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	Richmond
Staff involved in developing this EINA	Patricia Mighiu Shannon Katiyo
Date approved by Directorate Equality Group (if applicable)	N/A
Date approved by Policy and Review Manager	02.08.2023
Date submitted to Directors' Board	N/A

1. Summary

Introduction

The Joint Local Health and Wellbeing Strategy (JLHWS) is a strategic plan that sets out the priorities for collective action to be taken by the local authority, NHS, and other partners including the voluntary and community sector, over the next 5 years. The JLHWS aims to improve the health and wellbeing of Richmond residents, tackle inequalities, empower our communities, and focus on prevention. The health, care and wellbeing needs of Richmond residents were assessed in the latest revision of the Joint Strategic Needs Assessment (JSNA), published in 2022.

To help determine which priorities identified in the JSNA would be the focus of the refreshed JLHWS, we held a series of prioritisation seminars, one focusing on children 'Start Well,' and a second focusing on adults and older people 'Live Well and Age Well.' This life-course approach addresses the diverse needs and challenges of Richmond residents at different stages of life and acknowledges the wide range of factors influencing our health and wellbeing over time. The theme of the strategy, '18 Steps to Health and Wellbeing,' follows this life course approach.

The 'Start Well' seminar identified the main priorities as self-harm and social, emotional, and mental health needs; childhood obesity; and childhood immunisations.

The priority areas from the 'Live Well' chapter of the JSNA were immunisations, cervical cancer screening, long-term conditions, lifestyles and health behaviours, suicide prevention, and air quality and climate change. This prioritisation seminar identified falls and frailty, dementia, and social isolation as the priority areas for the 'Age Well' chapter of the JSNA.

Proposed Changes. The proposed changes that will arise following implementation of the strategy are based on the actions outlined below, and categorized according to life course:

START WELL

Self-harm and social, emotional, and mental health needs

- Promote Kooth as the local online mental health support service for young people.
- Ensure all schools have access to advice and support from wellbeing specialists in the Mental Health Support Teams.

- Introduce the Sutton self-harm prevention model as part of the implementation of the Thrive mental health framework.
- Deliver an emergency care service to support young people attending hospital due to deliberate self-harm.

Childhood obesity

- Deliver the Healthy Early Years London programme with early years' settings.
- Implement the Healthy Schools programme to promote healthy eating and physical activity.
- Expand parent-and-child cooking and healthy eating activities as part of the development of Family Hubs.
- Deliver the targeted Holiday Food and Activities initiative for children aged 5 to 16.
- Deliver targeted follow-up advice and support to parents following the National Childhood Measurement Programme.
- Expand the range of active play, sports, and adventurous activities available to children.

Childhood immunisations

- Improved community engagement to address inequalities:
    - Develop outreach programmes based on joint working with public health, Healthwatch, and voluntary sector and community groups, to support underserved groups to get vaccinated and tackle health inequalities.
    - Use population health management approach to understand groups with lower uptake.
- Improved access to immunisation services.
- Innovate and flex the system to improve uptake (e.g., centralised call centre for all immunisations).
- Improved access to better quality data to help identify gaps.

LIVE WELL

Adult Immunisations

- Improved community engagement to address inequalities.
    - Develop outreach programmes based on joint working with public health, Healthwatch, and voluntary sector and community groups, to support underserved groups to get vaccinated and tackle health inequalities.
    - Use population health management approach to understand groups with lower uptake.
- Improve access to immunisation services.
- Innovate and flex the system to improve uptake (e.g., centralised call centre for all immunisations).
- Improve access to better quality data to help identify gaps.

Cervical cancer screening

- To work in partnership to access and analyse more granular quantitative and qualitative data to help understand where the inequalities exist, the barriers to access, and how to target them effectively.
- To address health inequalities by targeting underserved populations and those less likely to take up services (example: utilising the Homeless Health Offer).
- To promote health education to highlight the importance of screening amongst the eligible cohort, including in schools.
- To carry out community engagement and communications, including engaging with women through primary care services and with faith groups to promote cancer screening. To provide communication in a variety of languages and formats to increase accessibility.
- To opportunistically offer cervical screening through sexual health clinics, in line with the current NHSE/CLCH program in development, with the potential to offer this via other sites.

Diabetes

- Work with people in groups most at risk to target NHS health checks.

- Develop community led health clinics to find people at risk of type 2 diabetes.
- Social prescribing to promote weight management services.
- Promote awareness of structured education programmes and how to access these.

Cardiovascular disease

- Work with people in groups most at risk to target NHS health checks.
- Develop community led health clinics to identify people with undiagnosed hypertension.
- Social prescribing to promote services that support lifestyle changes.
- Optimise the medical management of people with CVD in primary care.

Respiratory Health

- Improve access to smoking cessation and reducing the use of Vapes.
- Develop population health tools allowing us to identify groups more likely to smoke.
- Establish community spirometry hublets.
- Ensure clear pathways into post covid services including psychological therapies.

Post COVID-19 syndrome

- Develop a long COVID service which is fully integrated with psychological services and Adult Social Care through a care co-ordination approach.

Climate Change

- Work collaboratively as a health and social care system in achieving Net Zero targets and in reducing emissions.
- Implement the Climate Change Strategy to help tackle climate change.
- Borough adoption and implementation of the new Local Spatial Plan, to ensure new developments in the borough help to limit carbon emissions.
- 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.

Air quality

- For local organisations and partners to progress to achieving NetZero and reduce emissions.
- Implementation and progress of the Borough Air Quality Action Plan
- Work with local NHS bodies, local pharmacies, and voluntary sector partners to raise awareness of health, air pollution and vulnerable groups.

