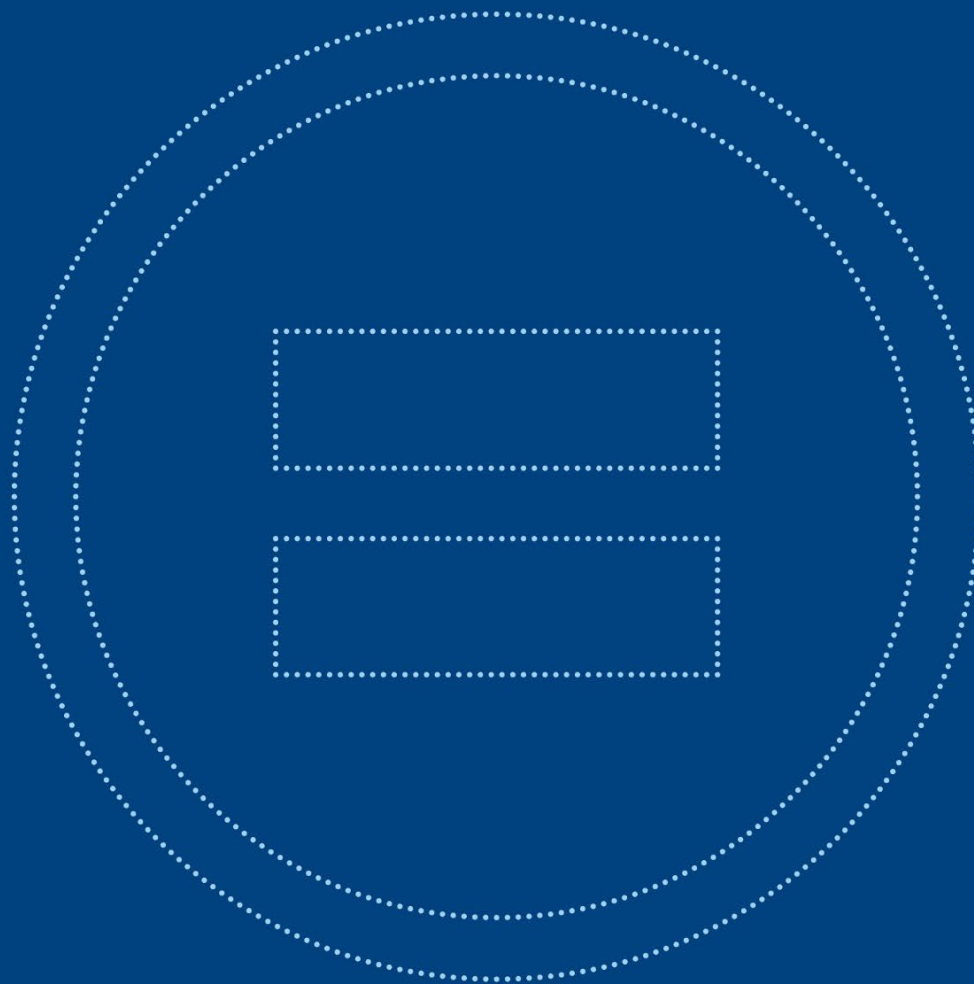


Equality. Fairer Scotland. Children's Rights. Impact Assessment Report

Lothian Weight Management Services - Review of
eligibility for Tier 2 and Tier 3 services and proposed new
eligibility criteria



Contents

Overview	3
List the evidence gathered	7
Impact on equality & socio-economic inequalities ...	31
Impact on UNCRC rights	44
Sharing with decision-makers	57
Monitoring the impact	65

Overview

Title of proposed work

Review of Tier 2 and Tier 3 Lothian-wide children and adult weight management service referral criteria.

Purpose/objective of review

Assess and mitigate changes to referral criteria:

- Support performance management and review of existing waiting list. Waiting list approx. 100 weeks from referral to Tier 3 specialist assessment appointment and 49 weeks for Tier 2.
- Support clinicians and referrers to understand criteria.
- Excludes remission and prevention services.

Who will be affected by this proposed work

Direct impact on adults and children and young people living with being overweight or obesity across Lothian.

