Regional Obesity Management Service (Northern Ireland) – Consultation 2023

Equality Screening, Disability Duties and Human Rights Assessment Template

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Part 1. Policy scoping

1.1 Information about the policy

Name of the policy

Regional Obesity Management Services (Northern Ireland) Consultation Document 2023

Is this an existing, revised or a new policy?

The Department of Health is consulting on its plans to introduce a prototype Regional Obesity Management Service (ROMS) in Northern Ireland. It is intended that this will include the provision of both preventative measures and active multidisciplinary weight loss strategies, including, where appropriate, bariatric surgery (weight loss surgery) and weight loss medication.

What is it trying to achieve? (intended aims/outcomes)

Obesity is one of the most significant public health issues facing Northern Ireland today. The 2019/20 Health Survey for NI reported that 65% of the adult population are classified as living with overweight (38%) or obesity (27%). Obesity levels have shown an upward trend since 2010/11.

The survey also reported that just over one in four[1] children and young people in Northern Ireland are living with overweight (20%) or obesity (6%). Child obesity remained relatively stable between 2010/11 and 2019/20.

It is recognised that having overweight or obesity can significantly affect life expectancy and can also increase the risk of a range of health conditions including: heart disease and stroke; type II diabetes; some cancers, including postmenopausal breast cancer; mental health issues such as depression; and complications in pregnancy. Indeed, the WHO European Regional Obesity Report 2022 states the "Recent estimates suggest that overweight and obesity is the fourth most common risk factor for non-communicable diseases, after high blood pressure, wider dietary risks and tobacco"[2].

In addition to the clear health problems associated with obesity, there is also a significant financial impact. The total direct and indirect costs to Health and Social Care in NI of overweight and obesity in 2015/16 were estimated at around £457 million. This is a significant increase from the 2009/10 estimate of £268 million.

For many people, advice on healthy living, including diet and physical activity, may be effective in achieving weight loss. However, for some people, more specialist support and intervention

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[1] Using the International Obesity task Force (IOTF) cut off points.
[2] https://apps.who.int/iris/bitstream/handle/10665/353747/9789289057738-eng.pdf

may be required. In other parts of the UK this specialist support, which may include the provision of weight loss medication and bariatric, or weight loss, surgery, is provided via specialist obesity management services. In Northern Ireland, these services have not traditionally been commissioned and are therefore not available within the health service.

Northern Ireland is therefore the only nation within the United Kingdom which does not already have an obesity management service provided by the health service.

Improving the health of the population of Northern Ireland is a key focus of the Department for Health and for the wider Northern Ireland Executive. In support of this, “We all enjoy long, healthy, active lives” is a key outcome in the draft Programme for Government[3].

The key objective of the ROMS is to achieve a significant risk reduction in the burden of obesity-related co-morbidities among the group of patients targeted in the service. It is intended that this will be achieved by facilitating significant and sustained weight reduction in the individuals and improvement in their long-term health.

Clinical best practice indicates that all patients with the disease of obesity (defined as having a BMI over 30, in addition to assessment using appropriate obesity staging systems[4]) with any obesity related complication should have access to this service. However, the available evidence suggests the need is greater for specific obesity-related complications or the needs of the subpopulations with obesity are large and unmet. For this reason, prioritisation of specific patient subpopulations may be necessary. These include for example, people living with a BMI over 35 (or as appropriate for their ethnic background) with certain health complications. Specific access criteria will be developed prior to commencement of the service in accordance with best practice.

This service will initially be introduced as a prototype model for a period of two years, at which point an evaluation will take place, with a view to further expansion.

Are there any Section 75 categories which might be expected to benefit from the intended policy?
If so, explain how.

This service will be a new regional service, and as such it will impact positively on all those who use it, who currently have no access to such services within NI. As it is a prototype designed to test the service model before further roll out, services will be based in limited locations in Northern Ireland, and access may be restricted according to clinical criteria during the testing period. This is necessary to test and ensure the safety and functionality of the service model. However, as the service will be provided on the basis of clinical assessment, there is no direct major negative impact on section 75 categories. In particular, people with disabilities may be expected to benefit from the introduction of this service.

[3] https://www.northernireland.gov.uk/programme-government-pfg-2021

[4] Obesity Staging Systems are systems used for obesity classification to provide clinically relevant insight into health-related risks for individuals.

Following this consultation, a service specification will be developed which will be subject to further scrutiny.

Who initiated or wrote the policy?

The Regional Obesity Management Service team within Elective Care and Cancer Policy Directorate, Department of Health

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Who owns and who implements the policy?

DoH will own the consultation and its responses, and will be ultimately responsible for the development of the prototype service. Health and Social Care Trusts will be responsible for implementing and delivering the prototype service.

