NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Weight Management: identification, assessment and management

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

1.0 Checking for updates and scope: before scope consultation (to be completed by the Developer and submitted with the draft scope for consultation)

1.1 Is the proposed primary focus of the guideline a population with a specific communication or engagement need, related to disability, age, or other equality consideration? Y/N If so, what is it and what action might be taken by NICE or the developer to meet this need? (For example, adjustments to committee processes, additional forms of consultation.)
No

1.2 Have any potential equality issues been identified during the check for an update or during development of the draft scope, and, if so, what are they?
• **Age** o Overweight and obesity rates increase with age. For people aged 45 to 64, 73% are living with overweight or obesity, and for people aged 65 to 74, 76% are living with overweight or obesity. In contrast, 43% of people aged 16 to 24 are living with overweight or obesity. Older people may need specific consideration in the guideline as they may

require additional support for some interventions.

- Younger people may need specific consideration, as obesity is a chronic, relapsing condition. Earlier onset of obesity is usually linked to worse health outcomes.

- **Disability**
  - People with a learning disability are more at risk of overweight or obesity and may require additional support for some interventions.
  - People with a physical disability may require additional support for some interventions.
  - People with severe mental health problems are more at risk of living with overweight or obesity and may require additional support for some interventions.

- **Gender reassignment**
  - No equality issues identified.

- **Pregnancy and maternity**
  - Pregnant women are excluded from the scope of this guideline update as they require different management and are covered by separate NICE guidance.

- **Race**
  - There are differences in the prevalence of overweight and obesity by ethnicity and the risk of resulting ill health.
  - For example, people of South Asian descent (defined as people of Pakistani, Bangladeshi and Indian origin) living in England tend to have a higher percentage of body fat at a given BMI compared to the general population. People of South Asian descent are also more likely to have more features of the metabolic syndrome (for example, higher triglycerides and lower high-density lipoproteins in females and higher serum glucose in males) at a given BMI. Likewise, compared to white European populations, people from black, Asian and other minority ethnic groups are at equivalent risk of type 2 diabetes but at lower BMI levels.
  - The differences in prevalence of people living with overweight or obesity and the impact on other health conditions may mean different groups need specific consideration.

- **Religion or belief**
    - No equality issues identified.

- **Sex**
    - While men are more likely than women to be living with overweight or obesity, they are less likely to seek support or treatment.

- **Sexual orientation**
    - People who are lesbian, gay, bisexual, trans or questioning (LGBT-Q) may be less likely to participate with weight-loss programmes due to both experienced and the perceived threat of discrimination.

- **Socio-economic factors**
    - Overweight and obesity rates differ between socio-economic groups. Children in the most deprived decile are twice as likely to be living with overweight or obesity than children in the least deprived decile. In adults, 35% of men and 37% of women were living with obesity in the most deprived areas, compared with 20% of men and 21% of women in the least deprived areas.
    - Geographical variation in access to NHS weight management services: a lack of universal commissioning of Tier 3 services (intensive weight loss programmes) means that that not all those living with obesity can access tier 4 services (bariatric surgery), owing to access to the former being a prerequisite to surgery.
    - Geographical variation will also exist in terms of whether local environments support people to maintain a healthy weight, and the extent to which local authorities can use legislative and policy levers to help create such environments.

- **Other definable characteristics**
    - Other health conditions: People who are taking some medications or receiving treatment may be at higher risk of excess weight gain due to the side effects of the medication or intervention.
    - Gypsy, Roma and Travellers: May be less likely to participate with weight-loss programmes due to poor access to, and uptake of, health services as well as both experienced and the perceived threat of discrimination.

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1.3 What is the preliminary view on the extent to which these potential equality issues need addressing by the Committee?

• Potential inequality issues will be noted in the review protocols and any evidence relevant to these groups and issues will be extracted. In addition, these issues will be highlighted to and discussed by the committee during development of recommendations.
 	
