**Form A**

**Assessment for Relevance Form**

**This is a legal document stating you have fully considered the impact on the protected characteristics and is open to scrutiny by service users/external partners/Equality and Human Rights Commission**

| **What is being assessed:** | The equality impact of the Early Intervention Programme targeted for those trying to achieve remission of type 2 diabetes. |
|---|---|
| **Named Officer / Directorate:** | Maureen Murray Dietetic Service Lead – South Ayrshire |

| **Protected Characteristics** | **Impact Rating** Positive, Adverse or Neutral Impact | **Rationale (provide evidence for your rating)** |
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| **Socio-economic factors such as poverty, unemployment, discrimination, poor working conditions and a lack of education can all affect an individual's ability to access services. This can also be further broken down depending on protected characteristics (listed below).** | | |
| **Age**<br>• Children and young people | Neutral | Child Healthy Weight programme available to Children & Young People and is out with the scope of this test of change. |
| • Adults | Positive | Available to adults aged 18-65 who have a diagnosis of type 2 diabetes of less than 6 years. The test of change is designed to support individuals to achieve remission of type 2 diabetes so the impact will be positive for the individual and the health service i.e. no diabetic medications, no or reduced hypertension medications, reduced risk of developing diabetic complications and reduced costs. |
| • Older People | Neutral | Due to the physiology of type 2 diabetes and insulin production, remission is less likely in older people so this group is also out with the scope of the test of change in line with current research.<br>Referrals accepted from age range 18-65 years. |
| **Disability** (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment, mental health) | Neutral | Referral to the programme is from healthcare professional to healthcare professional, disabilities are recorded as part of the referral and this allows the team to adopt a person centred approach. The team is aware that there are numerous hidden disabilities and that through communication with the individual the programme can be |

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| | | tailored to individual need e.g. finding out the best way to engage with them, if support to complete paperwork is required and digital pathway allows for the person to have a buddy/carer available to support them during the programme.<br>**Hearing Impairment:** if person is registered with Contact Scotland (https://contactscotland-bsl.org/ ) they can be supported to participate, if not registered BSL interpreters can also be sourced<br>**Visual Impairment:** NHS Ayrshire and Arran with RNIB provides an Eye Clinic Liaison Officer Service and support for people with sight loss can be sourced from this service.<br>**Mental Health & Learning Disabilities:** Referrals for those with learning disabilities or unstable mental health issues may not meet criteria for inclusion in the test of change but pathways are in place for referral to psychology within the remission project. Where appropriate, psychological input may be offered to enable those with mental health difficulties to get to a point of being able to engage in the total diet replacement programme. When mental health difficulties are considered to be a risk after assessment, the individual will be referred to appropriate services. |
| **Gender Reassignment (trans)** | Neutral | Referrals accepted (Aged 18-65) |
| **Marriage and Civil Partnership** | Neutral | Referrals accepted (Aged 18-65) |
| **Pregnancy and Maternity** | Neutral | Referrals accepted (Aged 18-65), however the following groups are out with the scope of the test of change due to the dietary restrictions required, those women actively trying to conceive at time of referral, women currently pregnant and those women who are 4 months post-partum. |
| **Race / Ethnicity** | Neutral | Referrals accepted (Aged 18-65). |
| **Religion / Faith** | Neutral | Referrals accepted (Aged 18-65) |
| **Sex (male/female/non binary)** | Neutral | Referrals accepted (Aged 18-65) |
| **Sexual orientation** | Neutral | Referrals accepted (Aged 18-65) |
| **If you have answered positive or adverse impact to any of the groups, an equality impact assessment should be carried out (see flowchart on page 4).** | | |

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| Impact on socio-economic disadvantage? | Rationale (provide evidence for your rating) |
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| People living on a low income compared to most others in Scotland | **Neutral**<br>Current delivery of the programme is a blend of telehealth and digital which; reduces financial burden of attending centralised appointments and reduces the environmental impact as there is a reduction in the need to travel.  However the team recognises that this method of delivery may exclude people due to digital poverty/poor digital infrastructure and lack of digital skills so telephone only appointments are available.<br>Face to Face delivery will be in a community local to the individual/group.<br>The programme/appointments will be available during the day with the option of twilight appointments to allow greater accessibility.<br>The product utilised during the programme is fully funded so there are no costs passed on to the individual. |
| People living in deprived areas | **Neutral**<br>Current delivery of the programme is a blend of telehealth and digital which; reduces financial burden of attending centralised appointments and reduces the environmental impact as there is a reduction in the need to travel.  However the team recognises that this method of delivery may exclude people due to digital poverty/poor digital infrastructure and lack of digital skills so telephone only appointments are available.<br>Face to Face delivery will be in a community local to the individual/group.<br>The programme/appointments will be available during the day with the option of twilight appointments to allow greater accessibility.<br>The product utilised during the programme is fully funded so there are no costs passed on to the individual. |
| People living in deprived communities of interest | **Neutral**<br>Current delivery of the programme is a blend of telehealth and digital which; reduces financial burden of attending centralised appointments and reduces the environmental impact as there is a reduction in the need to travel.  However the team recognises that this method of delivery may exclude people due |

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| | to digital poverty/poor digital infrastructure and lack of digital skills so telephone only appointments are available.<br>Face to Face delivery will be in a community local to the individual/group.<br>The programme/appointments will be available during the day with the option of twilight appointments to allow greater accessibility.<br>The product utilised during the programme is fully funded so there are no costs passed on to the individual.<br><br>Programme recognises the increased risk for some BAME communities and inclusion criteria reflect this.<br>Homelessness should not exclude people from the programme but support for product; delivery, mixing and blood testing etc. needs to be secured.<br>Pathways are in place for referral to psychology within the remission test of change. If after assessment mental health difficulties are considered to be a risk the individual may be excluded and referred to appropriate services.<br>Payment for product – being covered by funding – annually secured. |
| Employment | **Neutral**<br>Programmes and classes are scheduled to allow attendance out with working hours. |
| **If the policy involves a strategic decision you should carry out a Fairer Scotland Duty Assessment.** | |