1.2 Implementation factors

Are there any factors which could contribute to/detract from the intended aim/outcome of the policy/decision? **Yes**

If yes, are they (please delete as appropriate)

Financial:
Adequate funding will be required to deliver the prototype service, with additional funding required in future for further roll out of the service. The health service is currently operating within significant budgetary constraints, therefore the inability to secure adequate funding will detract from the full delivery of all desirable outcomes.

Other:
Availability of appropriately trained staff at all levels of the treatment pathway will be key to its successful implementation.

1.3 Main stakeholders affected

Who are the internal and external stakeholders (actual or potential) that the policy will impact upon? (please delete as appropriate)

- the public

- Health and Social Care staff
- service users
- other public sector organisations
- voluntary/community/trade unions
- manufacturers
- academia
- pharmaceutical industry

1.4 Other policies with a bearing on this policy

- what are they? Who owns them?
    - Healthy Futures – draft strategic framework to tackle obesity (DoH)
    - NICE Guidelines CG189 (National Institute for Health and Care Excellence)
    - Technical Appraisals TA875 and TA664 (National Institute for Health and Care Excellence)
    - Circular HSC (SQSD) 12/22 (DoH)
    - The Cancer Strategy (DoH)
    - The Diabetes Strategy (DoH)
    - Review of General Surgery (DoH)
    - Elective Care Framework NI (DoH)
    - Draft Programme for Government (Executive/TEO)
    - NICS Outcomes Delivery plan (NICS)
    - Food Strategy (DAERA)
    - Sport and Physical Activity Strategy (DfC)

1.5 Available evidence

What evidence/information (both qualitative and quantitative[5]) have you gathered to inform this policy? Specify details for each of the Section 75 categories.

Religious belief evidence / information:

Information on religious belief can be found in the 2021 Census[6]. One sixth (18.99 per cent) of the usually resident population on Census Day either had No Religion or Religion Not Stated. The figures for the main religions were: Catholic (42.31 per cent); Presbyterian (16.61

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[5] * Qualitative data – refers to the experiences of individuals related in their own terms, and based on their own experiences and attitudes. Qualitative data is often used to complement quantitative data to determine why policies are successful or unsuccessful and the reasons for this.
Quantitative data - refers to numbers (that is, quantities), typically derived from either a population in general or samples of that population. This information is often analysed either using descriptive statistics (which summarise patterns), or inferential statistics (which are used to infer from a sample about the wider population).

[6] Census 2021 main statistics religion tables | Northern Ireland Statistics and Research Agency (nisra.gov.uk)

per cent); Church of Ireland (11.55 per cent); Methodist (2.35 per cent); Other Christian or Christian-related denominations (6.85 per cent); and Other Religions (1.34 per cent).

There is no qualitative or quantitative evidence available in relation to the religious beliefs of those individuals who are living with obesity. Those who have different diets or eating habits for religious reasons will not be affected by the proposals as outlined, however, this may need to be considered on an individual basis by clinicians when developing treatment plans.

Political Opinion evidence / information:

There is limited data available on political opinion, however, data on the first preference votes per party in NI Assembly Elections 2022[7] can be used as proxy information:

- **DUP – 184,002**
- **Sinn Fein – 250,385**
- **UUP – 96,390**
- **SDLP – 78,237**
- **Alliance – 116,681**
- **TUV – 65,788**
- **People Before Profit Alliance (PBPA) – 9,798**
- **Green Party – 16,433**
- **Other – 44,968**

There is no qualitative or quantitative evidence available in relation to the political opinion of those individuals who are living with obesity.

Racial Group evidence / information:

Within NI, the Census 2021[8] shows the following breakdown of ethnic groups:

White	96.55%
Irish Traveller	0.14%
Roma	0.08%
Indian	0.52%
Chinese	0.50%
Filipino	0.23%
Pakistani	0.08%
Arab	0.10%
Other Asian	0.28%
Black African	0.42%
Black other	0.16%

[7] Northern Ireland Assembly Elections: 2022 - House of Commons Library (parliament.uk)
[8] Results | Northern Ireland Statistics and Research Agency (nisra.gov.uk)

Mixed	0.76%
Other ethnicities	0.19%

Data indicating ethnicity of people living with obesity is not available for Northern Ireland. However, the Office for Health Improvement and Disparities[9], England, indicates that in the year to November 2021, 63.5% of adults in England were overweight or living with obesity. Of this group, 72.0% of adults from black ethnic groups were overweight or living with obesity – the highest percentage out of all ethnic groups. 37.5% of adults from the Chinese ethnic group were overweight or living with obesity – the lowest percentage out of all ethnic groups. White British adults were more likely than average to be overweight or living with obesity (64.5%). The percentage of adults who were overweight or living with obesity was lower than average in the Asian (57.0%), white 'other' (57.9%) and mixed (59.5%) ethnic groups. The percentage of adults in the 'other' ethnic group who were overweight or living with obesity (66.2%) was similar to the national average. Compared with the year ending November 2016, the percentage of adults who were overweight or living with obesity went up in the white British ethnic group (from 62.1% to 64.5%), mixed ethnic group (from 53.9% to 59.5%) and 'other' ethnic group (from 58.9% to 66.2%). It would be reasonable to assume that these trends may be reflected in minority populations in Northern Ireland.