• The scope excludes weight management in:
  ○ Children under 2. NICE guidance on 'Maternal and Child Nutrition' (2014) is due to be updated. NICE guidance on 'Maternal and Child Nutrition' (2014) is due to be updated.
  ○ Pregnant women. NICE guidance on 'Weight management before, during and after pregnancy' (2010) is due to be updated.
  ○ Adults, children and young people who are underweight. NICE guidance on 'Eating disorders: recognition and treatment' (2020).
 	
These groups may require specific management and are covered by separate NICE guidance.

Completed by Developer: Katrina Penman and Robby Richey

Date: 6 April 2021

Approved by NICE quality assurance lead ____Simon Ellis
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Date_____6 April 2021_____

2.0 Checking for updates and scope: after consultation (to be completed by the Developer and submitted with the revised scope)

2.1 Have any potential equality issues been identified during consultation, and, if so, what are they?

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- **Age**
    - Older adults may be experiencing some functional loss, have other comorbidities and/or being frail. Further, while older people have comorbidity risk factors that are of concern at different BMIs, this may mean they are not considered for weight management programmes where it may be appropriate.

- **Disability**
    - Certain physical disabilities may impede the accuracy of measurements of overweight and obesity to determine health risk, for example, those with scoliosis and those with a different body composition due to lower muscle mass for a given weight. This may result in people wrongly being classified as ineligible for some weight management treatments.

- **Other definable characteristics**
    - Other health conditions:
        - People with endocrine disorders such as type 2 diabetes and hypothyroidism may be at higher risk of excess weight gain.
    - People living with autism may experience particular challenges accessing weight management services and may also require additional support for some interventions.
    - People with dementia may require additional support for some interventions.
    - People recovering from COVID-19 may need additional support for some weight management interventions.

2.2 Have any changes to the scope been made as a result of consultation to highlight potential equality issues?
Question 1.1 has been added to the scope, and question 1.2 has been amended, to clarify the need to consider thresholds for different ethnicities to assess health risk associated with overweight and obesity in children, young people and adults, particularly those in black, Asian and minority ethnic groups.

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2.3 Have any of the changes made led to a change in the primary focus of the guideline which would require consideration of a specific communication or engagement need, related to disability, age, or other equality consideration? If so, what is it and what action might be taken by NICE or the developer to meet this need? (For example, adjustments to committee processes, additional forms of consultation)
No specific communication or engagement need identified.

Updated by Developer _Robby Richey_____

Date_09 June 2021_____

Approved by NICE quality assurance lead ____Simon Ellis _____

Date___05/04/22_____

1.0.7 DOC EIA (2019)

3.0 Guideline development: before consultation (to be completed by the Developer before consultation on the draft guideline)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
The committee discussed the impact of new recommendations for the following groups: • People from minority ethnic family backgrounds: During the review protocol stage, people from minority ethnic family backgrounds were identified as an important subgroup. Evidence from a NICE weight management guideline (CG189) update (see the review question on accuracy of anthropometric measures) highlighted that people from South Asian, Middle Eastern, Chinese, other Asian and Black African or African- Caribbean family backgrounds are affected by obesity related comorbidities at lower BMI levels due to higher central adiposity at the same BMI compared to people with other family backgrounds. While evidence was not identified for this review, the committee recommended a lower BMI threshold (reduced by 2.5 kg/m^2) in this population for referral for assessment for bariatric surgery based on their clinical expertise. They also drafted a research recommendation to ensure that more evidence is available in the future. • Geographical variation: The briefing produced for NICE guideline developers and committee members on obesity, weight management and health inequalities highlighted that levels of adult obesity are unevenly distributed geographically across England. The report also highlighted that information on tier 3 services is limited but data has suggested that around 21% of the CCGs in England include a tier 3 adult service and the service varies across the country in terms of what is provided. To overcome these issues in geographical variation in service and to remove any unjustified barrier to an effective treatment, the committee removed the requirement of a person having tried tier 3 services before assessment for bariatric surgery. This has been discussed in the 'benefits and harms' and 'other factors the committee took into account' section of the committee's discussion of the evidence.