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, including reviewing concessions.
- Create pathways for inactive adults to take small steps or 'doses' of physical activity.
- Promote the benefits of physical activity to Richmond 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.
- 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

- Ensure that Licensing policy and applications consider the health and wellbeing of local communities by monitoring the number of new alcohol licenses, license renewals and change applications in Richmond by creating a pathway for reviewing applications received. This pathway will review on and off license requests and make recommendations based on local data linked to crime, hospital admissions, surrounding premises, road traffic incidents and complaints.
- Ensure implementation of the Combatting Drugs Partnership's delivery action plan to improve continuity of care in prison; facilitate the delivery of screening and brief advice for alcohol inpatient settings; improve pathways for children and young people with alcohol-related admissions; and deliver evidence-based school-based prevention and early intervention for substance use, including alcohol.
- Continue promoting the Drink checker tool to identify harmful drinking and provide information, advice, and education as to the risks of alcohol and the benefits of reducing intake.
- Ensure information is in easy-to-read formats and translated to be accessible to widest population.
- Improve availability of alcohol alternatives and alcohol-free social activities by partnering with businesses.
- Leverage social motivations by campaigns aimed at encouraging social contacts to support others to reduce their consumption.

Smoking

- Provide targeted interventions for high-risk groups such as young people, pregnant women, and people with mental health conditions, while maintaining a universal offer.
- Ensure access to evidence-based smoking cessation services, including nicotine replacement therapy, behavioural support, and digital interventions, to support people to quit smoking.
- Monitor progress towards reducing smoking rates and improving health outcomes by clear and measurable indicators, such as smoking prevalence, quit rates, hospital admissions for smoking-related illnesses, and health inequalities related to smoking.
- 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.
- 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, utilising the London Tobacco Alliance as a resource to effect change.

Suicide prevention

In addition to the action plan already set in the recent Richmond Self-Harm and Suicide Prevention Strategy 2022-25:

- Include health inequalities as an element for reduction when more data is available on demography of deaths by suicide and self-harm.
- Community led support network for higher risk groups.
- Tailored approaches to improve mental health in high-risk groups.
- Holistic and integrated approach that considers financial and other key determinants.
- To ensure there is resource to continue monitoring of Realtime Suicide Prevention data.

AGE WELL

Falls and frailty

- To work together with Richmond care homes and improve their access to the Urgent Community Response (UCR) falls pickup service, embed falls acoustic monitoring into care homes through the South West London Integrated Care Board Enhanced health in care homes programme, and provide additional support to care homes that have increased falls rates or no-pickup policies in place.

- To understand the numbers of people who are admitted as an emergency for less than 1 day or via the Same Day Emergency Care as a proportion of those people being admitted for a fall and working with Hounslow and Richmond Community Healthcare to consider alternative pathways away from hospital.
- To utilise population health management data from hospitals and community providers to ensure that falls recovery services are accessible for the Richmond population.
- To implement the Fracture liaison pathway at Kingston Hospital to identify bone density issues, refer into community falls services and to prevent subsequent falls and fractures.

Dementia

- Work together with primary care and the Hounslow and Richmond care home support team to ensure that every person diagnosed with dementia has a Universal Care Plan in place to support them and identify barriers to dementia care.
- Increase the number and rate of people diagnosed with dementia in care homes in line with the 70% expectation within the Enhanced Health in Care Homes Framework, adopting a model where clinicians visit care homes to case find (as within Kingston).
- Introduce a community-based loan service that loans 'sensory based, interactive digital technology' for people with dementia or cognitive impairment in care homes or within community settings, which provides both an in reach and outreach service.
- Provide access to psychosocial support for families and carers of people with dementia including bereavement and therapy services.
- Consider appropriate respite and activities for people with young onset dementia separately to older people's dementia services.
- Ensure timely diagnosis pathway including primary care, diagnostic testing and the memory assessment services at South West London and St Georges Mental Health NHS Trust, including appropriate pre-diagnostic support.

Social isolation

- Build 'social capital' and use local networks and community assets (e.g., volunteering) to increase resilience.
- Support the use of digital technology to aid access to health and wellbeing advice and reduce loneliness and isolation.
- Review and improve transport provision to enable increased access to social opportunities in the community.
- Ensure opportunities for breaks and social connections are available particularly for vulnerable groups (unpaid carers, older people with long term health conditions, mental health).
- Establish a system for community service providers to highlight gaps and issues that increase risk of social isolation in older people.

Positive impacts of the strategy:

The strategy sets out evidence-based priorities that the Health and Wellbeing Board will focus on to improve the health and wellbeing of the borough, which may include improvement to existing services, commissioning of new services, and other actions to reduce health inequalities and avoidable differences in health outcomes. The Health and Wellbeing Board has agreed that the guiding principles described below underlie the foundation of the refreshed strategy and are embedded into the action plans for the priority areas.

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 actions.

2. **Focus on prevention.**
   We want to promote positive health and wellbeing by delivering an evidence-based approach to prevention by embedding our Prevention Framework within the Health and Wellbeing Strategy. This will include facilitating making the healthy choice, the easy choice, supporting a tailored approach to prevention, connecting with polices 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 co-produce positive, sustainable benefits to our residents. This strategy wants to add social value to our communities and ensure that the actions we take leave a positive impact on the communities that we serve, which enables them to continue to improve their local communities after our initiatives complete.

4. **Putting families first**
   By keeping a holistic approach 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, with a particular focus on the transition periods which can present the most challenging times.