NICE CG 189[10] advises targeted advice for people from Black, Asian and minority ethnic family backgrounds who are at an increased risk of chronic health conditions at a lower BMI than people from a white family background (below BMI 25 kg/m2).

The ROMS consultation document highlights that the consideration of assessment for bariatric surgery at lower BMI thresholds for people from some ethnicities will reduce inequalities in obesity-related outcomes and improve accessibility of treatment. Specific access criteria will be developed prior to commencement of the service in accordance with best practice, which will reflect the specific needs of this group. This will mitigate the risk of people from these communities falling outside the standard clinical access criteria. As health and social care services are provided on the basis of assessed clinical need, no differential impact on the grounds of racial group has been identified.

The impact of barriers such as language should be considered and addressed at service development and implementation stage.

Age evidence / information:

The latest NISRA mid year population estimates[11] reported that:

- the proportion of the population aged 65 or more has increased from 13.0 per cent in mid-1997 to 17.6 per cent in mid 2022;
- In contrast, the proportion of the population aged 0 to 15 years has decreased from 24.7 per cent in mid 1997 to 20.4 per cent in mid-2022.

[9] Overweight adults - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)
[10] Obesity: identification, assessment and management (nice.org.uk)
[11] Statistical Bulletin - 2022 Mid-year Population Estimates for Northern Ireland (nisra.gov.uk)

- Over the three decades from the year ending mid-1992 to the year ending mid-2022 the median age (i.e. the age at which half the population is older and half is younger) of the Northern Ireland population has increased from 31.5 to 40.0 years.
- In the year mid-2021 to mid-2022, the population aged 65 and over increased by 1.9 per cent (from 329,200 to 335,400), representing 17.6 per cent of the population.
- In the year ending mid-2022, the number of children increased by 1,300 people (from 388,200 to 389,400), representing 20.4 per cent of the population.

The Health Survey 2019/20[12] reported that the lowest levels of adult overweight and obesity are seen in the age group 16-24. Rates of overweight and obesity tend to increase with age, with higher rates seen between the ages of 45 and 74:

2019/20 - Adults	Overweight	Obese	Total
Age-group	**%**	**%**	**%**
16-24	23%	14%	**37%**
25-34	38%	25%	**63%**
35-44	39%	27%	**66%**
45-54	42%	34%	**76%**
55-64	42%	30%	**72%**
65-74	43%	35%	**78%**
75+	36%	27%	**63%**
Total	**38%**	**27%**	**65%**

The Health Survey also reported that levels of overweight among children increases with age, however, levels of obesity are seen to decrease with age, as outlined in the table below. (NB. The Health Survey use International Obesity Task Force (IOTF) cut-off points of the BMI percentiles for children.)

2019/2020 – Children		
BMI (using IOTF)	**Age 2-10**	**Age 11-15**
Underweight	5%	6%
Normal weight	70%	68%
Overweight	18%	22%
Obesity	7%	4%
Total	100%	100%

According to NICE[13], surgical intervention is not generally recommended in children or young people, and bariatric surgery may be considered only in exceptional circumstances, if they have achieved or nearly achieved physiological maturity. Drug treatment is not generally

[12] Health survey Northern Ireland: first results 2021/22 | Department of Health (health-ni.gov.uk)
[13] Recommendations | Obesity: identification, assessment and management | Guidance | NICE

recommended for children younger than 12 years, other than in exceptional circumstances, if severe comorbidities are present. In children aged 12 years or older, drug treatment is recommended only if physical comorbidities or severe psychological comorbidities are present.

Marital Status evidence / information:

The 2021 Census data provides information on **marital status**. It showed that almost half (46%) of people aged 16 years and over were married, and over a third (38%) were single. Just over 2,700 people (0.2%) were in registered same-sex civil partnership. A further 10% per cent of usual residents were either separated, divorced or formerly in a same-sex civil partnership, while the remaining 6% were either widowed or a surviving partner.

There is no qualitative or quantitative evidence available in relation to the marital status of those living with obesity.

Sexual Orientation evidence / information:

The 2012 Life and Times Survey interviewed 1204 adults to establish their sexual orientation. 98% of respondents identified themselves as Heterosexual/Straight, 1% as Gay/Lesbian, and 1% provided No answer/Refusal. Figures published by the Office of National Statistics in 2010 recorded that 0.9% of the UK population identified themselves as gay or lesbian, while a further 0.5% identified themselves as bisexual (Measuring Sexual Identity: An Evaluation Report). It is likely that the true figures are significantly higher.

