Public Health England

Protecting and improving the nation's health

Health Equity Assessment Tool (HEAT): practice example

Simplified version
Weight loss management services

Weight loss management services – practice example

Programme or project being assessed:	Sheffield city region, weight loss management services (provider = Zest) Family Weight Loss (FWL) services, Adult priority 1 (AP1) and Adult priority 2 (AP2)	
Date completed:	August 2020	
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Name of strategic leader	Kristin Bash	
Question	Issues to consider	Response
1. What health inequalities (HI) exist in relation to your work?	• Explore existing data sources (see resources section – not exhaustive) on the distribution of health across different population groups • Consider protected characteristics and different dimensions of HI e.g. socioeconomic status or geographic deprivation	Adults **Diet** Fruit and vegetable consumption can be used as an indicator of an overall healthy diet. Within Sheffield around one in 4 residents report eating the recommended 5 portions of fruit and vegetables on an average day. Adults who live in the more deprived parts of Sheffield are on average consuming fewer fruit and vegetables than those in more affluent areas. **Impact of poor diet on adult health** Overweight and obesity – is the third largest contributor to ill health and early death (behind smoking and poor diet). There are many routes by which obesity is detrimental to wellbeing. Obesity can decrease life expectancy by up to 9 years; it contributes to insulin insensitivity - which is an important causal factor in diabetes, heart disease, hypertension and stroke. Obesity is also associated with the development of some cancers, osteoarthritis and sleep apnoea. Individuals are regarded as obese if they have a body mass index (BMI) of 30 or more. In Sheffield it is estimated that 23.7% of adult residents are obese. Around two-thirds of adults in Sheffield are above a healthy weight.

		Populations of interest NICE guidance has identified that individuals with the following conditions have been found to experience higher rates of obesity compared with people who do not have these conditions - people living with learning disabilities or severe mental health problems or a physical disability that limits mobility.[1] It is now generally accepted that South Asian populations are at greater risk of ill health at lower BMI levels than European populations. National data also shows that some ethnic groups have higher rates of obesity. Groups with higher rates are Black African (men and women), Black Caribbean (men and women), Pakistani women, White (men and women) and Irish men. [2] In children, obesity prevalence was highest for Black children in both reception and year 6.[3] Regional (Yorkshire & Humber) data shows that obesity is higher in women (31%) than in men (23%). However, overweight is higher in men (47%) than in women (30%). Combined overweight and obesity is 61% in women and 70% in men. Local figures are not available by gender.[4] **Maternity** – obesity can increase health risks for both the mother and child during and after pregnancy. There is evidence that suggests there is a strong link between obesity in mothers and child obesity. Data also shows that a woman's BMI tends to increase with each successive pregnancy. Therefore, intervention in the pre-conception and post-natal period is particularly important. Other conditions related to obesity and poor diet 30,235 adults were on the diabetes register at Sheffield GP practices in 2015 to 2016. This equates to a prevalence of 6.3%. 76,519 adults were on the hypertension register at Sheffield GP practices in 2015 to 2016. This equates to a prevalence of 13%. **Poverty** Obesity levels are higher in areas of poverty and deprivation, and generally follow a socioeconomic gradient. For example, the most

		recent National Child Measurement Programme (NCMP) data 2018/19 demonstrates that children living in areas classed as the most deprived in England are more than twice as likely to be obese – both at year of reception and year 6 – than children in the least deprived areas.[5] Healthier diets are becoming more expensive and therefore poverty has a large influence on the foods people consume. Food is often the flexible item in household budgets and therefore households on low incomes often respond by trading down on the food they buy, increasingly purchasing cheaper, energy dense, less nutritious food. Low income households are more likely to consume highly processed, high sugar and high saturated fat food. For some the level of food poverty is so great they must seek emergency food assistance, for example from food banks. In Sheffield 31% of children are estimated to be in poverty after housing costs are considered. There is wide variation across the city with ward prevalence ranging from 7% in Ecclesall ward to 51% in Burngreave ward.
2. How might your work affect HI (positively or negatively)? How might your work address the needs of different groups that share protected characteristics?	• Consider the causes of these inequalities. What are the wider determinants?* • Think about whether outcomes vary across groups, and who benefits most and least • Consider what the unintended consequences of your work might be	With the onset of Covid-19 and mandated social distancing requirements, changes were made to service delivery of the weight loss management services for Sheffield: • telephone and text support was offered in the first instance while online support was developed • June 2020 – online service delivery was initiated for Adult priority 1 and Adult priority 2 services, allowing for face-to-face support via a Zoom interface • July 2020 – online service delivery was started for Family Weight Loss Services, also through a Zoom platform delivery method These changes are likely to impact different groups of service users in different ways, although the specifics of impacts – including any positive effects – are under review. In the initial stage, considerations have been made for the following groups: • digital exclusion – individuals and families without access to reliable internet or devices will not be able to fully benefit from the online service delivery platform