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**Form B**

# EQUALITY IMPACT ASSESSMENT

**This is a legal document stating you have fully considered the impact on the protected characteristics and is open to scrutiny by service users/external partners/Equality and Human Rights Commission**

**If you require advice on the completion of this EQIA, contact elaine.savory@aapct.scot.nhs.uk**

**'Policy' is used as a generic term covering policies, strategies, functions, service changes, guidance documents, other**

| **Name of Policy** | Ayrshire & Arran Early Intervention Programme (Diabetes Remission using Counterweight Plus) | | |
|---|---|---|---|
| **Names and role of Review Team:** | Carolyn Oxenham – Diabetes Prevention Programme Manager<br>Maureen Murray – Dietetic Services Manager, South Ayrshire<br>Gail Blockley – Diabetes Remission Dietitian<br>Carolyn Patterson/Siobhan Manuell – Psychologist (Diabetes Prevention and Early Intervention) | **Date(s) of assessment:** | 16/09/2021 |

## SECTION ONE AIMS OF THE POLICY

**1.1. Is this a new or existing Policy : _____New______________**

**Please state which:** Policy ☐ Strategy ☐ Function ☐ Service Change ☐ Guidance ☐ Other ☒

**Introduction of a structured programme to support people in early diagnosis of type 2 diabetes achieve diabetes remission through a total diet replacement, food reintroduction and weight maintenance programme across the three local authorities.**

**Healthier Future – Prevention, Early Detection and Early Intervention for type 2 diabetes: https://www.gov.scot/publications/healthier-future-framework-prevention-early-detection-early-intervention-type-2/**

**Secondary intervention/prevention programme**

**1.2 What is the scope of this EQIA?**

**NHS A&A wide** ☒ **Service specific** ☐ **Discipline specific** ☐ **Other (please detail)**

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**1.3a. What is the aim?** The Scottish Government produced the document 'A Healthier Future – Framework for the Prevention, Early Detection and Early Intervention of Type 2 Diabetes' in 2018 which provided guidance to support people in early diagnosis of type 2 diabetes achieve remission.

Recent research has shown that it is possible to put type 2 diabetes in remission by using a total diet replacement intervention (TDR) in early diagnosis of diabetes (Lean et al, 2017). The study (DiRECT Study) showed when people with type 2 diabetes diagnosed for less than six years, replaced meals and snacks with an 825-853kcal/day formula TDR for 12 weeks they rapidly lost ectopic fat from the pancreas and liver. 86% participants who lost 15kg weight achieved remission of their diabetes and 73% participants with 10kg weight loss achieved remission. Remission is defined by: patients having achieved weight loss; fasting plasma glucose <7 mmol/l or HbA1c <48 mmol/mol (6.5%) on two occasions for at least 6 months and that the attainment of these glycaemic parameters is following the complete cessation of all glucose-lowering therapies.

Achieving remission leads to an elimination or delay in the long term complications of diabetes for these patients and reduces the impact on health care services in relation to demand and overall cost.

https://www.gov.scot/publications/healthier-future-framework-prevention-early-detection-early-intervention-type-2/

**1.3b. What is the objectives?**

The objective of the remission programme is to support people who have a diagnosis of type 2 diabetes of less than 6 years achieve remission of type 2 diabetes through the use of an intensive diet replacement programme. By achieving remission we are delaying the onset of diabetes, reducing or eliminating the medication used previously to manage their diabetes and/or hypertension and delaying the onset of complications related to diabetes, this will ultimately reduce the costs to the NHS of diabetes.

**1.3c. What is the intended outcomes?**

If a person achieves 10% weight loss then it can have the following clinical benefits: -

- Diabetes - 50% reduction in fasting glucose
- Hypertension - 10mmHg reduction in systolic and diastolic blood pressure
- Lipids – reduction of 10% total cholesterol, 15% LDL cholesterol, 30% triglycerides, increase of 10% in beneficial HDL cholesterol

The following outcome measures will be utilised: -

- Weight /BMI Measured at baseline and 3, 6 and 12 months. Compared to 10kg/15kg target loss.

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- HbA1c Measured at baseline and 3, 6 and 12 months. Remission defined as patients having achieved weight loss; fasting plasma glucose <7 mmol/l or HbA1c <48 mmol/mol (6.5%) on two occasions for at least 6 months and that the attainment of these glycaemic parameters is following the complete cessation of all glucose-lowering therapies.
- Lipids Total Cholesterol, LDL, HDL and Triglycerides at baseline and 12 months.
- Blood pressure At baseline and 12 months
- Medications Number of antidiabetic and antihypertensive medications at baseline and 12 months
- Wellbeing & Physical Activity Questionnaires at baseline,
- Anxiety & Depression Questionnaires at baseline, 3m and 12m
- Engagement Retention numbers, loss to follow up with reasons

**1.4. Who is this policy intended to benefit or affect? In what way? Who are the stakeholders?**

The beneficiaries of the policy are citizens of Ayrshire & Arran who have a diagnosis of type 2 diabetes of less than six years, who are prepared to follow an intensive diet replacement programme and also meet other inclusion criteria of the programme.