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 of the strategy:

One of the main aims of the strategy, and of the Health and Wellbeing Board, is to improve the health and wellbeing of Richmond residents and reduce inequalities across all ages. Nevertheless, there are several priority areas where data is lacking or insufficient to allow us to fully understand the impact on people with protected characteristics, and it is possible that this may result in a missed opportunity to address the inequalities that these groups may experience because of the actions proposed by the Strategy. It is also possible that certain groups may face barriers in accessing and benefiting from the proposed health and wellbeing initiatives. To mitigate this, we have engaged with relevant stakeholders to see how we can best engage vulnerable groups. For example, we have liaised with the Richmond Adult Social Care Team for people with learning disabilities to see how we can include this group.

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	Richmond Joint Strategic Needs Assessment (detailed data sources are included for each priority area)
Local data on equalities, population, deprivation	DataRich

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

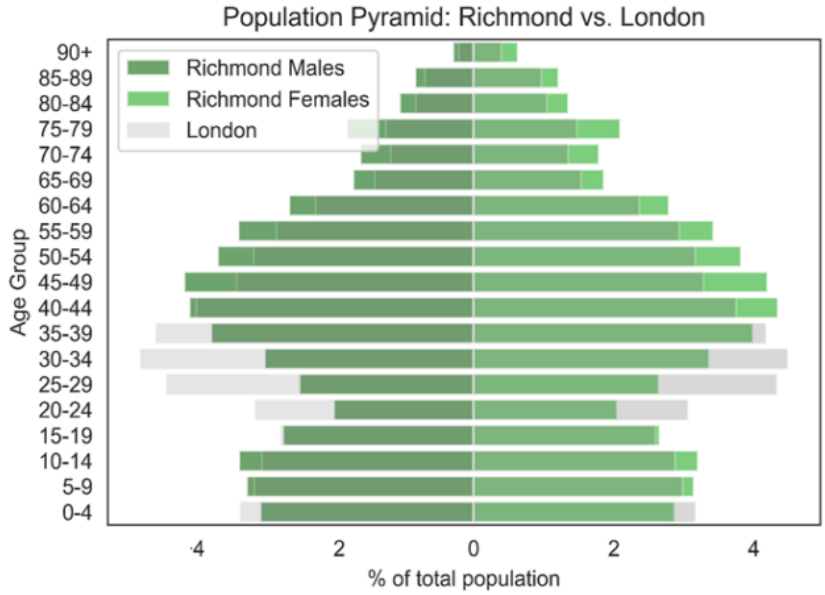
Individuals/Groups	Consultation/Engagement results	Date	What changed as a result of the consultation
Start Well Prioritisation Seminar Invitees included: Council Directorates Chair and Vice Chair/GP Borough Lead of the Health and Wellbeing Board Healthwatch Richmond Adult Social Care and Public Health Achieving for Children Carers representative NHS SWL CCG SWL & St George's Mental Health Trust Richmond Council for voluntary service Hounslow and Richmond Community Health NHS Trust Central London Community Healthcare NHS Trust PDM Richmond School Sport Partnership	The group took part in a prioritisation process to identify priority areas in the JSNA to take forward in the development of the refreshed strategy. The prioritisation framework was based on the following criteria: - Level of need and size of population affected - Comparative benchmark - Severity - Trend - Early intervention implications - Scale of inequality - Estimated economic cost	27.1.22	The Start Well seminar agreed that all the issues put forward for consideration would be prioritised in the refreshed strategy.
Live Well, and Age Well Prioritisation Seminar Invitees included: Council Directorates NHS SWL CCG SWL & St George's Mental Health Trust Richmond Council for voluntary service Hounslow and Richmond Community Health NHS Trust Central London Community Healthcare NHS Trust SouthWest London and St Georges Mental Health NHS Trust Richmond MIND Kingston and Richmond Local Pharmaceutical Committee	The group took part in a prioritisation process to identify priority areas in the JSNA to take forward in the development of the refreshed strategy. The prioritisation framework was based on the following criteria: - Level of need and size of population affected - Comparative benchmark - Severity - Trend - Early intervention implications - Scale of inequality - Estimated economic cost	21.7.22	Five main topics and 14 sub-topics were identified from the JSNA to be the focus of the prioritisation exercises. The Live Well and Age Well Prioritisation Seminar agreed to prioritise all the proposed subtopics for inclusion in the refreshed strategy.

RUILS South London and Maudsley Mental Health NHS Trust Achieving for Children Richmond Carers Centre Health Watch Richmond Richmond Housing Partnership			
Richmond Place Committee Membership includes: Richmond Health and Wellbeing Board Kingston Hospital NHS Foundation Trust HRCH NHS Trust Children's Services Healthwatch Richmond Richmond Community and Voluntary Services Richmond Place SWL & St George's Mental Health NHS Trust Richmond Carers Centre Richmond GP Alliance West Middlesex University Hospital and Chelsea & Westminster NHS Foundation Trust Central London Community Healthcare Trust SWL ICS Adult Social Care & Public Health	The Richmond 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.	19.7.23	The Committee advised that Carers should be included as a protected characteristic in the EINA.

3. **Analysis of need**
   This was based on information available in the refreshed Richmond Joint Strategic Needs Assessment and DataRich.

   Potential impact on this group of residents and actions taken to mitigate impact and advance equality, diversity and inclusion.