Report written by:

Lothian Weight Management and T2D Prevention Service & Head of Equality & Human Rights

Report authorised by:

Vanessa Hamilton, Head of Dietetics

Date: 4th June 2026

Current and proposed new criteria

Current adult referral and eligibility criteria

NHS Lothian will accept referrals for the following patients:

- Over 18 years old
- BMI of 25kg/ m² or above or for people from ethnic minority communities with BMI of 23kg/ m² or above
- Who are motivated and ready to make lifestyle changes.

Proposed new adult referral and eligibility criteria

It is proposed that the referral criteria are changed to:

NHS Lothian will accept referrals to the **adult tier 2 digital pathway** for the following patients who have a:

- BMI equal or greater than 30kg/m² or for people who are from non-white ethnic minority groups and have obesity-related clinical conditions who have a BMI equal or greater than 27.5kg/m²,
- Waist to height ratio equal or greater than 0.5 as an additional or alternative indicator of central adiposity and cardiometabolic risk (which is only applicable if BMI is less than 35),
- Willingness to engage in structural digital lifestyle intervention.

NHS Lothian will accept referrals to the **tier 3 specialist adult weight management service** for the following patients who have:

- A BMI equal or greater than 35kg/m² with one or more obesity related clinical conditions,
- Complex presentations (i.e. with psychological distress, complex disease that can't be managed effectively in tier 2),
- Where tier 2 digital weight management has been ineffective.

Current child health weight referral criteria

NHS Lothian will accept referrals for children and young people who:

- Are aged 2-18 years old,
- Have a BMI equal or greater than 91st centile
- With their parent/ carer, ready and willing to make positive lifestyle changes.

Proposed new child healthy weight referral criteria

It is proposed that the referral criteria is changed to:

NHS Lothian will accept referrals for children and young people who are:

- 2-18 years old,
- With their parent/ carer are ready and willing to make positive lifestyle changes and have:
 - A BMI equal or greater than 91st centile plus 1.34 standard deviations and a clinical condition associated with obesity, or
 - Clinical obesity (a BMI equal or greater to 98th centile plus 2.05 standard deviations with or without a clinical condition).

Part 1: Gathering the evidence

List the evidence gathered

- British Journal of General Practice (2021) [Health professionals' identified barriers to trans health care: a qualitative interview study](#), 71 (713)
- Carers Scotland (2025) State of Caring in Scotland 2024: [Health and social care support for unpaid carers](#)
- Glasgow Centre for Population Health (2024) [Examining the social determinants of LGBT+ Health and Wellbeing](#)
- Independent Care Review (2020) [The Promise](#)
- Kings Fund (2022) [Strategies To Reduce Waiting Times For Elective Care](#)
- Kings Fund (2023) [Tackling Health Inequalities On NHS Waiting Lists | The King's Fund](#)
- Lothian Public Health Survey 2023 <https://services.nhslothian.scot/publichealth/wp-content/uploads/sites/105/2024/06/NHS-Lothian-Public-Health-Survey-Results-2023.pdf>
- Mencap (2023) [The shocking truth of the health inequalities faced by people with a learning disability](#)
- NHS Lothian & NHSGG&C (2022) LGBT+ Health Needs Assessment
- NHS Lothian Director of Public Health Annual report 2024 <https://services.nhslothian.scot/publichealth/wp-content/uploads/sites/105/2025/03/Director-of-Public-Health-Annual-Report-2024-v1.0-1.pdf>
- [PHS report](#) Referrals to NHS board commissioned weight management services for children and adults published 26th March 2024
- Public Health Scotland [How large are health inequalities in Scotland?](#)
- Public Health Scotland (2023) [Monitoring racialised health inequalities in Scotland](#)
- Public Health Scotland (2024) [Sexual health and health inequalities](#)