There are a wide range of stakeholders; Scottish Government, Public Health Scotland, Diabetes Prevention National Advisors, Healthy Weight Leads, NHA Ayrshire and Arran public health and primary care services, diabetes services, nutrition and dietetic services, clinical health psychology service, diabetes MCN and citizens of Ayrshire & Arran.

**1.5. How have the stakeholders been involved in the development of this policy?**

NHS Ayrshire & Arran are delivering a test of change using this programme for a very restricted number of participants so support from other Health Boards has been sought – NHS Lanarkshire, Dumfries & Galloway and Lothian and through the support of these boards, the National Advisors at Scottish Government and Counterweight Plus a robust evidence base is available which includes user feedback and has aided in the development of the programme locally. Recruitment to the programme is with a restricted number of practices to allow full inclusion of the practice and their citizens referred to the programme, so a clear feedback loop is in place.
Dedicated resource from clinical health psychology has been secured and has allowed involvement in the design and delivery of pathways, as well as staff training and supervision. There are robust governance structures in place to support the implementation of the framework.

**1.6 Examination of Available Data and Consultation -** Data may include: consultations, surveys, databases, in-depth interviews, reviews of complaints made, user feedback, academic or professional publications, reports etc.)

Scottish Government developed a core data set for weight management and diabetes prevention programmes, which includes the following information, anthropometric and clinical data.

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Information is also collected on sci-diabetes and EMIS Web.

The professional publication 'A Healthier Future – Framework for the Prevention, Early Detection and Early Intervention of Type 2 Diabetes', was utilised to develop the test of change and the business case.

The programme utilises Counterweight Plus Structured Programme which requires data collected on weight loss and programme drop out.

**Name any experts or relevant groups / bodies you should approach (or have approached) to explore their views on the issues.**

Initially involved in the early adopters board expert group, which has been superseded by involvement in the Healthy Weight Leads meeting and the Remission thematic group. There is regular contact with the national advisors and other board's involved in the delivery of the counterweight plus programme. Locally, supported by Department of Nutrition and Dietetics, Weight Management Service, Diabetes MCN, Primary Care Groups, and General Practices participating in the test of change. There is a robust governance structure and feedback strategies in place.

**What do we know from existing in-house quantitative and qualitative data, research, consultations, focus groups and analysis?**

As this is a test of change, data will be analysed in due course. However from local data it is noted that NHS Ayrshire & Arran has one of the highest prevalence's for T2DM over Scotland this data is derived from local systems and published nationally.

https://www.diabetesinscotland.org.uk/wp-content/uploads/2020/10/Diabetes-Scottish-Diabetes-Survey-2019.pdf.

**What do we know from existing external quantitative and qualitative data, research, consultations, focus groups and analysis?**

Please refer to 'A Healthier Future – Framework for the Prevention, Early Detection and Early Intervention of Type 2 Diabetes' (page 6.). Recent research has shown that it is possible to put type 2 diabetes in remission by using a total diet replacement intervention (TDR) in early diagnosis of diabetes (Lean et al, 2017).

The study (DiRECT Study) showed when people with type 2 diabetes diagnosed for less than six years, replaced meals and snacks with an 825-853kcal/day formula TDR for 12 weeks they rapidly lost ectopic fat from the pancreas and liver. 86% participants who lost 15kg weight achieved remission of their diabetes and 73% participants with 10kg weight loss achieved remission.

The findings of this study have expanded evidence-based practice guidelines for dietitians to include TDR as an effective option for treatment of type 2 diabetes in primary care (Diabetes UK, 2018). A recent evaluation of Counterweight Plus, a service providing TDR to overweight and obese people and used in the DiRECT Study, considered the structured approach a lower cost non-surgical alternative to bariatric surgery. The results provided major personal, social and medical benefits and the intervention was favourably received by participants (McCombie et al, 2018).

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**1.7. What resource implications are linked to this policy?**

This test of change requires a variety of resource: -

- Counterweight Plus; Licence and training fees, written and online resources for programme delivery and TDR products
- NHS provided resources; Dietetic and Administration support for programme delivery, Digital Support services to devlop IT systems, monitoring equipment – blood pressure and blood glucose monitoring equipment and support from participating General Practices in relation to accommodation, medicines management and monitoring.

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| SECTION TWO | IMPACT ASSESSMENT |
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**Complete the following table, giving reasons or comments where:**

**The Programme could have a positive impact by contributing to the general duty by –**

- **Eliminating unlawful discrimination**
- **Promoting equal opportunities**
- **Promoting relations within the equality group**

**The Programme could have an adverse impact by disadvantaging any of the equality groups. Particular attention should be given to unlawful direct and indirect discrimination.**

**If any potential impact on any of these groups has been identified, please give details - including if impact is anticipated to be positive or negative.**

**If negative impacts are identified, the action plan template in Appendix C must be completed.**

**Equality Target Groups – please note, this could also refer to staff**

| | **Positive impact** | **Adverse impact** | **Neutral impact** | **Reason or comment for impact rating** |
|---|---|---|---|---|
| **2.1. Age**<br>Children and young people | | | √ | Child Healthy Weight programme available to Children & Young People and is out with the scope of this test of change |
| Adults | √ | | | Available to adults aged 18-65 who have a diagnosis of type 2 diabetes of less than 6 years. As the aim of the test of change is to support people into remission of their type 2 diabetes the impact will be positive for the individual and the health service i.e. no diabetic medications, no or reduced hypertension medications, reduced risk of developing diabetic complications, reduced costs. |