Protected group	Findings
Age	The table below shows the population pyramid by quinary age group for 2021 - Richmond vs. London:



Source: 2016-based Demographic projection, housing-led model, GLA

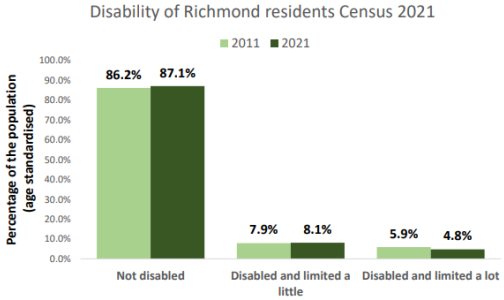
In 2021, 22.9% (44,489) of the total population was under 18 years old, which is higher than the London average (21.8%). Approximately 16% of the population of Richmond are over 65 compared to 12% in London and 18.5% nationally. By 2029, the borough's population will rise, with the biggest increase (48% rise) projected within the 80+ year old age group.

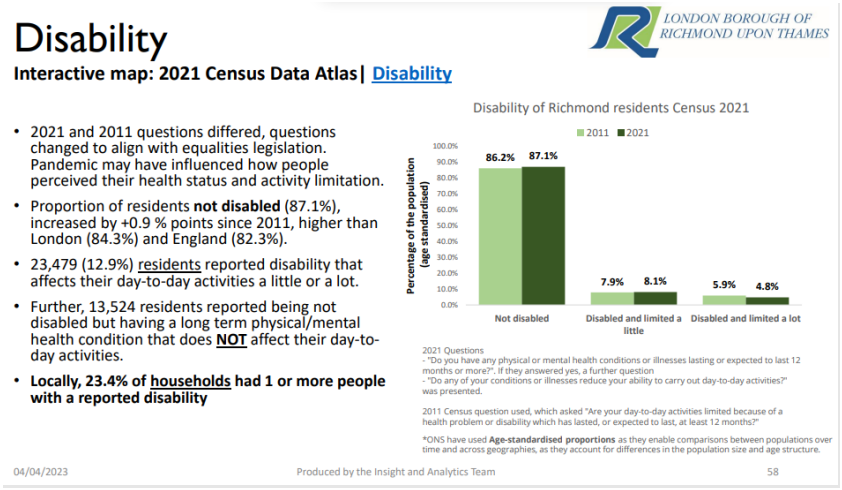
Around 56% of people with type 2 diabetes in Richmond are aged over 65. Richmond has one of the lowest percentages of people aged 40-64 with type 2 diabetes in London, and the second highest percentage of people with type 2 diabetes aged 80 and over.

Some of the most vulnerable groups susceptible to the effects of air pollution and climate change include young children and older adults over 65. Those who are elderly are particularly vulnerable to heat-related mortality and morbidity. For example, among the estimated 2,500 excess deaths that occurred in England during the three heatwaves experienced in the summer of 2020, the majority were among the 65 and older age group.

Disability

According to the latest census data (2021), 23,479 (12.9%) residents reported disability that affects their day-to-day activities a little or a lot. Locally, 23.4% of households had 1 or more people with a reported disability.



	In 2018/19 there were an estimated 620 (0.3%) patients with learning disabilities recorded on Richmond practice disease registers. In 2017, the proportion of primary, secondary, and special school children identified as having a learning disability in the borough was 4.4% (1,164), which was similar to the London average and lower than the England average of 5.6%.  National data shows that adults with a learning disability are less likely to attend for health checks. In a national survey of 47% of people with a learning disability who were registered with a GP, only 31% of women had smear tests compared to 73.2% of the general population. Adults with learning disabilities experience a higher rate of injuries and falls compared to the general population. Data from the 2021-22 season (SWL Immunisation Dashboard) showed that influenza vaccination uptake is lower amongst those with a learning disability. There are several risk factors for poor mental health among people living with a learning disability. It is estimated that there are 900 adults with a learning disability who also have a common mental disorder in Richmond.
Sex	The borough's population is made up of 51% females and 49% males; this proportion is projected to remain consistent in 2029 (51.6% and 48.4%, respectively). The proportion of women and men is roughly equal across the life-course age-bands until later in life, as women experience longer life expectancy than men. By the time people are aged 85 years and over, there are more than twice as many women as men. Date from the English Longitudinal Study on Ageing found that falls occur more commonly in women. Several risk factors for falls are associated with gender, namely incontinence and frailty in women, and depression, older age, and poor balance in men. Women are also more likely to develop dementia than men.
Gender reassignment	According to the latest census data (2021), 610 (0.39%) Richmond residents indicated that they identified with a gender different to their sex registered at birth, with 227 (0.15%) stating their gender identity was different to that at birth but did not provide a written response to what they identified with. In 2021, 0.09% and 0.07% of people aged 16 years and over in Richmond identified as a trans woman and a trans man, respectively.

	Richmond	Outer London	London	England
Gender identity the same as sex registered at birth	93.98% (n=146,446)	91.48%	91.21%	93.47%
Not answered	5.63% (n=8,778)	7.67%	7.88%	5.98%
Gender identity different from sex registered at birth but no specific identity given	0.15% (n= 227)	0.45%	0.46%	0.25%
Trans woman	0.09% (n=137)	0.15%	0.16%	0.10%
Trans man	0.07% (n=110)	0.17%	0.16%	0.10%
Non-binary	0.04% (n=64)	0.05%	0.08%	0.06%
All other gender identities	0.05% (n=72)	0.03%	0.05%	0.04%

Marriage and civil partnership

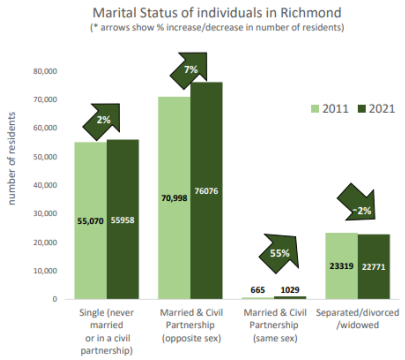
The table below shows the latest data from ONS, Census 2021 of the legal partnership status of Richmond residents. There were no specific findings in relation to the priority areas.