3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?
The committee also identified also identified the following equalities issues: • **Deprivation:** The 2014 guidance stated that bariatric surgery is a treatment option for people living with obesity if all appropriate non-surgical measures

have been tried but the person has not achieved or maintained adequate weight loss and the person has been receiving or will receive intensive weight management in a tier 3 service. The committee noted that there is variation in the commissioning of weight management services across England. The committee highlighted that obesity has increased in the most deprived communities in England which highlights the need of weight management services in these areas. The briefing produced for NICE guideline developers and committee members on obesity, weight management and health inequalities highlighted that in 2019/20, there were 6,740 hospital admissions with a primary diagnosis of obesity and a main or secondary procedure of bariatric surgery. Rates of referral were higher in the most deprived areas, although this appeared to be proportional to actual rates of severe obesity. The 'Getting It Right the First Time (GIRIT) report published in 2017 further highlighted that provision of surgery was not necessarily higher in areas that have the greatest prevalence of obesity which has led to a widening gap between the most and least deprived areas.

The committee further noted that restricting assessment for bariatric surgery to those who have been able to access tier 3 services runs the risk of further exacerbating health inequalities. Taking this into account, the committee agreed that requiring all non-surgical interventions or tier 3 services to be tried before assessment for bariatric surgery could be considered as an unjustified barrier to the service. Therefore, the committee changed existing recommendations to remove the requirement of having tried all non-surgical interventions or tier 3 services at the point of referral for assessment for bariatric surgery. Instead, they recommended that it is important to assess a person's previous attempts to manage their weight, including any past engagement with weight management services at point of assessment. This can allow people who may not have been able to engage with weight management services due to the lack of services in their area to still be assessed for surgery.

Also, as there is variation in the referral pathway for bariatric surgery the committee opted to not refer to specific tiers of the care model to avoid further variation in practice. Instead, they chose to outline the key principle of care which is people should be referred to specialist services for assessment where a person will be assessed by a weight management multidisciplinary team.

- **People with genetic causes of obesity:** In people with genetic causes of obesity, non-surgical approaches may not be appropriate. Including non-surgical interventions as a prerequisite for referral for assessment further delays people from getting an effective intervention. The committee pointed out that its important that people get assessed by a weight management

multidisciplinary team who can assess the person's medical needs.

- **Gender differences in accessing services:** The briefing produced for NICE guideline developers and committee members on obesity, weight management and health inequalities highlighted that registry data from 2020 showed that men seek bariatric surgery later in the course of their disease, as they generally have a higher BMI and more obesity-related disease than female patients. It was noted that the recommendations have now been expanded to include further obesity-related conditions to be considered at point of referral, which should allow more people to be assessed for bariatric surgery.

3.3 Have the Committee's considerations of equality issues been described in the guideline for consultation, and, if so, where?
Yes – in the 'benefits and harms' and 'other factors the committee took into account' section of the committee's discussion of the evidence.

3.4 Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
The new recommendations should reduce inequalities as the recommendations now allow referral for bariatric surgery to be considered at a lower BMI threshold for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family backgrounds. The committee also drafted a research recommendation to facilitate further research in people from minority ethnic family backgrounds. This further research can allow more robust recommendations to be drafted for this population in the future. Additionally, by removing the criteria of a person having tried all appropriate non-surgical measures, including tier 3 services allows more people to access to assessment for bariatric surgery, especially in those areas that lack tier 3 services.

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3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No. The committee did acknowledge there are other guidelines (notably, NG96, NG93 and CG142) that can be used by health and care professionals when planning care for people with learning disabilities and neurodevelopmental disabilities.

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in box 3.4, or otherwise fulfil NICE's obligation to advance equality?
The updated recommendations should reduce inequalities as these enable more people from minority ethnic family backgrounds to be referred for assessment for bariatric surgery. Additionally, the updated recommendations should help reduce geographical variation in practice. Committee discussions around equality issues have been added to the evidence review.