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| Older People | | | √ | Due to the physiology of type 2 diabetes and insulin production, remission is less likely in older people so this group is also out with the scope of the test of change in line with current research. Referrals accepted from age range 18-65 years. |
| **2.2. Disability** (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment, mental health) | √ | | | All referrals to this programme are from healthcare professional to healthcare professional any disabilities are recorded in the referral and the programme can be adapted. The team can adopt a person centred approach by adapting the delivery route of the programme to suit the individual; asking what is the best way to engage with an individual, support to complete paperwork, suggest remote access to allow the person to have a buddy/carer available to support them during the programme etc. |
| Sensory Disability | | | √ | Referrals for those with sensory impairment are accepted.<br>If the person is registered with Contact Scotland (https://contactscotland-bsl.org/ ) they can be supported to participate, if not registered BSL interpreters can also be sourced.<br>NHS Ayrshire and Arran with RNIB provides an Eye Clinic Liaison Officer Service and support for people with sight loss can be sourced from this service. |
| Learning Difficulties | √ | √ | | Referrals for those with learning disabilities may not meet criteria for inclusion in this test of change. This will require to be assessed on a case by case basis depending on the individual's level of learning disability and their ability to follow the programme. Pathways are in place for referral to psychology within the remission project. Where appropriate, psychological input may be offered to enable people to get to a point of being able to engage in the liquid replacement diet. |

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| Mental Health | √ | √ | | Referrals for those with unstable mental health issues may not meet criteria for inclusion in this test of change, assessment will be on an individual basis. Pathways are in place for referral to psychology within the remission project. Where appropriate, psychological input may be offered to enable those with mental health difficulties to get to a point of being able to engage in the liquid replacement diet.<br>When mental health difficulties are considered to be a risk after assessment, they may be excluded and referred to appropriate services. |
| **2.3. Gender Reassignment** | | | √ | Referrals accepted from all adults aged 18 to 65 who have a diagnosis of type 2 diabetes of less than 6 years and there would be no differential impact on gender re-assignment. |
| **2.4 Marriage and Civil partnership** | | | √ | Referrals accepted from all adults aged 18 to 65 who have a diagnosis of type 2 diabetes of less than 6 years and there would be no differential impact on marriage and civil partnership. |
| **2.5 Pregnancy and Maternity** | | | √ | Referrals accepted from all adults aged 18 to 65 who have a diagnosis of type 2 diabetes of less than 6 years however the following groups are out with the scope of the test of change due to the dietary restrictions required, those women actively trying to conceive at time of referral, women currently pregnant and those women who are 4 months post-partum.<br>For those who are pregnant and develop gestational diabetes mellitus (GDM) there is another programme to support them and this has been impact assessed separately. |

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| **2.6 Race/Ethnicity** | | | √ | People from Black African, African Caribbean and South Asian (Indian, Pakistani, and Bangladeshi) backgrounds are at a higher risk of developing type 2 diabetes from a younger age. Family history, and social and environmental factors play a part. People from South Asian backgrounds for example are more likely to experience insulin resistance at a younger age. This could be linked to how fat is stored in the body and particularly around the middle. This is known as visceral fat and it can build up around important organs like the liver and pancreas. Having too much of this type of fat is just one of the factors that can affect your health and increase the risk of type 2 diabetes.<br><br>**Mitigation:** For Type 2 Remission people who are not of the above ethnic groups the inclusion criteria is BMI >27kgm$^2$ with type 2 diabetes. This is lowered for the above mentioned minorities to BMI >25kgm$^2$ with type 2 diabetes.<br><br>We recognise that those who do not speak English or it is not their primary language will require information in a format or language suitable to their needs to make sure they are fully informed of the programme and communications relating to it. The current programme provider is able to supply programme content in a number of languages.<br><br>For those who require additional language support, existing organisational processes will be implemented to support clear communication between the individual and the health care practitioner.<br><br>In addition the product constituents will be discussed with the person to ensure that they are acceptable. (Please see Appendix A) |
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| Gypsy / Travellers | √ | √<br>√ | | This population group can be less likely to engage with healthcare due to their transient nature. They may move between Health Boards throughout the year and may therefore not be known to the GP practices or the Board. This makes it difficult to capture them in the programme. This also presents challenges for raising awareness through communications as it may be difficult to contact these groups of people. Literacy is also problematic within this community to alternative methods of communication should be considered.<br>Gypsy/Travellers typically experience significantly poorer health and shorter life expectancy compared to the general population. Despite this greater health need, they experience considerable barriers in accessing health services and preventive healthcare.<br>Given the culture and traditions of Scottish Gypsy/Travellers, it is crucial that NHS Ayrshire & Arran works together with established services, including local authority liaison officers, which support the communities. This will ensure that those Gypsy/Travellers who are shifting/travelling during their participation in the type 2 remission programme can continue to access the programme, even if they are currently living out-with their GP practice area.<br>**<u>Mitigation:</u>**<br>Engagement with local officers and literacy support teams to provide tailored approaches to ensure this group are not disadvantaged. |
| **2.7 Religion/Faith** | | | √ | Referrals accepted from all adults aged 18 to 65 who have a diagnosis of type 2 diabetes of less than 6 years and there would be no differential impact on this client group. However we recognise that some religions may not accept some or all medical interventions offered. In addition the product constituents will be discussed with the person to ensure that they are acceptable.<br>**<u>Mitigation:</u>**<br>Links to be established with staff who liaise with the various faith groups in Ayrshire. |