Marriage and civil partnerships

Interactive map: 2021 Census Data Atlas| Marital Status

LONDON BOROUGH OF RICHMOND UPON THAMES

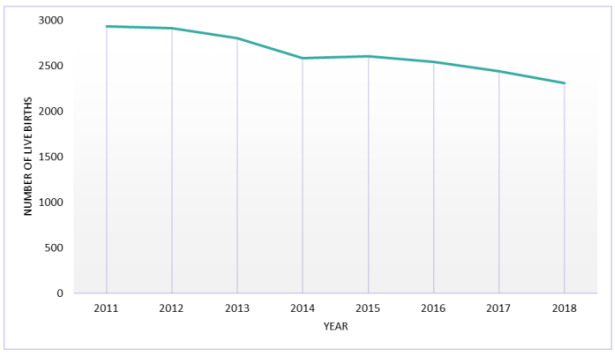
- Half of the borough (49%) is **'married or in a civil partnership'** which is higher than Outer London (45%), London (39.4%) and England (44.3%).
- People in England and Wales are generally getting married at an older age 34.3 years for men and 32.3 years for Women and as the borough has the oldest median age in London this could explain the higher marriage rate.
- **Same sex couples who are married** has increased by 55%, which is likely due to the legalisation of same sex marriages in 2014. This increase is around the same as London (54%), but lower than England (90%).



Pregnancy and maternity

The number of children born in Richmond is decreasing and is projected to further decrease by 2029.

Figure 7: Number of live births, 2011–18, Richmond.



Source: Office of National statistics, Live Births [23]

Pre-existing conditions such as severe mental illness can be a risk factor for maternal deaths during pregnancy or for up to a year after the end of the pregnancy. Maternal suicide remains the leading cause of direct maternal deaths. In Richmond, it is estimated that 182 to 273 women will develop mild to moderate depressive illness and anxiety, and 55 women will have severe depressive illness.

Smoking is the single biggest modifiable risk factor for poor birth outcomes. In 2018/19, the percentage of mothers in Richmond who were smoking at the time of booking their first midwife appointment was the 5th lowest in London. Pregnant

	women are also included among the most vulnerable groups susceptible to the effects of air pollution and climate change.
Race/ethnicity	The largest ethnic group in Richmond are those identifying as White British (66.3%). Compared to London (39%) and Outer London (41.9%), Richmond has much higher proportion of White British population. Almost 1 in 6 Richmond residents are from a Black, Asian and Minority Ethnic group, a lower proportion than is seen in London and outer London. This population is younger with a higher proportion of children and fewer seniors. For example, 21% of children in Richmond are from a Black, Asian and Minority Ethnic group vs. 16% of the overall population. In 2019, there were 2,556 people aged 65 years or older (8%) from a Black, Asian and Minority Ethnic group in Richmond. By 2029, this number is predicted to increase to 4,240, an increase of 66%.

Ethnic Group Breakdown

LONDON BOROUGH OF RICHMOND UPON THAMES

Ethnicity	Richmond 2011	Richmond 2021	% Change	Ethnicity	Richmond 2011	Richmond 2021	% Change
White	**86.0%**	**80.5%**	**-5.5%**	**Black**	**1.5%**	**1.9%**	**0.4%**
English, Welsh, Scottish, Northern Irish or British	71.4%	63.0%	-8.4%	African	0.9%	1.2%	0.3%
Irish	2.5%	2.5%	-0.1%	Caribbean	0.4%	0.5%	0.0%
Gypsy or Irish Traveller	0.1%	0.0%	0.0%	Other Black	0.2%	0.3%	0.1%
Roma	N/A	0.2%	N/A	**Mixed**	**3.6%**	**5.5%**	**1.8%**
Other White	11.9%	14.7%	2.8%	White and Asian	0.7%	2.2%	1.5%
Asian	**7.3%**	**8.9%**	**1.7%**	White and Black African	0.4%	0.6%	0.2%
Bangladeshi	0.5%	0.5%	0.0%	White and Black Caribbean	1.5%	0.8%	-0.7%
Chinese	0.9%	1.4%	0.5%	Other Mixed or Multiple ethnic groups	1.0%	1.8%	0.8%
Indian	2.8%	3.7%	0.9%	**Other ethnic group**	**1.6%**	**3.3%**	**1.6%**
Pakistani	0.6%	0.9%	0.3%	Arab	0.6%	0.9%	0.3%
Other Asian	2.5%	2.5%	0.0%	Any other ethnic group	1.0%	2.4%	1.4%

04/04/2023 Produced by the Insight and Analytics Team 36

Childhood obesity prevalence changes with ethnic group. In Richmond, the prevalence of obesity is the highest in Black Ethnic groups and the lowest in White Ethnic groups.

In Richmond, around 15% of people at high risk of type 2 diabetes and 22% of people with type 2 diabetes are of ethnic minority origin.

Women from ethnic minority groups are less likely to attend cervical screening compared to White British women, and this disparity is particularly great for certain ethnic minority groups including Indian and Bangladeshi women. Uptake of influenza vaccination is lower among African, White, and Black African and White and Black Caribbean groups.

Certain ethnic groups are also disproportionately affected by dementia. The prevalence of dementia amongst South Asian and Black ethnic groups is expected to increase sevenfold over the next 40 years, compared to an expected doubling of dementia prevalence overall. As described in the Dementia Health Needs Assessment for Richmond (DataRich – Dementia), the differential risk profile of dementia is also manifesting in Richmond.