- RNID (2025) [Still ignored: the fight for accessible healthcare 2025 Policy Report England](#)
- [Scotland Census results 2022](#)
- Scottish Government (2019) [A Fairer Scotland for Older People: framework for action](#)
- Scottish Government (2022) [Health inequalities statistics released](#)
- Scottish Government (2022) [Long-term Monitoring of Health Inequalities Report](#)
- Scottish Government (2022) [Minority ethnic groups – understanding diet, weight and type 2 diabetes: scoping review](#)
- Scottish Government (2022) [Health and Social Care Strategy for Older People Feedback](#)
- Scottish Government (2023) [Scotland's Gender Equality Index 2023](#)
- Scottish Government (2025) [Socioeconomic inequality and barriers to primary care in Scotland: A literature review](#)
- Scottish Trans (2025) [Scottish Trans and Non-binary Experiences Report](#)
- State of the Nation National Tier 3 Adult weight management survey – distributed to 14 health board Adult Weight Management Tier 3 leads via the Public Health Scotland Healthy Weight Leads network, December 2024
- The Alliance (2023) [Bridging the gap. Addressing health inequalities in Scotland's Primary Care](#)
- The Alliance (2024) [Children's right to health: is Scotland fulfilling its obligations?](#)
- Type 2 Diabetes Prevention Framework Annual report 24/25- submitted to Scottish Government May 2025
- University of Glasgow (2025) [The Scottish Deep End Project Report 43 Language and cultural health inequalities](#)
- UK Health Security Agency (2025) [Health inequalities in health protection report 2025](#)

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
Number of adults (18+) referred per 1000, population	<p>Who uses the service</p> <p>Referrals rate 2021-2022 <u>Lothian Weight management service referral rate</u> Oct 21- Sept 22- 4,804 referrals. 6.4 per 1000 population <u>National WM referral rate</u> varied from 0.6, per 1000 (NHS Grampian) to 12.6 per 1000 (NHS Western Isles)</p> <p>Change in referral 2019-22 <u>Lothian:</u> Numbers of referrals increased by 44% over 3-year period from Oct 2019 to Sept 2022 (2435 to 5424). <u>National:</u> all referrals increased by 35% over 3-year period (7317 to 21,114).</p> <p>Tier 3 referrals Tier 3 referrals nationally: 7768 Oct 21-Sept 22. Lothian referrals: 2666 Oct 21-Sept 22</p> <p>Lothian referrals 23/24: 3293.</p> <p>Lothian Population level data: 2023 Lothian, average body mass index (BMI), based on self-reported height and weight was 27.4, with 36.8% of people being classed as having a healthy weight according to their BMI. By comparison, the 2022 Scottish Health survey found that the average adult BMI was 28.0, with 32% being classed as having a healthy weight. A higher proportion of City of Edinburgh's population was classed as having a healthy weight (42.2%) than in the other local authority areas, each of which had 31.1% or a smaller proportion being a healthy weight.</p> <p>Lothian Public Health Survey 2023 Percentage in each weight category according to body mass index (BMI)</p>

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<p>BMI weight categories</p> <ul style="list-style-type: none"> • The largest proportions of the population fall into the healthy weight (36.8%, BMI 18.6 -24.9) and pre-obesity (35.7%, BMI 25-29.9) categories, together accounting for just over 72% of people. • Obesity affects around 26% overall, with most in Obesity Class I (16.3%, BMI 30-34.9), and smaller proportions in Class II (6.3%, BMI 35-39.9) and Class III (3.5%, BMI greater than or equal to 40). • Only a small minority are underweight (1.4%, BMI equal or less than 18.5). <p>Most people are either a healthy weight or pre-obese, while around one quarter are living with obesity, predominantly Class I.</p>
Referral source	<p>National data for the number of adult referrals, referral source Oct 2019 to Sept 2022</p> <p>Tier 2, Referral sources GP Practice were the largest referral source in all years. Referrals rose sharply from 1,986 to 7,972, with the majority of growth in 2021–22.</p> <p>Self-referral Decreased between 2019–20 and 2020–21, then increased markedly in 2021–22 (1,254 referrals)</p> <p>Allied Health Professionals Gradual increase across the period (195 to 483), remaining a smaller but steadily growing referral source.</p> <p>Secondary care Modest numbers initially, followed by a clear rise in 2021–22 (238 to 666).</p> <p>Other health professionals and 'Other' Contributed relatively few referrals throughout, with no clear upward trend.</p> <p>Not known Negligible</p> <p>Tier 3, Referral sources GP Practice were the largest referral source in all years.</p>