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| 2.8 Sex (male/female) | | | √ | Referrals accepted from all adults aged 18 to 65 who have a diagnosis of type 2 diabetes of less than 6 years and there would be no differential impact on this client group.<br>While we are aware that men are less likely to engage with health services, we will monitor this throughout the test of change, but local experience to date has shown no bias with our most successful participant to date being male. |
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| **2.9 Sexual Orientation**<br>• Lesbians<br>• Gay men<br>• Bisexuals | | | √ | Referrals accepted from all adults aged 18 to 65 who have a diagnosis of type 2 diabetes of less than 6 years and there would be no differential impact on this client group |
| **2.10 Carers** | | | √ | Referrals are accepted from all adults aged 18 to 65 who have a diagnosis of type 2 diabetes of less than 6 years and there would be no differential impact on this client group.<br>If the service user is a carer we offer a variety of appointment times which would provide flexibility in attendance. If the service user is attending with a carer we are able to facilitate this and have an adaptable and flexible process for this. |
| **2.10 Homeless** | | √ | | Referrals are accepted from all adults aged 18 to 65 who have a diagnosis of type 2 diabetes of less than 6 years<br>**Mitigation:** We accept the barrier for access for this group of service users is that we currently only accept clinician referrals and often this client group is not registered with a GP practice and we recognise additional work should be undertaken to engage with the homelessness liaison nurses who could refer individuals, we aim to increase connections and provide a tailored approach for the individual. In addition consideration would need to be given to how the person would take delivery of the product, access appropriate facilities to store and make up the products, this will also be discussed with the liaison nurses. |

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| **2.12 Involved in criminal justice system** | | | √ | Referrals are accepted from all adults aged 18 to 65 who have a diagnosis of type 2 diabetes of less than 6 years and there would be no differential impact on this client group.<br>We would approach this on an individual basis and provide tailored information for the individual. The provision of the service through digital platforms means we can continue to support clients on release from custodial sentences. |
| **2.13 Literacy** | | | √ | Referrals accepted from the patient group. The test of change requires a level of literacy skills for written resources to be completed but this is not a barrier to being a participant on the programme.<br>We would approach this on an individual basis and provide support/signposting to support to allow the individual to participate in the programme. Teach-back methodology could be implemented to ensure the individual fully understands the programme. |
| **2.14 Rural Areas** | | | √ | Referrals are accepted from all adults aged 18-65 who have a diagnosis of type 2 diabetes of less than 6 years and there would be no differential impact on this client group.<br>Services to be delivered face to face in local communities however the COVID-19 pandemic has enabled us to utilise digital platforms which has reduced access issues in our rural communities. |

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| **2.15 Staff**<br>• Working conditions<br>• Knowledge, skills and learning required<br>• Location<br>• Any other relevant factors | √ | | √ | Referrals for Staff Members: - Referrals are accepted from all adults aged 18-65 who have a diagnosis of type 2 diabetes of less than 6 years and there would be no differential impact on this client group.<br>Impact on Staff delivering Programme: - Staff are trained and have to fulfil annual competencies to deliver the programme. There is a need to deliver to suit the clients so this can mean variation in hours and this is described within job description. To date this programme has been delivered remotely so this has meant no travelling time for the clients or the staff and as it has been 1:1 the remote platform being utilised has been reliable. Currently programme is being delivered by 1 dietitian but peer support is being provided by the weight management dietitians and psychologist who is providing clinical supervision. |

**2.16. What is the socio-economic impact of this policy / service change? (The Fairer Scotland Duty places responsibility on Health Boards to actively consider how they can reduce inequalities of outcomes caused by socio-economic disadvantage when making strategic decisions)**

| | Positive | Adverse | Neutral | Rationale/Evidence |
|---|---|---|---|---|
| **Low income / poverty** | | √ | √ | Face to Face delivery within local areas and communities as much as possible, able to signpost to local services for those who require further specific input relating to poverty, housing and employment.<br>Programme provides product free of charge so low income is not a barrier.<br>Digital pathways are currently in place so transport costs also not a barrier to attending. However we recognise that digital exclusion may be an issue.<br>**Mitigation:** Programme can be delivered by telephone if digital literacy/exclusion is an issue. |

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| **Living in deprived areas** | | √ | √ | Face to Face delivery within local areas and communities as much as possible, able to signpost to local services for those who require further specific input relating to poverty, housing and employment.<br><br>Programme provides product free of charge so low income is not a barrier.<br><br>Digital pathways are currently in place so transport costs also not a barrier to attending.  However we recognise that digital exclusion may be an issue.<br><br>**Mitigation:** Programme can be delivered by telephone if digital literacy/exclusion is an issue. |
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| **Living in deprived communities of interest** | | √ | √ | Face to Face delivery within local areas and communities as much as possible, able to signpost to local services for those who require further specific input relating to poverty, housing and employment.<br><br>Programme provides product free of charge so low income is not a barrier.<br><br>Digital pathways are currently in place so transport costs also not a barrier to attending. However we recognise that digital exclusion may be an issue.<br><br>**Mitigation:** Programme can be delivered by telephone if digital literacy/exclusion is an issue.<br><br>Programme recognises the increased risk for some BAME communities and inclusion criteria reflect this.<br>Homelessness should not exclude people from the programme but support for product mixing and blood testing etc. needs to be secured.<br>Pathways are in place for referral to psychology within the remission project. If after assessment mental health difficulties are considered to be a risk the individual may be excluded and referred to appropriate services.<br>People with disabilities, single parents, those experiencing gender based violence, or those accessing food banks are more likely to experience higher levels of deprivation and lower levels of disposable income thus reducing access to healthier food choices. The programme can be adapted to meet the needs of a wide range of individuals on a case by case basis to ensure ability to engage in and follow the programme.<br><br>Psychology services have supported staff training to allow service delivery to be trauma informed. |
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| Employment (paid or unpaid) | | | √ | Delivered within local areas and communities as much as possible, able to signpost to local services for those who require further specific input relating to poverty, housing and employment etc.<br>The sessions will be run through the day but also twilight sessions to try to accommodate the working population, and in particular those who do not get paid when they have to take time from work for healthcare appointments. |
|---|---|---|---|---|