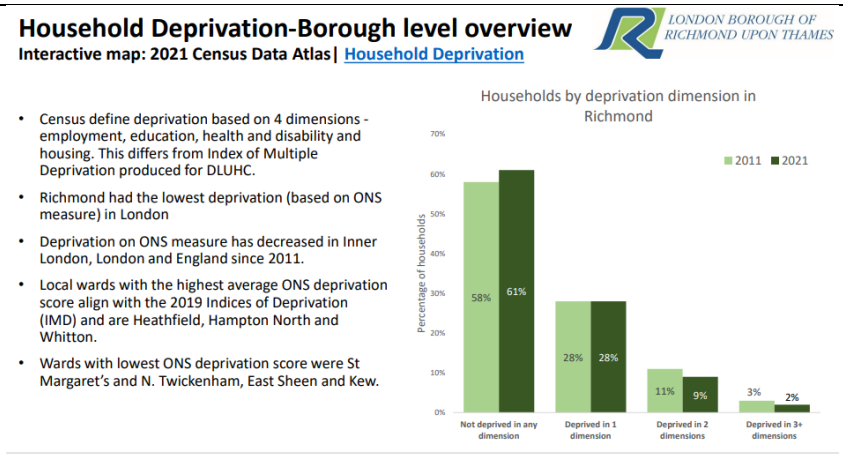
As described in the updated Richmond Mental Health Needs Assessment, it is estimated that most adults with a common mental disorder in Richmond will be from White British or White Other ethnic groups. However, a higher percentage of Black men than White men experience psychotic disorders. In 2020/21 and

<table>
<tr><td></td><td>2021/22 (Q1-3), there was an increased rate of referrals to the Early Intervention Teams among Black or Black British, Mixed and Asian or Asian British ethnic groups.</td></tr>
<tr><td>Religion and belief, including non-belief</td><td>Estimates from the ONS Annual Population Survey showed that over half (51.3%) of the Richmond population in 2018 identify as Christian. Muslim faith was the second most popular religion at 3.6%. 35.8% of residents stated having no religion. There were no specific findings in relation to the priority areas.

Table 6: Religious identity, numbers and percentage, 2008 and 2018, Richmond and London.
<table><tr><th>Religious Identity</th><th>2008
n (%)</th><th>2018
n (%)</th><th>London 2018
%</th></tr><tr><td>Christians</td><td>125,200 (69.5)</td><td>99,200 (51.3)</td><td>44.5</td></tr><tr><td>Muslim</td><td>11,500 (6.4)</td><td>7,000 (3.6)</td><td>14.2</td></tr><tr><td>No religion</td><td>37,600 (20.9)</td><td>69,200 (35.8)</td><td>29.4</td></tr></table>Note: Data not available for all religions, suppressed by data provider due to small numbers at Borough level by data provider.

Source: ONS Annual Population Survey via London Data Store</td></tr>
<tr><td>Sexual orientation</td><td>According to the latest census data (2021), 5,237 (3.4%) of 16+ year olds were either gay/lesbian, bisexual or any other sexual orientation in Richmond.

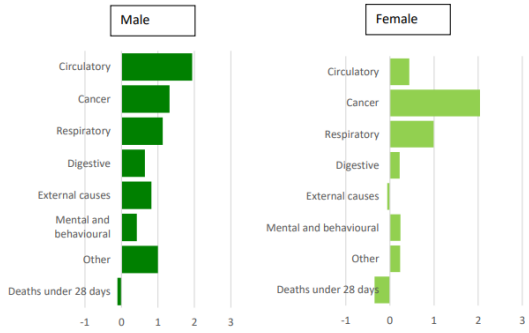
<table><tr><th></th><th>Richmond</th><th>Outer London</th><th>London</th><th>England</th></tr><tr><td>Straight or Heterosexual</td><td>89.0% (n=138,752)</td><td>88.0%</td><td>86.2%</td><td>89.4%</td></tr><tr><td>Gay or Lesbian</td><td>1.9% (n=2,894)</td><td>1.3%</td><td>2.2%</td><td>1.5%</td></tr><tr><td>Bisexual</td><td>1.2% (n=1,848)</td><td>1.1%</td><td>1.5%</td><td>1.3%</td></tr><tr><td>All other sexual orientations</td><td>0.3% (n=495)</td><td>0.4%</td><td>0.5%</td><td>0.3%</td></tr><tr><td>Not answered</td><td>7.6% (n=11,845)</td><td>9.1%</td><td>9.5%</td><td>7.5%</td></tr></table>
As outlined in the Richmond Mental Health Needs Assessment, it is estimated that there are 937 (13.2%) non-heterosexual girls (14-19), of whom an estimated 327 have a mental health disorder. Of the 511 (7.1%) non-heterosexual boys (14-19 years), an estimated 178 have a mental health disorder.</td></tr>
<tr><td>Across groups i.e., older LGBT service users or Black, Asian & Minority Ethnic young men.</td><td>No data available.</td></tr>
<tr><td>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</td><td>Deprivation:
Richmond has remained within the least deprived 1st quartile of London local authorities, ranking 1st out of 33 in 2019, similar to 2015. Richmond has no areas that are among the 10% most deprived in the country. Richmond ranks amongst the least deprived boroughs in London for five of seven deprivation domains of the Index of Multiple Deprivation, IMD (Income; Employment; Education, Skills & Training; Barriers to Housing & Services and Education). People in more deprived areas are more likely to be disproportionately impacted by air pollution.</td></tr>
</table>



Deprivation is an important determinant of life expectancy. Consistent with national data, life expectancy is lower in areas of higher deprivation within the borough. Males in the least deprived areas of the borough live 6.5 years longer and females 2.6 years longer than their counterparts in the most deprived areas of the borough.