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<p>Referrals rose from 2,268 to 5,448</p> <p>Secondary care Increased notably in 2021–22 (356 to 909)</p> <p>Self-referral Increased to 628 referrals in 2021–22.</p> <p>Allied Health Professionals Increased to 525 referrals in 2021–22.</p> <p>Other health professionals and 'Other' Consistently small contributors, with little variation over time.</p> <p>Not known No missing data</p> <p>Lothian- referrals 2023/24- Tier 2 GP practice is the main referral source 83% of all referrals Self referral routes combined account for 9%,</p> <p>Lothian referrals 2023/4- Tier 3 GP practice is the main referral source, 75% of all referrals Self referral routes combined account for 11%</p>
Weight status by age group	<p>Lothian Public Health Survey 2023 Percentage categorised as being healthy weight, overweight and obese by age group.</p> <ul style="list-style-type: none"> • The proportion of people at a healthy weight decreases steadily with age, from 62.5% in 16–24 year olds to around 24–27% in people aged 55 and over. • Conversely, the proportion who are overweight or obese increases with age, rising from 30.6% in the 16–24 age group to a peak of around 75% in those aged 65–74. • From mid-adulthood onwards (35–44 years and older), around two-thirds or more of each age group are classified as overweight or obese.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<ul style="list-style-type: none"> In the oldest age group (75+), the pattern remains similar, with 72.2% overweight or obese and 26.6% at a healthy weight. <p>Overall pattern: There is a clear age gradient, with healthy weight more common in younger adults and overweight/obesity increasingly prevalent across older age groups.</p>
People in different age groups	<p>Among all adults in 2022/23, the prevalence of increased health risk was highest among adults aged 55-64 (78%) and lowest in those age 16-24 (27%).(Scottish Health Survey 2023)</p> <p>Waiting list Categorising data using the Scottish Government Broad Age Categories (statistics.gov.scot : Population Estimates: Young and Old) shows that there are disproportionately more people who are working age (defined as age 16-64) on the Tier 3 and Tier 2 Lothian Adult Weight Management and T2D prevention service waiting lists compared to the local population. Appears to be expected when consider percentage of Lothian working age population who have a BMI in the overweight or obesity category.</p> <p>1st contact Tier 2 referrals: Age at 1st contact Most referrals were for people aged 40–59, accounting for 46% combined of all referrals</p> <ul style="list-style-type: none"> 40–49 years: 516 referrals (22%) 50–59 years: 560 referrals (24%) Referrals were also common among those aged 30–39 (466 referrals, 20%). Younger adults aged 18–29 made up 14% of referrals (320 people). Older age groups were less represented: 60–69 years: 375 referrals (16%), 70 and over: 123 referrals (5%) <p>Overall, referrals peak in midlife, with a clear drop in referrals among the oldest age group.</p>