Completed by Developer: Kate Kelley, Associate Director GDT-B

Date: 21/02/2023

Approved by NICE quality assurance lead ___Simon Ellis _____

Date____05/04/22_____

1.0.7 DOC EIA (2019)

4.0 Final guideline (to be completed by the Developer before GE consideration of final guideline)

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
Disability: Stakeholder feedback indicated that learning disabilities can be a factor that can lead to inequalities in access to services and response to surgery. Based on this understanding, the stakeholders highlighted that it is important to consider this as part of the assessment for bariatric surgery. The committee agreed with these sentiments and also discussed the findings from the health inequalities briefing produced for NICE guideline developers and committee members which highlighted that among adults with disabilities, the prevalence of obesity is 20% higher than among those not reporting disabilities. Based on the stakeholder feedback, the committee amended the recommendations to state that factors, such as learning disabilities and neurodevelopmental disabilities need to be assessed as part of the comprehensive, multidisciplinary assessment for bariatric surgery as this can impact a person's response to surgery. Furthermore, stakeholder feedback also indicated the importance of communication in people with learning disabilities and autistic people. To facilitate care in this population, a learning disability team or liaison nurse could also be part of the multidisciplinary team (MDT) carrying out the assessment for surgery. Based on this feedback, the committee amended the rationale and impact section of the guideline and the committee discussion section in evidence review A on bariatric surgery to highlight other members who may be part of the MDT. **Pregnancy:** Stakeholder feedback highlighted that there was no reference in the guideline on providing women of reproductive age with preconception and family planning support. Feedback further highlighted that this was an important factor as bariatric surgery can improve fertility rapidly, and there are increased risks if pregnancy occurs too quickly or if there are nutritional deficiencies. Pregnancy is out of scope for this guideline and the review conducted as part of this update did not focus on preconception and family planning support, however the committee agreed with stakeholders that this support was important to highlight in existing recommendations. Based on this feedback, the committee refreshed an existing recommendation to highlight that the hospital specialist or bariatric surgeon should discuss plans for conception and pregnancy with people who are living with obesity and are considering bariatric surgery. **Health inequalities:** Stakeholder feedback highlighted that wider patient factors

1.0.7 DOC EIA (2019)

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
such as deprivation and language-barriers may lead to inequalities in access to services and response to surgery. Based on this understanding, the stakeholders highlighted that it is important to assess these factors as part of the assessment for bariatric surgery. The committee agreed with these sentiments and highlighted that wider factors of health inequalities need to be assessed as part of the assessment. Based on the stakeholder feedback, the committee amended the recommendations to state that factors, such as language barriers, deprivation and other factors of health inequalities need to assessed as part of the comprehensive, multidisciplinary assessment for bariatric surgery as these can impact a person's response to surgery.

4.2 If the recommendations have changed after consultation, are there any recommendations that make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
There are no recommendations that make it more difficult in practice for a specific group to access services compared to other groups.

4.3 If the recommendations have changed after consultation, is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
Minor amendments made to the recommendations after consultation do not have the potential to result in any adverse impact on people with disabilities.

4.4 If the recommendations have changed after consultation, are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in question 4.2, or otherwise fulfil NICE's obligations to advance equality?
There are no recommendations that make it more difficult in practice for a specific group to access services compared to other groups. Where possible, all equality issues identified have been detailed either in the committee discussion sections of

4.4 If the recommendations have changed after consultation, are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in question 4.2, or otherwise fulfil NICE's obligations to advance equality?
the evidence review and/or in the rationale and impact sections in the final guideline.

4.5 Have the Committee's considerations of equality issues been described in the final guideline, and, if so, where?
Where possible, the Committee's consideration of equality issues is detailed either in the committee discussion sections of the evidence review and/or in the recommendation rationale and impact sections in the final guideline.

Updated by Developer: Kate Kelley, Associate Director GDT-B

Date: 01/06/2023

Approved by NICE quality assurance lead __Simon Ellis _____

Date____12/07/22_____