In males, the biggest contribution to the gap in life expectancy between the most and least deprived quintiles in the borough is circulatory disease and cancer, while in females it is cancer and respiratory disease.

Figure 24: Life expectancy gap and cause of death between the most deprived quintile and least deprived quintile, years of life, 2015–17, Richmond.



Dietary inequalities disproportionately impact those in the poorest areas versus the most affluent. The Survey of Londoners estimates that 13% of adults in Richmond are living in low or very low food security, meaning that they forgo a balanced diet, cut the size of meals, or skip meals because money is not available for the necessary food.

Overweight and obesity disproportionately affect those from more deprived areas, and this association is seen most strongly in children, with obesity prevalence in the most deprived decile being approximately twice that of the least deprived.

Deprivation has disproportionate negative impacts according to levels of deprivation. 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. Further, smoking

accounts for approximately half of the difference in life expectancy between the richest and the poorest in society. Smoking rates are almost three times higher amongst the lowest earners compared to the highest earners.

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.

Incidence and mortality rates from respiratory disease are higher in disadvantaged groups and areas of social deprivation. The most deprived communities have increased exposure to risk factors due to higher incidence of smoking rates, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards. Data from the ONS found that self-reported long COVID was more common in people living in more deprived areas. The Office for Health Improvement and Disparities Post Covid-19 syndrome London region Health Needs Assessment 2021 found a higher uptake of post-COVID-19 service in people from less deprived areas.

People who are socioeconomically disadvantaged or who live in areas of socioeconomic deprivation have an increased risk of suicidal behaviour. Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent, and hospital admission rates for self-harm are two times higher.

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.

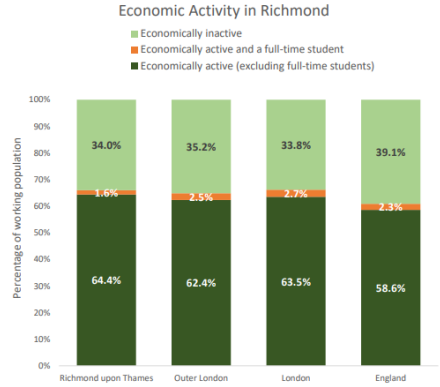
Low-income groups & employment:
Richmond performs well compared to other London boroughs for most indicators such low pay with a poverty rate of 15%, the lowest in London. Only 11% of employed residents earn less than the London Living Wage - the joint lowest percentage in London. A summary of the latest 2021 census data regarding economic activity in Richmond is shown below:

Economic Activity

Interactive map: 2021 Census Data Atlas| Economic Activity

LONDON BOROUGH OF RICHMOND UPON THAMES

- Two thirds (66%) of residents over the age of 16 are economically active.
- Economic inactivity in Richmond (34%) has risen by +9.5% points since 2011, this is similar to London and below England (39.1%).
- The ONS Annual Population Survey (APS) for all residents 16+ reports lower levels of inactivity (30.2%) due to differences in reporting. As per the APS Economic Inactivity in Richmond is around the same level as it was 10 years ago.
- Among the 34% economically inactive 18% were retired and 6% were students not working, 5% looking after home and family and 2.2% long-term sick or disabled.
- Economic Inactivity (excluding students and the retired) is highest in Heathfield and Hampton North.



In November 2018, 0.5% of borough residents were claiming income support which was lower than the London and national average. 2,137 households claimed universal credit with the majority being single adult households with no dependent children. Of those individuals claiming universal credit, 0.7% were in employment and 1.2% were not in employment. Richmond ranked as the 4th lowest borough in London for those claiming child benefit payments and the borough ranked 4th lowest in London for fuel poverty.

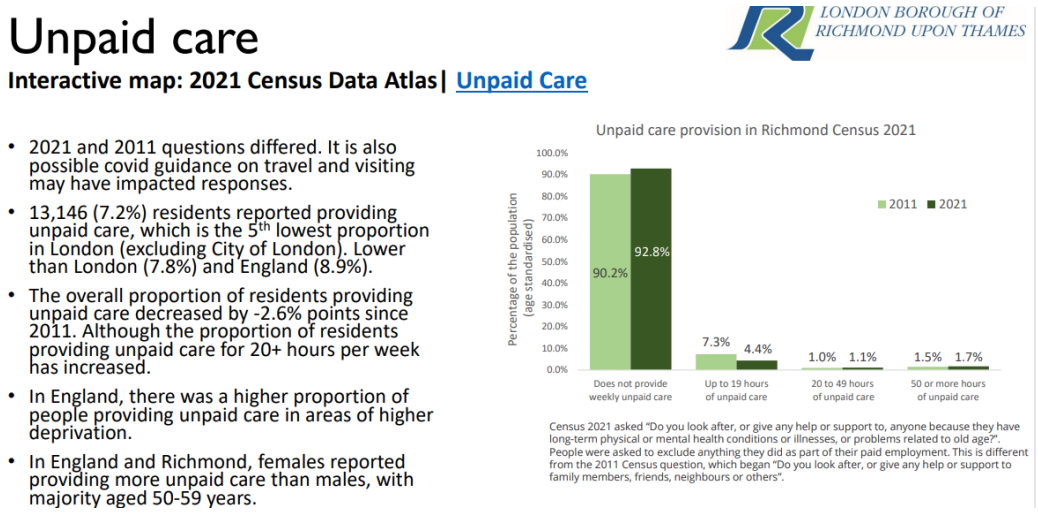
Economic factors such as insufficient income to afford expenses needed to socialize contribute to people becoming disconnected from social groups; this and other risk factors associated with social isolation are more prevalent in socially disadvantaged groups.