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<p>Tier 3 referrals: Age at 1st contact Most referrals were for people aged 40–59, making up 47% of all referrals:</p> <ul style="list-style-type: none"> • 40–49 years: 568 referrals (21%) • 50–59 years: 693 referrals (26%) • Adults aged 30–39 accounted for 19% of referrals (502 people). • Younger adults aged 18–29 made up 10% of referrals (278 people). • Older adults were less represented: 60–69 years: 473 referrals (18%) and 70 and over: 166 referrals (6%) <p>Overall, referrals peak in midlife, with substantially fewer referrals among the youngest and oldest age groups.</p>
<p>Barriers to accessing health services by age group</p>	<p>Children & young people</p> <ul style="list-style-type: none"> • Cost of transport to appointments. • Taking time off work or school. • Navigating NHS systems / awareness of how to access services. • Long waiting times, especially mental health. • Complex complaints procedures. • Lack of child and youth friendly services (feeling unwelcome or misunderstood) <p>People of working age (16-64)</p> <ul style="list-style-type: none"> • Many working age adults struggle with low health literacy, which affects their ability to recognise symptoms, understand when and how to seek care and navigate healthcare system effectively. • Inflexible working hours and lack of paid sick leave can prevent people from attending appointments. • Shift workers and those in precarious employment may find it particularly difficult to access services during standard hours. • Increasing reliance on digital booking systems and online consultations can exclude those without these skills. • Complex administrative processes can deter people from following up on referrals.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<ul style="list-style-type: none"> • Stigma around mental health, particularly in workplace settings can discourage people from seeking help. • Navigating different services can be confusing and time consuming, especially for people managing chronic conditions. <p>Older people (65+)</p> <ul style="list-style-type: none"> • Reduced mobility, particular impact on people living in rural or remote areas. • Inaccessible buildings. • Digital exclusion, including digital platforms for booking appointments or accessing health information. • Older adults over 60 years old are still less likely to use the internet. • Cost of transport to appointments. • Fragmented services / navigating multiple services for physical, mental and social care which can be confusing and overwhelming. • Loneliness and isolation reducing motivation to seek help or attend appointments • Stigma around ageing or mental health preventing discussing their needs openly. • Feeling that services are not tailored to their needs or that they are not listened to during consultations
Health inequalities by age group	<p>Children & young people</p> <ul style="list-style-type: none"> • Children and young people in deprived areas are more likely to experience poor mental health and chronic conditions. • Babies born in deprived areas are more likely to have low birthweight, which is linked to poorer health outcomes in later life. • Children in deprived areas face higher rates of asthma, dental decay and developmental concerns. • The number of children aged 5-10 living in poverty increased from 18.4% to 26.1% <p>Working age people (16-64)</p>

Relevant group	<p>What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?</p>
	<ul style="list-style-type: none"> • Working-age adults, especially those in insecure employment or low-income jobs, who face higher rates of mental ill health and lifestyle related diseases. • Mental health issues and substance use disproportionately affect younger and middle-aged adults in deprived areas. • Younger and middle-aged adults, especially in deprived communities, face a significantly higher risk of drug-related hospital admissions and alcohol-specific deaths. <p>Older people (65+)</p> <ul style="list-style-type: none"> • Older adults in deprived areas are more likely to live with multiple long-term conditions. • Older adults in deprived areas are more likely to suffer from chronic conditions such as coronary heart disease, chronic obstructive pulmonary disease and diabetes and hospital admissions are higher.
<p>Disabled people</p>	<p>Weight Management data No data available for Lothian WM service or via National WM datasets</p> <p>Lothian whole population data: People across Lothian were asked to report which types of long-term conditions they have had for (or expect to last) 12 months or more. Overall, approximately:</p> <ul style="list-style-type: none"> • half (48.8%) reported that they had no long-term conditions, • 31.5% having a single long-term condition and • 12.8% with two long-term conditions. • 6.9% reported having three or more conditions. <p>Comorbidities refers to the presence of multiple long-term health conditions and can significantly impact treatment and care management.</p> <p>The most commonly reported categories of condition were:</p> <ul style="list-style-type: none"> • Long-term illness (19.8%),