| **SECTION THREE CROSSCUTTING ISSUES** | | | | |
|---|---|---|---|---|
| **What impact will the proposal have on lifestyles? For example, will the changes affect:** | | | | |
| | **Positive impact** | **Adverse impact** | **No impact** | **Reason or comment for impact rating** |
| **3.1 Diet and nutrition?** | √ | | | The current programme being delivered locally is Counterweight Plus, it supports behaviour change through addressing learned food behaviours – Total Diet Replacement phase/Food re-introduction phase and maintenance phase (programme duration 12 – 24m).<br>By encouraging weight loss through the programme the aim is to support people to achieve remission of type 2 diabetes, which will mean improved quality of life, a reduction in medications required, delayed onset of type 2 diabetes and its potential complications.<br>Food re-introduction is based on the Eatwell plate which introduces a balanced diet with the evidence base for cardiovascular disease, bone health, cancer – other co-morbidities /diseases effected by malnutrition. |
| **3.2 Exercise and physical activity?** | | | √ | Additional physical activity is not encouraged in the first phase of the programme but it is advocated in the food re-introduction (building up to 30 minutes moderate activity) and maintenance phase. Signposting to local services to support physical activity is available. |

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| 3.3 Substance use: tobacco, alcohol or drugs? | | | √ | While the programme focuses on remission of type 2 diabetes there is potential to refer people to other support services:-<br>Tobacco - Quit Your Way,<br>Alcohol & Drugs - Addiction Services.<br>There is no clear guidance from Counterweight Plus with regards to those with addictions.<br>**Mitigation:** The person's circumstances will be considered during the assessment and if stability is not demonstrated, then careful consideration would be required for appropriateness of person for inclusion in programme. |
|---|---|---|---|---|
| **3.4 Risk taking behaviour?** | | | √ | Management of risk taking behaviour is not addressed as standard within the Counterweight Plus programme.<br>**Mitigation:** The assessment/screening appointments do recognise disordered eating/eating disorders and psychological support and signposting to appropriate services are part of the local pathway. Suicide risk is also routinely screened for and can be further assessed by Clinical Psychology if required, as well as onward referral to other services as required.<br>However some risk taking behaviours would be contraindications to participating in this programme. |

| **SECTION FOUR CROSSCUTTING ISSUES** | | | | |
|---|---|---|---|---|
| **Will the proposal have an impact on the physical environment? For example, will there be impacts on:** | | | | |
| | **Positive impact** | **Adverse impact** | **No impact** | **Reason or comment for impact rating** |

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| 4.1 Living conditions? | | | √ | Delivered within local areas and communities where possible, able to signpost to local services for those who require further specific input relating to poverty, housing and employment. |
|---|---|---|---|---|
| **4.2 Working conditions?** | | | √ | Delivery is flexible with face to face, telehealth and digital pathways available. Delivered within local areas and communities where possible, able to signpost to local services for those who require further specific input relating to poverty, housing and employment. |
| **4.3 Pollution or climate change?** | √ | | | Delivery is flexible with face to face, telehealth and digital pathways available. Delivery in local communities at times that suit – reduces the need for travel to centralised locations this has also been positively impacted by the development of the digital pathways |

**Will the proposal affect access to and experience of services? For example:**

| | Positive impact | Adverse impact | No impact | Reason or comment for impact rating |
|---|---|---|---|---|
| **Health care** | √ | | | Improved access to relevant education relating to lifestyle and will aim to address health and wellbeing to reduce the progression of type 2 diabetes and its potential complications. The project aims for remission of type 2 diabetes and also gives opportunities to signpost to other appropriate health services. |
| **Social Services** | | | √ | Currently not a referral route to the programme.<br>**Mitigation:** Contact services to assess need. |
| **Education** | | | √ | The programme itself will not impact on access to or experience of educational services. |
| **Transport** | √ | | | Delivered remotely and practitioner delivers product/resource to patient currently but home delivery from company being investigated. |

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| **Housing** | | | √ | When individuals join the programme they can be signpost to local services for those who require further specific input relating to poverty, housing and employment. However the programme itself will not impact on access to or experience of housing services. |
|---|---|---|---|---|

| **SECTION FIVE** **MONITORING** |
|---|
| **How will the outcomes be monitored?**<br>Clinical outcomes including:<br>Weight, body mass index, waist circumference (as clinically indicated), HbA1c (specifically for remission), lipids, blood pressure, diabetes medications required.<br>Specifically 15kg weight loss is an outcome after 12 weeks on a total diet replacement.<br>Health & Wellbeing outcomes:<br>Quality of life questionnaire<br>Mental Wellbeing Questionnaire<br>Weight Loss Readiness Tool II<br>Counterweight Plus outcomes: completion of the programme and 15kg weight loss |
| **What monitoring arrangements are in place?**<br>Pre and post assessments in place in order to attain measurements and complete paperwork. Blood results taken by GP or practice nurse at referral. Self-monitoring devices are provided for blood pressure if clinically indicated and blood glucose.<br>Risk assessment is carried out with psychology support and pathways are in place to manage this. |
| **Who will monitor?**<br>Diabetes remission dietitian. |
| **What criteria will you use to measure progress towards the outcomes?** |

