</td><td>5.2</td><td>8</td><td>7.2</td></tr><tr><td>***Pakistani***</td><td>10559</td><td>3.2</td><td>1.9</td><td>3</td></tr><tr><td>***Indian***</td><td>8322</td><td>2.5</td><td>3.6</td><td>7.1</td></tr><tr><td>***Other BAME***</td><td>50527</td><td>15.4</td><td>25.1</td><td>22.2</td></tr><tr><td>**Total**</td><td>**328830**</td><td>**100**</td><td>**100**</td><td>**100**</td></tr></table> *Source: GLA Housing-led ethnic group projections* Avoidable inequalities in vaccination still exist within some population groups. The likelihood of complete and timely vaccination may still be influenced by where people live, their socioeconomic status, and their ethnic group.

	Unpublished flu data from the Southwest London Health Insights Dashboard suggests that the following groups are likely to have lower levels of coverage or are underrepresented within the vaccinated relative to the demographic composition of the borough: African, any other black background, mixed and white and black Caribbean groups showing underrepresentation. Ethnic group analysis showed lower levels of uptake amongst Arab and Black or Black British groups. Analysis undertaken by the council insight and analytics team highlighted lower uptake in particular groups in Wandsworth: A very strong correlation is observed between low COVID-19 vaccination uptake and those living in more deprived LSOAs in the borough. Ethnicity: Uptake of bowel screening in England is lower in the ethnically diverse areas (38% compared to 52% to 58% in other areas). Certain Black, Asian and minority ethnic groups have a greater chance of developing Type 2 diabetes than people from white ethnic groups. The South Asian population living in the UK are up to six times more likely to develop Type 2 diabetes than that of the white population. People of African and African-Caribbean descent are three times more likely to have Type 2 diabetes than the white population. Additionally, for these ethnic groups, the risk of Type 2 diabetes increases at an earlier age and at a lower BMI level. In Wandsworth, around 43% of people at high risk of Type 2 diabetes and nearly 60% of people with Type 2 diabetes are of ethnic minority origin. People from Black, Asian, and Minority Ethnic groups are most likely to be physically inactive. In Wandsworth, the prevalence of obesity is also higher amongst children from ethnic minorities – boys in Year 6 from all Black, Asian, and Minority Ethnic groups are more likely to be obese than White British boys. Girls in Year 6 are more likely to be obese if they are from Black or Black African ethnic groups. Between Reception and Year 6 the prevalence of obesity varies between ethnicities. For Black ethnic groups prevalence is 181% higher in year 6; for White ethnic groups it is 261% higher; and among Asian ethnicities the rate is 316% higher.
Religion and belief,	. The table below shows religion, belief, and non-belief in Wandsworth. There were no specific findings in relation to the priority areas.

<table>
<tr><td>including non-belief</td><td>

Religon	Population
Christian	52.96%
No religion	26.95%
Muslim	8.06%
Religion not stated	7.86%
Hindu	2.12%
Buddhist	0.84%
Jewish	0.53%
Other religion	0.42%
Sikh	0.27%

</td></tr>
<tr><td>Sexual orientation</td><td>
The table below shows sexual orientation in Wandsworth.
Sexual Orientation
Interactive map: 2021 Census Data Atlas| Sexual Orientation

First time Census has collected data on sexual orientation. The question was voluntary and only asked of people aged 16+ (n= 273.558).
Locally, 14,148 (5.2%) of 16+ year olds were either gay/lesbian, bisexual or any other sexual orientation. This was lower than Inner London (6.4%) and higher than England (3.2%) and London (4.3%).
Locally, males were more likely to identify as LGB+ with the majority aged between 25-44 years (higher proportion aged 24-34 years old). In females, the majority of LGB+ were more likely to be aged between 16-34 years (higher proportion aged 25-34 years old).
England wide analyses show that majority of LGB+ were aged 16-34. In England, highest proportion was among those 16-24 years (6.91%) and the proportion was lower among older age groups.
In England, among 16-24 years olds, bisexual was the most common identity. Gay and Lesbian was higher than bisexual among older age groups.
In England, females were more likely to identify as LBG+. Among 16-24 year old almost double the proportion of females identified as LBG+ compered to males (9.38% vs. 4.5%)

	Wandsworth	Inner London	London	England
Straight or Heterosexual	86.5% (n=236,553)	83.5%	86.2%	89.4%
Not answered	8.3% (n=22,821)	10.1%	9.5%	7.5%
Gay or Lesbian	3.0% (n=8,342)	3.6%	2.2%	1.5%
Bisexual	1.7% (n=4,762)	2.2%	1.5%	1.3%
All other sexual orientations	0.4% (n=1,080)	0.7%	0.5%	0.3%

LGB+ An abbreviation used to refer to people who identify as lesbian, gay, bisexual, and other minority sexual orientations (for example, asexual).