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<ul style="list-style-type: none"> • Mental health conditions (16.0%), • Physical disability (11.1%) • Deafness/partial hearing loss (10.3%). <p>Sex differences in long-term conditions were observed for:</p> <ul style="list-style-type: none"> • mental health conditions - 18.1% of females, 13.8% of males, • Deafness - 9.5% of females - 11.2% of males • Other types of long-term condition - 12.2% of females, 9.9% of males <p>Associations with deprivation were observed for some of the common long-term conditions:</p> <ul style="list-style-type: none"> • Mental health conditions, with 18.0% of those living in the most deprived areas (SIMD decile 1) reporting a mental health condition, compared to 11.2% of those living the least deprived areas (SIMD decile 10). • 15.5% of those living in the most deprived areas reported having a physical disability, compared to 7.7% of those in the least deprived areas • 10.2% of those living in the most deprived areas reported having a learning disability, compared to 2.3% of those in the least deprived areas. • There was less variability across deprivation groups for other categories of long-term conditions. <p>Barriers to accessing health services</p> <ul style="list-style-type: none"> • Inaccessible buildings • Inadequate signage and navigation • Lack of accessible information • Poor staff awareness in communicating with people who are Deaf, having hearing and/ or sight loss or learning disabilities. • Impact of lack of continuity of care for people with relational injury and/ or psychological trauma.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<ul style="list-style-type: none"> • Lack of process to follow up people who recurrently miss appointment and are known to have significant physical and / or mental health issues. • Feeling disrespected, dismissed or not taken seriously by healthcare professionals. • Assumptions about capacity and not being able to make decisions about their own care. • Inaccessible complaints processes. • Long waiting times and inflexible appointments disproportionately affect people who need support to attend or communicate during appointments. • Lack of specialist services tailored to specific disabilities. <p>Health inequalities</p> <ul style="list-style-type: none"> • More likely to experience chronic conditions, mental health issues and multi-morbidity at younger ages than non-disabled people. • Life expectancy is lower for people with particular disabilities, especially those with learning disabilities or severe mental illness. • More likely to live in poverty, which compounds health risks and limits access to nutritious food, safe housing and preventive care. • Rates of depression, anxiety and social isolation are significantly higher in disabled people, especially people with physical disabilities or sensory loss.
Trans and non-binary people	<p>Weight management data Do not currently collect information within Lothian WM services or national datasets for WM.</p> <p>Lothian Public Health Survey 2023- whole population Overall, 135 people identified as transgender, which ranges from 0.5% of the population in East Lothian to 1.1% of the population in City of Edinburgh and West Lothian. Owing to the relatively small sample of trans individuals, there are wide margins of uncertainty around any estimates for this group, making applicability to the whole trans population in Lothian difficult. Further, with most trans people (79.4%) being aged under 35 years, analyses of this group may be largely driven by age (i.e., the findings may reflect the patterns shown by Lothian’s population of under 35 year-olds, rather than reflecting any unique association with transgender</p>

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<p>status). Where analyses by trans status are conducted with data from this survey, it is important to bear these limitations in mind. Internal analyses are being conducted amongst the sample of trans individuals to help inform Lothian’s services and policies.</p> <p>Barriers to accessing health services</p> <ul style="list-style-type: none"> • Discrimination and transphobia - 54% had at least one negative experience in a public service, including healthcare • Many avoid seeking care – 61% avoided at least one public service due to fear of being harassed, outed or misgendered. • Healthcare professionals lack training in trans health leading to misgendering and inappropriate questioning, lack of understanding of transition-related care, and inability to provide affirming care for non-transition related issues. • Inadequate referral pathways with GPs unsure how to support trans patients. • Health records and IT systems not accommodating non-binary identities or chosen names/ pronouns • Forms and documents frequently assume binary sex/ gender norms causing distress and exclusion. <p>Health inequalities</p> <ul style="list-style-type: none"> • Over 50% experience depression, anxiety or stress with the highest rates among all LGBT+ groups. • Social isolation is widespread – 73% felt isolated from family and friends and 38% reported feeling lonely all the time or often. • Disabled trans and non-binary people face higher rates of poverty and isolation.
<p>People who are pregnant or on maternity leave</p>	<p>Weight management data: Pregnancy is listed on the exclusion criteria from the service as it would go against national guidance to recommend weight loss during pregnancy. No data on those on maternity leave accessing service.</p>