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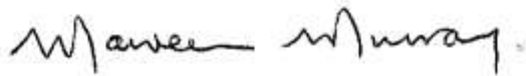
| Outcomes of the programme are measured externally against the Adult Weight Management Standard, Child Healthy Weight Standards and the Diabetes Prevention Framework. The Scottish Government report on the Diabetes Prevention programme using information provided in the core dataset which is externally evaluated by the Scottish Government. |
|---|
| **PUBLICATION** |
| Public bodies covered by equalities legislation must be able to show that they have paid due regard to meeting the Public Sector Equality Duty (PSED). This should be set out clearly and accessibly, and signed off by an appropriate member of the organisation.<br><br>Once completed, send this completed EQIA to the **Equality & Diversity Adviser** |

| **Authorised by** | Maureen Murray | **Title** | DIETETIC SERVICE MANAGER - SOUTH |
|---|---|---|---|
| **Signature** |  | **Date** | 29/9/21 |

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**Product Compendium**
All values are per 54g serving

| Product | Energy (kcal) | Fat (g) | CHO (g) | Protein (g) | Fibre (g) | Sodium (g) | Allergens | Lactose Free | Vegan |
|---|---|---|---|---|---|---|---|---|---|
| **Shakes** | | | | | | | | | |
| Banana | 200 | 3.5 | 20 | 21 | 2.5 | 1.5 | Milk, Soy | No | No |
| Cappuccino | 200 | 3.3 | 23.7 | 17.4 | 2.4 | 0.7 | Soy | Yes | Yes |
| Chocolate | 200 | 3.3 | 21.4 | 20.1 | 3.0 | 1.0 | Milk, Soy | No | No |
| Vanilla | 200 | 2.5 | 27 | 16 | 2.8 | 0.6 | Milk, Soy | No | No |
| **Soups** | | | | | | | | | |
| Vegetable (with croutons) | 200 | 6.1 | 20.5 | 17.3 | 2.9 | 1.7 | Milk, Soy, Wheat | No | No |
| Potato and Leek | 200 | 3.4 | 27.4 | 13.7 | 2.5 | 1.8 | Soy, Celery | Yes | Yes |
| Oriental Chilli | 200 | 3.5 | 23 | 17 | 2.6 | 1.6 | Milk, Soy | No | No |
| Chicken and Mushroom | 200 | 3.6 | 23.7 | 16.6 | 2.7 | 1.7 | Milk, Soy, Wheat | No | No |
| **Porridge** | | | | | | | | | |
| Porridge | 200 | 3.6 | 27 | 13 | 2.7 | 0.5 | Oat, Milk, Wheat, Barley, Spelt, Rye, Soy | No | No |

- All products are suitable for vegetarians.
- Whilst there is a minimal risk of cross contamination from gluten containing cereals, the product has not gone through certification testing for this.
- All products are produced in a Halal certified facility and do not contain any haraam (forbidden) ingredients. Counterweight is not a Halal certified company.
- The products are not officially certified as Kosher however they do not contain any non-kosher ingredients.
- Products **are not suitable for people with nut or sesame seed allergy.**

**Form C**

## Identified Negative Impact Assessment Action Plan

**Name of EQIA:** Ayrshire & Arran Early Intervention Programme (Diabetes Remission using Counterweight Plus)

| Date | Issue | Action Required | Lead (Name, title, and contact details) | Timescale | Resource Implications | Comments |
|---|---|---|---|---|---|---|
| 16/09/2021 | Literacy of resources to support current remission programme. | Ask communications team to review all local resources associated with remission programme to ensure Plain English and literacy levels.<br><br>Request company who provide the remission programme to report on the literacy levels of their resources. | C Oxenham<br>Diabetes Prevention Programme Manager<br>Carolyn.oxenham@aapct.scot.nhs.uk<br><br>Liz Duncan<br>Diabetes Prevention Project Co-ordinator<br>Liz.Duncan@aapct.scot.nhs.uk | 31/01/2022<br><br>30/11/2021 | Resources used to support the programme may need to be updated – time and costs | |