In the 2021 Census, a sexual orientation question was asked only of those people aged 16 and over. 2.1% of respondents identified as lesbian, gay, bisexual or other, with 90% of respondents identified as straight or heterosexual. 7.9% of respondents did not state their sexual orientation.

There is no qualitative or quantitative evidence available in relation to the sexual orientation of those living with obesity.

Gender (Men & Women generally) evidence / information:

The 2021 Census[14] data showed that 50.81% of all usual residents in Northern Ireland are female, with 49.19% of the population male.

The table below adapted from the Health Survey Northern Ireland 2019/20[15] indicates that men are more likely than women to have overweight, while females are more likely than

[14] Census 2021 main statistics demography tables – age and sex | Northern Ireland Statistics and Research Agency (nisra.gov.uk)
[15] Health survey Northern Ireland: first results | Department of Health (health-ni.gov.uk)

males to have normal weight. When it comes to living with obesity, there is little difference between men and women:

BMI	All Adults	Male adults	Female adults
Underweight	1%	1%	2%
Normal weight	33%	28%	38%
Overweight	38%	43%	33%
Obesity	24%	26%	23%
Obesity Class III[16]	3%	2%	4%
Total	100%	100%	100%

A body mass index (BMI) over 25 is considered overweight, with obesity considered to be a BMI over 30[17]. The new ROMS prototype is intended to provide services for individuals with a BMI of over 30 (i.e. with the disease of obesity). As levels of obesity are very similar between men and women (28% and 27% respectively), there will be no differential impact on the grounds of gender.

Disability evidence / information:

In the 2021 Census data for health, disability and unpaid care[18] indicates that from a population of 1,903,176 usual residents, 18.11% record 1 long term health condition, with 7.96% percent recording 2 long term health conditions. 4.26% record 3 long-term health conditions, and 2.43% state 4 long term health conditions.

In terms of households (768,810), the number of households with 1 resident having a limiting long term health problem or disability is 33.63% and 2 or more residents having a limiting long-term health problem or disability is 11.23%.

Of all usual residents, 11.45% state day to day activities were limited a lot with 12.88% confirming their day-to-day activities limited a little.

People with mobility limitations and intellectual or learning disabilities are at greatest risk for obesity. People with disabilities can find it more difficult to eat healthy, control their weight, and be physically active. This might be due to:

- A lack of healthy food choices;
- Difficulty with chewing or swallowing food, or its taste or texture;
- Medications that can contribute to weight gain, weight loss, and changes in appetite;
- Physical limitations that can reduce a person's ability to exercise;
- Pain;
- A lack of energy;

[16] *BMI >40kg/m2*
[17] Obesity (who.int)
[18] Census 2021 main statistics health, disability and unpaid care tables | Northern Ireland Statistics and Research Agency (nisra.gov.uk)

- A lack of accessible environments (for example, sidewalks, parks, and exercise equipment) that can enable exercise;
- A lack of resources (for example, money, transportation, and social support from family, friends, neighbours, and community members)[19].

For individuals who are living with obesity and also physical disabilities, there may be challenges in using BMI or waist-to-height ratio to assess obesity. For example, some people may be unable to get on scales independently or be lifted safely. In such circumstances, reasonable adjustments would be needed, e.g. using seated or hoist scales, or scales that can be used for wheelchairs (including moulded wheelchairs). Measurements may also need to be modified, for example using sitting height or demi-span (the distance between the mid-point of the sternal notch and the finger roots with the arms outstretched laterally) instead of overall height, meaning specialist assessment may be needed. It may also be challenging to take measurements in people who are housebound because it may not be possible to access equipment such as specialist scales during home visits.

A report by the Sainsbury Centre for Mental Health in 2006 found that the rate of obesity among people with learning disability (LD) was significantly different to those without such a disability (28.3% compared to 20.4%) (Emerson 2006)[20]. There is also a likely link between obesity and depression, however, evidence was not found to document the significance of this.

People with mental health needs or intellectual disabilities may not always be able to access all the weight loss programmes that are available to the general population. Specific and targeted support may be required, which more appropriately meets the individual's needs. This may include the provision of information and resources in accessible formats and a person centred approach in engagement with services, to support understanding. Another important consideration in adults with learning disability, physical disabilities such as brain injuries, or mental illness, would include assessment of mental capacity of the individual to consent to specific interventions and making best interest decisions if the person lacks capacity.

Overall, the introduction of a new ROMS does not provide any negative impact based on disability and, on balance, will likely provide positive impacts for those whose disability is caused or impacted by obesity. As set out above, additional measures may be required to assist individuals with disabilities in accessing the service. A person-centred approach should be taken to ensure their needs are met.

Dependants evidence / information:

In 2021, of 768,802 households in Northern Ireland, 30.67% contained **dependent children**,.

According to the Health Survey NI 2021/22, under a fifth (17%) of respondents looked after another person who is sick, disabled or elderly for an hour or more each week (up from 14% in 2018/19). Females (22%) were more likely than males (13%) to have caring responsibility.