Sexual orientation has been recognised as an additional risk factor for mental health and suicide.

https://www.datawand.info/wp-content/uploads/2023/05/Census-2021-results-Wandsworth-APRIL-23-PUB.pdf
</td></tr>
<tr><td>Across groups i.e., older LGBT service users or Black, Asian & Minority Ethnic young men.</td><td>No data was available</td></tr>
<tr><td>Socio-economic status (to be treated as a protected characteristic under Section 1 of the Equality Act 2010)</td><td>The figures below show household deprivation, economic activity, and levels of unpaid care in Wandsworth. Wandsworth has a higher proportion of deprived households compared to Inner London, London or England. A lower proportion of residents reported providing unpaid care compared to London and England, and Wandsworth had lower levels of economic inactivity compared to the rest of London.</td></tr>
</table>

Include the following groups:

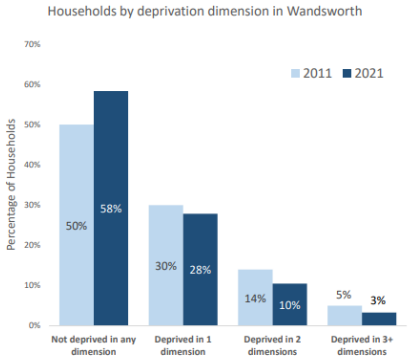
- **Deprivation (measured by the 2019 English Indices of Deprivation)**
- **Low-income groups & employment**
- **Carers**
- **Care experienced people**
- **Single parents**
- **Health inequalities**
- **Refugee status**

https://www.datawand.info/wp-content/uploads/2023/05/Census-2021-results-Wandsworth-APRIL-23-PUB.pdf

Household Deprivation – Borough level overview

Interactive map: 2021 Census Data Atlas | Household Deprivation

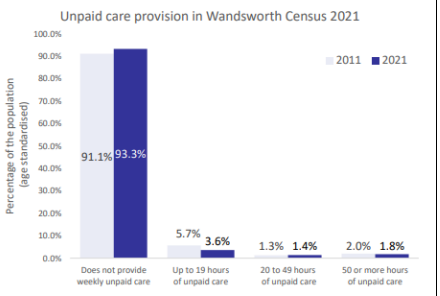
- Census define deprivation based on 4 dimensions - employment, education, health and disability and housing. This differs from Index of Multiple Deprivation produced for DLUHC.
- The proportion of not deprived households is 10% points higher in Wandsworth (58%) than Inner London, London and England (48%). This may be partly due to the younger highly educated and employed population of the borough.
- Deprivation on ONS measure has decreased in Inner London, London and England since 2011.
- Local wards with the highest average ONS deprivation score align with the 2019 Indices of Deprivation (IMD) and are Roehampton, Falconbrook, Furzedown, Shaftsbury & Queenstown and Tooting Broadway.
- Wards with lowest ONS deprivation score were Northcote, Nine Elms, Thamesfield and Lavender.



Unpaid care

Interactive map: 2021 Census Data Atlas| Unpaid Care

- 17,705 (6.8%) of Wandsworth residents reported providing unpaid care, the lowest proportion in London (excluding City of London). Lower than London (7.8%) and England (8.9%).
- The overall proportion of residents providing unpaid care decreased by -2.2% points since 2011. Although the proportion of residents providing unpaid care for 20-49 hours per week has increased slightly.
- Possible reasons for lower local proportion providing care could be higher percentage of young adults in the borough who are single, couples without children and adults likely living away from their parents and other family members
- In England, there was a higher proportion of people providing unpaid care in areas of higher deprivation.
- In England and Wandsworth, females reported providing more unpaid care than males, with the majority aged 50-59 years.