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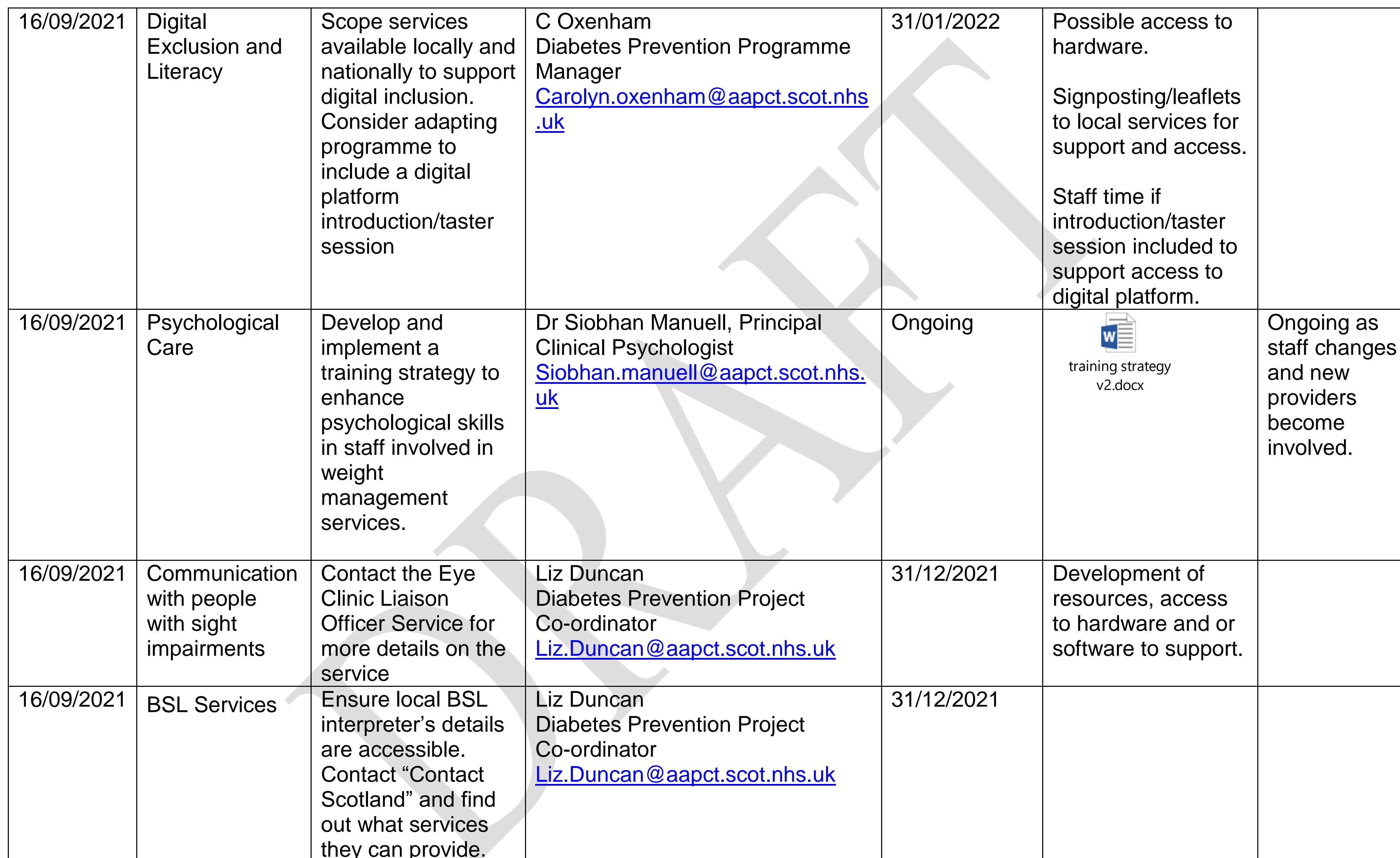


| | | | | | | |
|---|---|---|---|---|---|---|
| 16/09/2021 | Digital Exclusion and Literacy | Scope services available locally and nationally to support digital inclusion. Consider adapting programme to include a digital platform introduction/taster session | C Oxenham<br>Diabetes Prevention Programme Manager<br>Carolyn.oxenham@aapct.scot.nhs.uk | 31/01/2022 | Possible access to hardware.<br><br>Signposting/leaflets to local services for support and access.<br><br>Staff time if introduction/taster session included to support access to digital platform. | |
| 16/09/2021 | Psychological Care | Develop and implement a training strategy to enhance psychological skills in staff involved in weight management services. | Dr Siobhan Manuell, Principal Clinical Psychologist<br>Siobhan.manuell@aapct.scot.nhs.uk | Ongoing | training strategy v2.docx | Ongoing as staff changes and new providers become involved. |
| 16/09/2021 | Communication with people with sight impairments | Contact the Eye Clinic Liaison Officer Service for more details on the service | Liz Duncan<br>Diabetes Prevention Project Co-ordinator<br>Liz.Duncan@aapct.scot.nhs.uk | 31/12/2021 | Development of resources, access to hardware and or software to support. | |
| 16/09/2021 | BSL Services | Ensure local BSL interpreter's details are accessible. Contact "Contact Scotland" and find out what services they can provide. | Liz Duncan<br>Diabetes Prevention Project Co-ordinator<br>Liz.Duncan@aapct.scot.nhs.uk | 31/12/2021 | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 16/09/2021 | Social work sensory impairment service | Establish links with the services and investigate opportunities | C Oxenham<br>Diabetes Prevention Programme Manager<br>Carolyn.oxenham@aapct.scot.nhs.uk | 31/01/2022 | | |
| 16/09/2021 | Social work | Scope potential for accepting referrals from this team. | C Oxenham<br>Diabetes Prevention Programme Manager<br>Carolyn.oxenham@aapct.scot.nhs.uk | 31/01/2022 | | |
| 16/09/2021 | BAME Communities | Identify local communities and any established links, contact and scope opportunities | Liz Duncan<br>Diabetes Prevention Project Co-ordinator<br>Liz.Duncan@aapct.scot.nhs.uk | 31/01/2022 | Established links will support the service to understand how members of the communities may engage. Assessments will consider beliefs and cultures. Allowing the service to have a good understanding of what is important to them i.e. cultural expectations and norms | |
| 16/09/2021 | Traveller Communities | Identify local communities and any established links, contact and scope opportunities | C Oxenham<br>Diabetes Prevention Programme Manager<br>Carolyn.oxenham@aapct.scot.nhs.uk | 31/01/2022 | Established links will support the service to understand how members of the communities may engage. | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Potential for cross board co-operation and for participants to complete phases in different board areas. | |
| 16/09/2021 | Homelessness services | Identify local links, establish contact and scope opportunities | C Oxenham<br>Diabetes Prevention Programme Manager<br>Carolyn.oxenham@aapct.scot.nhs.uk | 01/02/2022 | | Consideration needed for storage of product, mixing of product and blood sampling through programme |
| 16/04/2021 | Criminal Justice System | Identify local communities and any established links, contact and scope opportunities | C Oxenham<br>Diabetes Prevention Programme Manager<br>Carolyn.oxenham@aapct.scot.nhs.uk | 01/02/2022 | | |

Further Notes:

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| Signed: | [signature] | Date: | 29/9/21 |
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