Data from the 2021-22 season (SWL Immunisation Dashboard) showed that influenza vaccination uptake is low amongst homeless groups (28.6%).

The risk of malnutrition is affected by income. In a report from Age UK (2021), 24% of older people believed they would have to choose between eating and heating their home as energy bills rise.

Carers and Care experienced people:
It is estimated that there are a total of 2,100 parent carers in the Borough, making up around 13% of the carer population. The 2011 Census identified that there are 864 carers in Richmond upon Thames aged younger than 24 years who provide unpaid family care; assuming the same proportion applied to the 2020 population gives an estimate of 960 children and young adults providing care. 2011 Census Data reveals that 14.1% of the carer population are from Black, Asian and Minority Ethnic groups, 14.5% are from non-British White Ethnic Groups, and the remaining 71.4% are White British.

The latest national data from the State of Caring 2018 report shows that 72% of carers experience mental ill health, and 61% live with physical ill health as a result of caring. In Richmond, 21% of carers report having as much social contact as they want while 15% report that they had little social contact with people and felt socially isolated.



Young carers are three times more likely to have a mental health condition than their peers.

	Single parents: The latest available data from November 2018 showed that of the 2,137 households on universal credit, 29% (625) were single adult households with dependant(s). In 2021, 8.8% of households were single-family households (lone parent) (ONS 2021); this increased from 7.8% in 2021. **Health inequalities** In Richmond and nationally, life expectancy is lower in areas of higher deprivation. Based on the latest data from 2017–19 males in the least deprived areas of the borough live 6.5 years longer and females live 1.5 years longer than their counterparts in the most deprived areas of the borough. **Refugee status** No data available

Data gaps

Data gap(s)	How will this be addressed?
There are data gaps for the following characteristics: gender identify and sexual orientation (2021 was the first time the census collected data on these protected characteristics); across groups i.e., older LGBT service users or Black, Asian & Minority Ethnic young men.	A recommendation is for Joint Local Health and Wellbeing implementation leads/groups to conduct topic specific EINAs. As part of the consultation process, data will be collected on protected characteristics (i.e., carer status).

4. Impact

Protected group	Positive	Negative
Age	The population of Richmond is expected to increase over the coming years, with the biggest increase (48% rise) projected within the 80+ year old age group. 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.	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.
Disability	Positive impacts are anticipated for people with a disability in relation to:	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this

	- increased uptake of cervical cancer screening by targeting underserved populations and those less likely to take up services (i.e., women with any disability including learning disability) - improved mental health outcomes through the implementation of community led support networks and tailored approaches to improve mental health	protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.
Sex	Positive impacts are anticipated in relation to: - increased cervical cancer screening by community engagement and communications, including engaging with women through primary care services. - Providing targeted interventions to stop smoking for high-risk groups such as pregnant women. -	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.
Gender reassignment	None identified	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.
Marriage and civil partnership	Positive impacts are anticipated for people from the LGBTQ+ population in relation to: - improved mental health outcomes through the implementation of community led support networks and tailored approaches to improve mental health in this high-risk groups	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.
Pregnancy and maternity	The strategy anticipates a positive impact on pregnant women through: - providing targeted interventions for high-risk groups such pregnant women to stop smoking	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.
Race/ethnicity	Black, Asian, and Minority Ethnic groups represent 16% of the Richmond population. The strategy	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this

	recognizes the impact of ethnicity on health and wellbeing outcomes, and positive impacts are anticipated for people from Black, Asian and Minority Ethnic groups in relation to: - Promoting the benefits of physical activity to Richmond adults, specifically targeting those groups who are the least physically active and improve signposting to opportunities to be physically active. - increased uptake of cervical cancer screening by targeting underserved populations and those less likely to take up services (i.e., women from certain ethnic minority groups), including by providing communication in a variety of languages and formats to increase accessibility. - Ensure information regarding the harmful effects of alcohol and available services is in easy-to-read formats and translated to be accessible to widest population.	protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.
Religion and belief, including non-belief	Positive impacts are anticipated for people from diverse religious beliefs in relation to: - increased uptake of cervical cancer screening by engaging directly with faith groups to promote cancer screening.	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.
Sexual orientation	Positive impacts are anticipated for people from the LGBTQ+ population in relation to: - improved mental health outcomes through the implementation of community led support networks and tailored approaches to improve mental health in this high-risk groups	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.
Socio-economic status (To be treated as a protected characteristic under Section 1 of the Equality Act 2010) Include the following groups:	Positive impacts are anticipated for people from this protected characteristic in relation to: - Providing access to psychosocial support for families and carers of people with dementia including	There is no evidence to suggest that implementation of this strategy will have a negative impact on people in this protected group. Implementation of the strategy will be monitored, and any unintended consequences will be acted upon.

• **Deprivation (measured by the 2019 English Indices of Deprivation)** • **Low-income groups & employment** • **Carers** • **Care experienced people** • **Single parents** • **Health inequalities** • **Refugee status**	bereavement and therapy services. - Improved community engagement to address inequalities in access/update of immunizations 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 and tackle health inequalities. - address health inequalities in cervical cancer screening by targeting underserved populations and those less likely to take up services (example: utilising the Homeless Health Offer). - Identifying barriers to participation in physical activity and reducing them where possible, including reviewing concessions. - Working with organisations who are supporting food insecurity to promote the benefits of healthy eating and consider providing a community recipe resource. - Ensure opportunities for breaks and social connections are available particularly for vulnerable groups (unpaid carers, older people with long term health conditions, mental health).	

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, including any impact on protected characteristics, 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	11 August 2023 – 21 September 2023