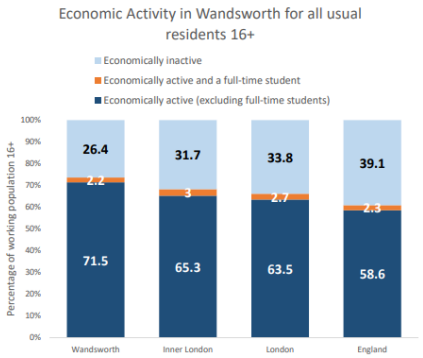
Census 2021 asked "Do you look after, or give any help or support to, anyone because they have long-term physical or mental health conditions or illnesses, or problems related to old age?". People were asked to exclude anything they did as part of their paid employment. This is different from the 2011 Census question, which began "Do you look after, or give any help or support to family members, friends, neighbours or others".

*ONS have used **Age-standardised proportions** as they enable comparisons between populations over time and across geographies, as they account for differences in the population size and age structure.

Economic Activity

Interactive map: 2021 Census Data Atlas| Economic Activity

- Almost 3 in 4 (73.7%) residents over the age of 16 are economically active.
- Wandsworth has the lowest level of Economic inactivity (26.4%) in London, which is up +4.3% points since 2011, and is below England (39.1%). Of those inactive 10% were retired and 6% were students not working, 4.6% were looking after home and family and 2.7% were long-term sick or disabled
- The ONS Annual Population Survey (APS) for all residents 16+ reports lower levels of inactivity (23.4%) due to differences in reporting. As per the APS Economic Inactivity in Wandsworth has reduced by around -2% points in the last 10 years.
- Among the 26% economically inactive, 10% were retired and 6% were students not working, 4.6% were looking after home and family and 2.7% were long-term sick or disabled.
- Economic Inactivity (excluding students and the retired) is highest in Roehampton, York Gardens, and West Hill North.



Obesity and overweight disproportionately affects those from more deprived areas. This is seen most strongly in children with

	obesity prevalence, in the most deprived decile twice as high as those in the least deprived decile. Avoidable inequalities in vaccination still exist within some population groups. The likelihood of complete and timely vaccination may still be influenced by where people live, their socioeconomic status, and their ethnic group. Unintentional injuries are a major cause of inequality. Unintentional injuries are related to socioeconomic deprivation. Children and young people from the most deprived areas in England experience 40% more admissions for nonintentional injury than those in the least deprived. Deprivation: People in more deprived groups are less likely to complete bowel screening (35% for the most deprived group compared to 61% for the least deprived). People in the most deprived areas of England are almost 4 times as likely to die prematurely from CVD compared with those in the least deprived areas. There is also a higher prevalence of many behavioural risk factors (smoking, physical inactivity, eating few than five portions of fruit and vegetables a day, and excess weight) in more deprived areas compared with less deprived areas. Prevalence of Type 2 diabetes is 60% more common among individuals in the most deprived quintile compared with those in the least deprived quintile in England. There is variation in Diabetes prevalence across the Borough. Diabetes is most prevalent in Roehampton and the Furzedown & Tooting cluster (Furzedown East, Furzedown West, Tooting North, Tooting West, Tooting East,). A GLA backed study published in 2019 found that, in areas where the most deprived Londoners were likely to live the annual average NO2 was 3.8 µg/m3 higher than the least deprived areas or 13 per cent higher. The above study also found communities which have higher levels of deprivation, or a higher proportion of people from a non-white ethnic background, were still more likely to be exposed to higher levels of air pollution in London. Many of the risk factors associated with social isolation are more prevalent in socially disadvantaged groups. Social disadvantage is linked to many of the life experiences that increase risk of social isolation, including poor maternal health, teenage pregnancy, unemployment, and illness in later life. In

	addition, deprived areas often lack adequate provision of good quality green and public spaces, creating barriers to social engagement. Access to transport is also vitally important in building and maintaining social connections. The alcohol harm paradox explains that alcohol related health harms are more significant in areas of higher levels of deprivation, even though on average the consumption in these areas is lower due to affordability of alcohol. People living in deprived areas are more likely to experience alcohol-related hospital admissions or die from alcohol-related causes. While there is lower level of general consumption in deprived areas, there are higher levels of very heavy drinking. This is because poorer areas tend to have much higher numbers of people with complex needs, and a lack of services that can support those people. Higher rates of smoking, and lower levels of nutrition are also a significant factor in amplifying the harmful outcomes of drinking in poorer communities. People who are socioeconomically disadvantaged or who live in areas of socioeconomic deprivation have an increased risk of suicidal behaviour. Features of socioeconomic disadvantage include low income, unmanageable debt, poor housing conditions, lack of educational qualifications, unemployment and living in a socioeconomically deprived area. There is a strong association between area-level deprivation and suicidal behaviour: as area-level deprivation increases, so does suicidal behaviour. Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent. Admissions to hospital following self-harm are two times higher in the most deprived neighbourhoods compared to the most affluent. The risk of suicidal behaviour increases when an individual faces negative life events, such as adversity, relationship breakdown, social isolation, or experiences stigma, emotional distress, or poor mental health. Socioeconomically disadvantaged individuals are more likely to experience ongoing stress and negative life events, increasing their risk of suicidal behaviour. In the UK, socioeconomically disadvantaged individuals are less likely to seek help for mental health problems than the more affluent and are less likely to be referred to specialist mental