[19] Disability and Obesity | CDC
[20] Obesity in people with intellectual disabilities | Intellectual Disability and Health

Around a quarter of those aged 45-54 (27%) and 55-64 (24%) had caring responsibility for someone.

There is no qualitative or quantitative evidence available in relation to people living with obesity who have dependants.

As health and social care services are available to everyone equally, on the basis of clinical need, no differential impact on the grounds of having dependants has been identified.

1.6 Needs, experiences and priorities

Taking into account the information referred to above, what are the different needs, experiences and priorities of each of the following categories, in relation to the particular policy/decision?

Specify details of the needs, experiences and priorities for each of the Section 75 categories below:

Religious belief

It may be necessary for weight management services to consider specific diets or eating habits of those from specific religious communities, when considering weight management interventions. This will be done on an individual basis in discussion with the individual and in line with best practice and clinical guidance.

As health and social care services are available to everyone equally, on the basis of clinical need, no differential impact on the grounds of religious belief has been identified.

Political Opinion

No evidence of specific need has been identified. As health and social care services are available to everyone equally, on the basis of clinical need, no differential impact on the grounds of political opinion has been identified.

Racial Group

There is evidence that individuals from BME communities are at greater risk of chronic health conditions at a lower BMI. NICE CG 189[21] advises targeted advice for people from Black, Asian and minority ethnic family backgrounds who are at an increased risk of chronic health conditions at a lower BMI than people from a white family background (below BMI 25 kg/m2).

[21] Obesity: identification, assessment and management (nice.org.uk)

The ROMS consultation document highlights that ethnic background should be considered when determining access to the new services. This will be reflected in the development of access criteria, which will be based on best practice. This will mitigate the risk of people from these communities falling outside the standard clinical access criteria, which will reduce inequalities in obesity-related outcomes and improve accessibility of treatment.

The impact of barriers such as language should also be considered and addressed at service development and implementation stage, ensuring availability of interpreters where required, and the provision of written information in a language in which the individual can understand.

The risk of health conditions occurring at a lower BMI for some BME communities constitutes a minor impact for those from a different racial group, however, this will be mitigated by ensuring that the needs of individuals with obesity from ethnic backgrounds is reflected in the criteria for determining access to services at assessment. This will ensure that those individuals who most need the service will have access to it.

Age

It has been demonstrated that obesity rates increase gradually with age, therefore it is likely that adults in the age bracket 45-74 may be slightly more likely to access this service than other age groups. However, services will be provided on the basis of assessed clinical need, which will consider a range of factors including co-morbidities. This will ensure that those individuals who most need the service will have access to it. No specific needs are therefore identified for adults in different age groups.

It has been demonstrated that around a quarter of all children have overweight or obesity. According to NICE, the majority of support that should be provided to children in relation to weight management should be provided as part of lifestyle management services. These services fall outside the scope of the ROMS service prototype. In some very exceptional circumstances it may be appropriate to treat children within a ROMS; this would be done in line with best practice and clinical assessment as appropriate. In such circumstances appropriate support must be provided by a multi-disciplinary team appropriately trained to assess the treatment and support needs of the child.

As it is likely that the majority of children with obesity would fall outside the scope of the new service prototype (as per NICE guidance), it is considered that the impact on children is minor.

Marital status

No evidence of specific need has been identified. As health and social care services are available to everyone equally, on the basis of clinical need, no differential impact on the grounds of marital status has been identified.

Sexual orientation

No evidence of specific need has been identified. As health and social care services are available to everyone equally, on the basis of clinical need, no differential impact on the grounds of sexual orientation has been identified.

Men and Women Generally

No evidence of specific need has been identified. As levels of obesity are very similar between men and women (28% and 27% respectively), there will be no differential impact on the grounds of gender.

Disability

For individuals who are living with obesity and also physical disabilities, there may be challenges in using BMI or waist-to-height ratio to assess obesity. For example, some people may be unable to get on scales independently or be lifted safely. In such circumstances, reasonable adjustments would be needed, e.g. using seated or hoist scales, or scales that can be used for wheelchairs (including moulded wheelchairs). Measurements may also need to be modified, for example using sitting height or demi-span (the distance between the mid-point of the sternal notch and the finger roots with the arms outstretched laterally) instead of overall height, meaning specialist assessment may be needed. It may also be challenging to take measurements in people who are housebound because it may not be possible to access equipment such as specialist scales during home visits.

People with mental health needs or intellectual disabilities may not always be able to access all the weight loss programmes that are available to the general population. Specific and targeted support may be required, which more appropriately meets the individual's needs. This may include the provision of information and resources in accessible formats and a person centred approach in engagement with services, to support understanding. Another important consideration in adults with learning disability, physical disabilities such as brain injuries, or mental illness, would include assessment of mental capacity of the individual to consent to specific interventions and making best interest decisions if the person lacks capacity.