		• Individuals with Learning Disability or who are on the Autistic Spectrum – it is unclear how changes to service delivery will impact these service users. An initial challenge in evaluation relates to the lack of detail provided on the referral form sent by the GP. This is currently being investigated with a view to adding this information for monitoring and intervention to ensure accessibility Individuals with Serious and Enduring Mental Illness (SEMI) – this population is more at risk of overweight and obesity due to a variety of factors. It's been identified by the service that detail on mental health conditions is lacking on the referral form and therefore it is not currently possible to track the impact of service changes for this group. Changes to the referral form are being made to address this gap.
	a) Protected characteristics	Initial review of service users (compared with referrals made into the system) identified, that compared with individuals with White British ethnicity, there was a lower uptake and level of engagement with individuals who have a Black, Asian or Other minority ethnicity (BAME). This was a preliminary analysis involving small numbers so interpretation is limited. It is being followed-up on with a more complete set of data as it becomes available.
	b) Socio-economic status or geographic deprivation	Initial review of service users (compared with referrals made into the system) identified a higher uptake and level of engagement with individuals (adults) who live in areas with higher levels of deprivation. This was a preliminary analysis involving small numbers, so interpretation is limited. It is being followed-up on with a more complete set of data as it becomes available.
	c) Specific socially excluded or vulnerable groups e.g. people experiencing homelessness, prison leavers, young people leaving care	No assessment was available for these groups in initial analysis. Further investigation into these population groups – including if there is capability to assess them as separate groups – is in process.

3. What are the next steps?	• What specific actions will you take to address health inequalities and the needs of groups/communities with protected characteristics? • Is there anything that can be done to shift your work 'upstream' to make it more likely to reduce health inequalities?	A full Health Inequality Impact Assessment is underway using the full HEAT. This will assess the impact of changes made to the service due to the Covid-19 outbreak, how these impacts may be disproportionately distributed, and how best to mitigate any negative impacts. Assessment will also be made to determine where changes may have led to increased engagement in specific population groups, how this may affect health inequalities within these groups, and how to capitalise on these changes where appropriate.
4. How will you monitor and evaluate the effect of your work?	• What quantitative and/or qualitative evaluation will be established to check you have achieved the actions you set? • What output or process measures will you use?	Data collected over 2020 to 2021 Q2 by Zest (service provider) will be analysed to determine uptake, engagement and outcome levels – differences between population group, and comparison to 2019-20 Q2 data will be made. Qualitative data will be collected through questionnaires and telephone interview with individuals who did not take up the referral to the service, those who dropped out of the service mid-way, and those who participated in the service. Data on AP2 service users who were referred to the bariatric pathway and have had surgery delayed indefinitely will be analysed separately to identify any health inequality impacts within this group.
5. Review (to be completed 6 to 12 months after first completion)	• Consider lessons learnt - what will you do differently? Identify actions and changes to your programme to drive improvement	TBD

[1] NICE. Obesity: identification, assessment and management. Clinical Guideline. 2014. https://www.nice.org.uk/guidance/cg189
[2] National Obesity Observatory. Obesity and Ethnicity. 2011.
[3] NHS Digital. National Child Measurement Programme, England 2018/19 School Year. Ethnicity. 2019. https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2018-19-school-year/ethnicity
[4] Further data can be found here: https://app.box.com/s/og3q86aqejc99okxe9xyvpfvo21xai21
[5] NHS Digital. National Child Measurement Programme, England 2018/19 School Year. 2019. https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2018-19-school-year