	health services following self-harm by GPs located in deprived areas. People in lower socioeconomical groups and most impacted by health inequalities and the wider determinants of health are most likely to be physically inactive. Much of Wandsworth is deprived in terms of income deprivation affecting older people, and the most deprived areas are Roehampton, Latchmere, West Putney, Tooting, Graveney and Bedford (Indices of deprivation). The most deprived areas of the borough in terms of overall deprivation are Roehampton, West Putney, Latchmere, Queenstown, and Tooting. The scale of inequality in Wandsworth is notable with pockets of deprivation and population-based inequalities which are linked to physical inactivity. Carers are amongst one of the groups that are mostly likely to be physically inactive - nearly half (46%) of carers are inactive, compared with 33% of adults Healthy Eating Dietary inequalities disproportionately impact those in the poorest areas versus the most affluent. Nationally, 69% of those in the most deprived groups are overweight or obese with many consuming insufficient fruit and vegetables, fibre and vegetables. With food prices rising year-on-year by 6.7% as of April 202225, those on lower income will seek low-cost alternatives which tend to be more refined and ultra-processed. Unhealthy foods are also easier to access in poorer areas. The density of fast-food outlets is five times higher in areas of deprivation compared to the most affluent areas. Risks of developing serious COVID increase progressively with increase in BMI. COVID-19 was two times higher for people from the poorest areas versus people in the wealthiest areas, a high BMI (obesity) can be mitigated against with addressing physical inactivity and diet. There is a link between social exclusion and health inequalities, which identifies exclusionary processes (as mentioned) as the driver. Where social isolation is the result of exclusionary processes, it is a driver of health inequalities. Smoking prevalence increases with deprivation, the increased expenditure on smoking imposes a comparatively higher cost on proportionally more low-income households compared to high income households. Smoking rates are higher within

	certain groups and deprived communities and the rate of decline of smoking prevalence has not been equal among all populations. Targeting groups that are more likely to smoke is, therefore, one of the ways that services seek to reduce health inequalities. Rates of smoking are also high among low-income groups thereby exacerbating Long Term Conditions and deepening health inequalities. Smoking is responsible for half the difference in life expectancy between the richest and poorest in society and, later in life, people who smoke are almost twice as likely to need some form of social care than never smokers

Data gaps

Data gap(s)	How will this be addressed?
Data on protected Characteristics is available at Borough Level but isn't always available for specific population groups in relation to strategic priorities.	A recommendation is for Joint Local Health and Wellbeing implementation leads/groups to conduct topic specific EINAs.

4. Impact

Protected group	Positive	Negative
Age	Wandsworth has a particularly young, demographic with an increasing older population. The Strategy will have a positive impact by ensuring a focus on priorities across the entire life course. Start Well: Positive impacts anticipated on children's emotional and mental wellbeing, reduced levels of obesity and increase in uptake of routine immunisations. Live Well: Positive impacts anticipated around improved lifestyle behaviours, support with type 2 diabetes, long term conditions, and mental health Age Well: Positive impacts anticipated around reducing falls, social isolation, and dementia prevention, diagnosis and care.	No negative impact from the implementation of this strategy is expected on any age group. Monitoring implementation of the strategy will help ensure that any unintended consequences are noted and addressed.