Overall, the introduction of a new ROMS does not provide any negative impact based on disability and, on balance, will likely provide positive impacts for those whose disability is caused or impacted by obesity. Any issues relating to access should be mitigated by taking a person-centred approach to assessment, support and treatment as appropriate.

Dependants

There is no differential impact on the priorities and needs in relation to dependants.

Part 2. Screening questions

2.1 What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? minor/major/none

Details of the likely policy impacts on Religious belief: None expected

What is the level of impact? ~~Minor / Major /~~ None

Details of the likely policy impacts on Political Opinion: None expected

What is the level of impact~~? Minor / Major /~~ None

Details of the likely policy impacts on Racial Group: Minor - some BME communities are at risk of greater health complications at lower BMI.

What is the level of impact? Minor / ~~Major / None~~

Details of the likely policy impacts on Age: Minor – only a small cohort of children are likely to be able to access future ROMS services in very exceptional circumstances. This will be provided in line with best practice. While obesity rates tend to increase among adults as they age, this increase is not significant and would not constitute a differential impact on equality of opportunity.

What is the level of impact? Minor / ~~Major / None~~

Details of the likely policy impacts on Marital Status: None expected

What is the level of impact? ~~Minor / Major /~~ None

Details of the likely policy impacts on Sexual Orientation: None expected

What is the level of impact? ~~Minor / Major /~~ None

Details of the likely policy impacts on Men and Women: None expected

What is the level of impact? ~~Minor (positive) / Major /~~ None

Details of the likely policy impacts on Disability: Minor - Will likely provide positive impacts for those whose disability is caused or impacted by obesity. Any issues relating to access will be mitigated by taking a person-centred approach to assessment, support and treatment as appropriate.

What is the level of impact? Minor / ~~Major / None~~

Details of the likely policy impacts on Dependants: None expected

What is the level of impact? ~~Minor / Major /~~ None

2.2 Are there opportunities to better promote equality of opportunity for people within the Section 75 equalities categories? Yes/ ~~No~~

Detail opportunities of how this policy could promote equality of opportunity for people within each of the Section 75 Categories below:

Religious Belief - If Yes, provide details:
If No, provide reasons:
No. The options will apply to all irrespective of religious belief.

Political Opinion - If Yes, provide details:
If No, provide reasons
No. The options will apply to all irrespective of political opinion.

Racial Group - If Yes, provide details:
If No, provide reasons
Yes. The risk of health conditions at a lower BMI for some BME communities constitutes a minor impact for those from a different racial group, however, this will be mitigated by ensuring that ethnic background is a key consideration for determining access to services at assessment.

Age - If Yes, provide details:
If No, provide reasons:
No. The options will apply to all adults irrespective of age. Only a very small cohort of children may access the service in very exceptional circumstances, as per best practice and clinical guidelines.

Marital Status - If Yes, provide details:
If No, provide reasons
No. The options will apply to all irrespective of marital status.

Sexual Orientation - If Yes, provide details:
If No, provide reasons:
No. The options will apply to all irrespective of sexual orientation.

Men and Women generally - If Yes, provide details:
If No, provide reasons:
No. The options will apply to all irrespective of gender.

Disability - If Yes, provide details:
If No, provide reasons:
Yes. Overall, the introduction of a new ROMS does not provide any negative impact based on disability and, on balance, will likely provide positive impacts for those whose disability is caused or impacted by obesity. However, a person-centred approach should be taken to assessment, support and treatment to ensure the individual's needs are met.

Dependants - If Yes, provide details:
If No, provide reasons:
No. The options will apply to all irrespective of those with or without dependants.

2.2 To what extent is the policy likely to impact on good relations between people of different religious belief, political opinion or racial group?

Please provide details of the likely policy impact and determine the level of impact for each of the categories below i.e. either minor, major or none.

Details of the likely policy impacts on Religious belief: The policy will not have an impact on good relations between people of different religious belief.

What is the level of impact? ~~Minor / Major /~~ None

Details of the likely policy impacts on Political Opinion: The policy will not have an impact on good relations between people of different political opinion.

What is the level of impact? ~~Minor / Major /~~ None

Details of the likely policy impacts on Racial Group: The policy will not have an impact on good relations between people of different Racial Group.

What is the level of impact? ~~Minor / Major /~~ None

2.3 Are there opportunities to better promote good relations between people of different religious belief, political opinion or racial group?

Detail opportunities of how this policy could better promote good relations for people within each of the Section 75 Categories below:

Religious Belief - If Yes, provide details:
If No, provide reasons:
No. New service will apply to all on the basis of assessed clinical need.

Political Opinion - If Yes, provide details:
If No, provide reasons
No. New service will apply to all on the basis of assessed clinical need.

Racial Group - If Yes, provide details:
No. New service will apply to all on the basis of assessed clinical need.