Disability	Around 10% of the population experience limitations to day to day activities. Positive impacts are anticipated for people with a disability in relation to • equity of access to opportunities for attaining a healthy weight, through physical activity and healthy eating. • Improved community mental health services for children with a disability	No negative impact from the implementation of this strategy is expected based on disability. Monitoring implementation of the strategy will help ensure that any unintended consequences are noted and addressed.
Sex	The strategy considers the disproportionate impact of sex for particular health issues and positive impacts are anticipated in relation to: • A targeted focus engaging with women through primary care services to promote cancer screening programmes. Increasing equity of access and promoting physical activity • Reducing stigma around mental health in men	No negative impact from the implementation of this strategy is expected based on sex. Monitoring implementation of the strategy will help ensure that any unintended consequences are noted and addressed.
Gender reassignment	None identified	No negative impact from the implementation of this strategy is expected based on gender reassignment. Monitoring implementation of the strategy will help ensure that any unintended consequences are noted and addressed.
Marriage and civil partnership	None identified	No negative impact from the implementation of this strategy is expected based on marriage and civil partnership status. Monitoring implementation of the strategy will help ensure that any unintended consequences are noted and addressed.
Pregnancy and maternity	The strategy anticipates a positive impact on pregnant women through: • Providing targeted smoking interventions for high-risk	No negative impact from the implementation of this strategy is expected based on maternity status. Monitoring implementation of the strategy will help ensure that any

	groups such as pregnant women • Raising awareness of health and air quality co-benefits and to highlight the impact of air pollution on vulnerable groups such as pregnant women • Using Core20PLUS5 data to target preventative strategies to support the most deprived and vulnerable communities (which include maternity)	unintended consequences are noted and addressed.
Race/ethnicity	Wandsworth is a diverse borough with 43% of the population from black, Asian and other minority ethnic groups. The strategy anticipates positive impacts through: • Reducing stigma associated with mental health and suicide among ethnic minority groups • Dementia: Build on the 'Think Brain Health Campaign' dementia awareness training public health offer, linking to the prevention framework, targeting those identifying themselves as Black, Asian and Mixed ethnicity	No negative impact from the implementation of this strategy is expected based on ethnicity. Monitoring implementation of the strategy will help ensure that any unintended consequences are noted and addressed.
Religion and belief, including non-belief	Over 60% of Wandsworth residents identify with a particular faith. The strategy anticipates positive impacts through • Engaging with faith groups to promote cancer screening • Improving the model of community health checks and increasing delivery of holistic health checks in faith and community settings	No negative impact from the implementation of this strategy is expected based on belief or religion. Monitoring implementation of the strategy will help ensure that any unintended consequences are noted and addressed.
Sexual orientation	Around 4.7% of resident identified as gay, lesbian or bisexual. The strategy anticipates positive impacts through:	No negative impact from the implementation of this strategy is expected based on sexual orientation. Monitoring implementation of the strategy will help ensure that any unintended

	• Reducing stigma surrounding mental health and suicide for the LGBT community	consequences are noted and addressed.
Socio-economic status (to be treated as a protected characteristic under Section 1 of the Equality Act 2010) Include the following groups: • **Deprivation (measured by the 2019 English Indices of Deprivation)** • **Low-income groups & employment** • **Carers** • **Care experienced people** • **Single parents** • **Health inequalities** • **Refugee status**	Wandsworth has a higher proportion of deprived households compared to London or England. The strategy anticipates positive impacts through: • Using the NHS Core20PLUS5 data to target cardiovascular disease preventative strategies to support the most deprived and vulnerable communities • Developing new and strengthen existing smoking cessation pathways across different health organisations and partnerships across NHS Trusts, the local authority and voluntary sector, particularly those aimed at targeted groups and reducing inequalities. • Using a targeted approach for mental health, allocating local resource to support the geographic and areas and resident cohorts of greatest need • Dementia: Carer respite: explore opportunities to ensure good access to short breaks for unpaid carers • Reduce stigma associated with mental health and suicide among carers	No negative impact from the implementation of this strategy is expected on socio-economic status. Monitoring implementation of the strategy will help ensure that any unintended consequences are noted and addressed.

5. Actions to advance equality, diversity and inclusion

Action	Lead Officer	Deadline
Additional EINAs will be conducted for any new Strategies or Service changes that arise from the actions in the Joint Local Health and Wellbeing Strategy	Priority Leads	To be confirmed

Impact of the actions will be monitored and reported to the Health and Wellbeing Board throughout the life cycle of the strategy	Priority Leads	Quarterly Health and Wellbeing Board Meetings

6. Further Consultation (optional section – complete as appropriate)

Consultation planned	Date of consultation
Public Consultation	31 July 2023