2.5 Additional considerations

Multiple identity

Generally speaking, people can fall into more than one Section 75 category. **Taking this into consideration, are there any potential impacts of the policy/decision on people with multiple identities?**

(*For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people).*

Provide details of data on the impact of the policy on people with multiple identities. Specify relevant Section 75 categories concerned.

This service is not currently available in NI. Just over a quarter of the population of NI may be expected to benefit from the development of new treatment options for obesity, in line with clinical assessment of need. Within that context there is a range of potential people with multiple identities. However, there is little data available on persons living with obesity who have multiple identities.

However, it may be assumed that the introduction of new weight management services may have an impact on people with multiple identities, specifically concerning Age, Racial Group and Disability. This may include older adults or children with a disability living with obesity (age), individuals from BME communities who have a disability and obesity. As set out previously, services will be provided using a person centred approach in line with best practice and assessed clinical need.

2.6 Was the original policy / decision changed in any way to address any adverse impacts identified either through the screening process or from consultation feedback. If so please provide details.

Not applicable at this stage. Once the public consultation exercise has been completed, consideration will be given to how the feedback received will influence the development of the service.

Part 3. Screening decision

3.1 Would you summarise the impact of the policy as; No Impact/ Minor Impact/ Major Impact?

Overall positive impact on individuals living with obesity, as they may have access to new services and support that are currently not available to them, in line with best practice and clinical assessment of need. This will bring Northern Ireland into line with the rest of the UK, resolving the current issue of inequity of access across the UK. Any minor impacts in terms

of access will be addressed through mitigation, as set out above (e.g. consideration of lower BMI threshold for BME communities, person-centred care to meet the needs of individuals with communication needs or disabilities).

3.2 Do you consider that this policy/ decision needs to be subjected to a full equality impact assessment (EQIA)?

No – screened out.

3.3 Please explain your reason.

The intention of the ROMS consultation is to address the harms associated with obesity by providing new options for treatment, which are not currently available in NI. The new service will be developed in line with best practice, and access to the service will be subject to clinical assessment of need. As just over a quarter of the NI population have obesity, it is estimated that a similar proportion may eventually have access to the new services once fully developed, which will be provided in line with clinically assessed need (as is the case for all health and social care services). The initial prototype may restrict access initially until the new model can be tested for efficacy and safety; however, all access criteria will be based on best practice and appropriate clinical guidelines.

The impact screening exercise did not identify any major impact for any of the Section 75 categories. Minor positive impacts were identified, and where minor negative impacts were identified, mitigation will be put in place as set out previously and below.

It is therefore determined that an EQIA is not required at this stage. This position may be reconsidered at a later date during the service development stage.

3.4 Mitigation

When the public authority concludes that the likely impact is 'minor' and an equality impact assessment is not to be conducted, the public authority may consider mitigation to lessen the severity of any equality impact, or the introduction of an alternative policy to better promote equality of opportunity or good relations.

Can the policy/decision be amended or changed or an alternative policy introduced to better promote equality of opportunity and/or good relations? No

Planned mitigations have already been set out above, e.g. consideration of ethnic background when considering BMI and access to services. Further mitigations may be considered based on relevant responses received during the consultation process.

If so, give the reasons to support your decision, together with the proposed changes/amendments or alternative policy.

N/A

3.5 Timetabling and prioritising

Factors to be considered in timetabling and prioritising policies for equality impact assessment.

If the policy has been **'screened in'** for equality impact assessment, then please answer the following questions to determine its priority for timetabling the equality impact assessment.

On a scale of 1-3, with 1 being the lowest priority and 3 being the highest, assess the policy in terms of its priority for equality impact assessment.

Effect on equality of opportunity and good relations – **Rating** ____ (1-3)

Social need – **Rating** ____ (1-3)

Effect on people's daily lives – **Rating** ____ (1-3)

Relevance to a public authority's functions – **Rating** ____ (1-3)

Note: The Total Rating Score should be used to prioritise the policy in rank order with other policies screened in for equality impact assessment. This list of priorities will assist the public authority in timetabling. Details of the Public Authority's Equality Impact Assessment Timetable should be included in the quarterly Screening Report.

Is the policy affected by timetables established by other relevant public authorities?

If yes, please provide details.

Planned consultation on new Obesity Strategy for NI - planned to run consultations in tandem as they are linked.

Part 4. Monitoring

Monitoring is an important part of policy development and implementation. Through monitoring it is possible to assess the impacts of the policy / decision both beneficial and adverse.

4.1 Please detail how you will monitor the effect of the policy / decision?

The effectiveness of this consultation will be monitored by the Department in partnership with key stakeholders who have an interest in this policy. Based on responses received it may be necessary to revisit this screening decision post consultation.

Responses to the consultation will also inform the service development stage, at which point equality considerations will also be revisited.

Appropriate monitoring arrangements in respect of the impact and effectiveness of the new services will be considered during the service development and implementation phase. This is particularly important given that this prototype will run as a pilot project initially.

4.2 What data will you collect in the future in order to monitor the effect of the policy / decision?

Specific requirements for data collection will be considered during the service development and implementation phase together with service design and delivery partners, including commissioners and HSC Trusts.

***Please note**: - For the purposes of the annual progress report to the Equality Commission you may later be asked about the monitoring you have done in relation to this policy and whether that has identified any Equality issues*.

Part 5. Disability Duties

5.1 Does the policy/decision in any way promote positive attitudes towards disabled people and/or encourage their participation in public life?

Yes
As set out above, there may be some circumstances where a person's disability is caused or affected by having obesity, and vice versa. Providing access to obesity treatment options, in line with assessed need and person centred care, may support people with disabilities to participate more in public life, for example, if their mobility or mental health improves.

5.2 Is there an opportunity to better promote positive attitudes towards disabled people or encourage their participation in public life by making changes to the policy/decision or introducing additional measures?

No.

Part 6. Human Rights

6.1 Does the policy / decision affects anyone's Human Rights?

Details of the likely policy impacts on Article 2 – Right to life:
Obesity can significantly affect life expectancy and can lead to a number of health complications including cancer, heart disease, stroke, diabetes and mental illness. By providing new obesity treatment options in line with assessed need, this may positively impact upon individuals' health and therefore life expectancy.

What is the impact? Positive / ~~Negative (human right interfered with or restricted) / Neutral~~

Details of the likely policy impacts on Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on Article 5 – Right to liberty & security of person:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on Article 6 – Right to a fair & public trial within a reasonable time:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on Article 7 – Right to freedom from retrospective criminal law & no punishment without law:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on Article 8 – Right to respect for private & family life, home and correspondence:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on Article 9 – Right to freedom of thought, conscience & religion:

What is the impact? ~~Positive / Negative~~ / Neutral

Details of the likely policy impacts on Article 10 – Right to freedom of expression:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on Article 11 – Right to freedom of assembly & association:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on Article 12 – Right to marry & found a family: Obesity can impact upon fertility. By providing new obesity treatment options in line with assessed need, this may positively impact upon a woman's ability to conceive and therefore found a family.

What is the impact? Positive / ~~Negative / Neutral~~

Details of the likely policy impacts on Article 14 – Prohibition of discrimination in the enjoyment of the convention rights:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on 1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property:

What is the impact? ~~Positive / Negative /~~ Neutral

Details of the likely policy impacts on 1st protocol Article 2 – Right of access to education:

What is the impact? ~~Positive / Negative /~~ Neutral

6.2 If you have identified a likely negative impact who is affected and how?

At this stage we would recommend that you consult with your line manager to determine whether to seek legal advice and to refer to Human Rights Guidance to consider:

- *whether there is a law which allows you to interfere with or restrict rights*
- *whether this interference or restriction is necessary and proportionate*
- *what action would be required to reduce the level of interference or restriction in order to comply with the Human Rights Act (1998).*

Not applicable.

6.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy/decision.

Not applicable.

Part 7 - Approval and authorisation

Screened by:	**Position/Job Title**	**Date**
Taryn McKeen	Deputy Principal	26/10/23
Approved by:		
Catriona O'Connor	Principal	02/11/23
Copied to EHRU:		

The Screening Template is 'signed off' and approved by a senior manager responsible for the policy (at least Grade 7), made easily accessible on the public authority's website as soon as possible following completion and made available on request.

ADDITIONAL INFORMATION TO INFORM THE ANNUAL PROGRESS REPORT TO THE EQUALITY COMMISSION

(PLEASE NOTE : THIS IS NOT PART OF THE SCREENING TEMPLATE BUT MUST BE COMPLETED AND RETURNED WITH THE SCREENING)

1. Please provide details of any measures taken to enhance the level of engagement with individuals and representative groups. Please include any use of the Equality Commissions guidance on consulting with and involving children and young people.

Pre-consultation – during development of ROMS proposal, engagement carried out with individuals with lived experience and other stakeholders including clinicians, representative organisations, policy makers and commissioners.

2. In developing this policy / decision were any changes made as a result of equality issues raised during:

   (a) pre-consultation / engagement; none
   (b) formal consultation; not yet complete
   (c) the screening process; and/or none
   (d) monitoring / research findings. None/not yet complete

   If so, please provide a brief summary including how the issue was identified, what changes were made, and what will be the expected outcomes / impacts for those effected.

3. Does this policy / decision include any measure(s) to improve access to services including the provision of information in accessible formats? If so please provide a short summary.

The consultation document is high level and therefore does not go into detail regarding this; however, it is recognised that this will be required to ensure information is available in an accessible format to meet the needs of those accessing the service.

Thank you for your co-operation.
Equality and Human Rights Unit.