<p>Relevant group</p>	<p>What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?</p>
<p>People from different ethnic backgrounds</p>	<p>Lothian Public Health 2023 survey: whole population data In terms of the ethnic background of the entire population, 89.6% are white, and the next largest ethnic group is Asian, Scottish Asian or British Asian comprising 6.1%.</p> <p>Percentage in each SIMD quintile by ethnicity Deprivation patterns vary by ethnic group, rather than following a single consistent gradient.</p> <ul style="list-style-type: none"> • White ethnic group shows a clear deprivation gradient, with the lowest proportion in SIMD 1 (9.7%) and the highest in SIMD 5 (33%). • Asian (Scottish Asian or British Asian) group has higher proportions in less deprived areas, rising from 13.5% in SIMD 1 to 24.6% in SIMD 5. • Mixed or multiple ethnic groups show the highest proportion in SIMD 5 (35.6%), with lower and more variable percentages across SIMD 1–4. • African, British African, Caribbean or Black group has the highest proportion in SIMD 1 (32.5%), with percentages decreasing steadily towards SIMD 5 (12.6%), showing an inverse pattern compared with the White group. <p>A substantial proportion of service users have ethnicity recorded as “not known” limiting the interpretation of data. 37.5% in Tier 2 and 41.4% in Tier 3 are ‘not known’</p> <p>White Ethnicity makes up the majority of service users in Tier 2 (58.7%) and Tier 3 (55.5%) compared with 89% of the Lothian population.</p> <p>Weight management data All non-white ethnic groups are under-represented in both Tier 2 and Tier 3 services compared with their proportion of the Lothian population:</p> <ul style="list-style-type: none"> • Asian groups account for around 1.3–1.5% of users, compared with 5.2% of the population. • African groups account for <0.5%, compared with 2.1% of the population. • Mixed or multiple ethnic groups and Caribbean or Black groups each account for ≤0.15% of service users, below population estimates.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<p>Barriers to accessing health services</p> <ul style="list-style-type: none"> • Lack of interpreting services or translated materials. • Appointments requiring an interpreter for communication take significantly more time to ensure safety and quality. • Services not reflecting cultural or religious needs, such as dietary restrictions or same/ single sex preferences for care. • Experiences of direct or perceived racism discourage people from seeking care • Fear of being judged or misunderstood by healthcare professionals • Historical and ongoing experiences of inequality reduce trust • Some communities feel excluded from public health messaging or decisions • Increasing reliance on online booking systems and health services can disadvantage those without digital access or literacy, particularly new migrants. • Some ethnic groups are more likely to live in deprived areas which influences health. <p>Health inequalities</p> <ul style="list-style-type: none"> • Obesity rates were highest among women of African ethnicity and lowest among those of Asian ethnicity. • Gypsy, Roma and Traveller Communities have lower life expectancy and high rates of mental health issues. • Ethnic minorities are underrepresented in mental health services use despite evidence of higher distress levels in some groups. • Black men are more likely to be diagnosed with severe mental illness and are disproportionately represented in involuntary psychiatric admissions. • Many refugees and asylum seekers arrive in Scotland with physical and mental health problems associated with the reason they had to seek asylum. • South Asian communities have the highest rates of T2 Diabetes. • Black African and Caribbean groups have 3x higher T2D rates than white Scottish. • South Asian people have a higher risk of heart disease and stroke, often at a younger age. • Black Caribbean people have higher rates of hypertension and stroke. • Chronic Kidney Disease is more common in Black African and Caribbean populations. • Sickle Cell Disease predominately affects people of African and Caribbean descent.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
People with religious or protected beliefs	<p>Weight management data Do not currently collect information within service</p> <p>Lothian population data (2022) Just over half of the population (51.1%) report having no religion, making this the largest group. Christian denominations combined account for around 39% of the population</p> <ul style="list-style-type: none"> • Church of Scotland: 20.4% • Roman Catholic: 13.3% • Other Christian: 5.1% <p>Muslim residents represent 2.2% of the population. Other religions each make up small proportions (≤0.9%), including Hindu, Buddhist, Sikh, Jewish, Pagan and other religions. Religion not stated accounts for 6.2% of the population.</p> <p>Barriers to accessing health services</p> <ul style="list-style-type: none"> • Religious dietary requirements (e.g. halal, kosher, vegetarian) are not always accommodated and can affect nutrition, trust and overall wellbeing. • Religious beliefs can influence preferences around end of life care, organ donation and reproductive health. • Muslim communities in particular report experiences of Islamophobia in healthcare settings. <p>Health inequalities</p> <ul style="list-style-type: none"> • Scottish health survey data between 2017 and 2019 found that Roman Catholics were significantly less likely to report good or very good health than those with no religion, once age differences had been taken into account • Many religious communities in Scotland – such as Muslim, Sikh, Hindu and Jewish populations are also ethnic groups – and face language barriers, cultural insensitivity and discrimination in health care setting which can affect access and outcomes. • Many religious groups are also part of communities that face high rates of deprivations, which is a major driver of health inequality

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
Men and women	<p>Weight management data In 2022/ 2023 combined, just under two-thirds of adults had a least an increased health risk based on their BMI and waist circumference (64%). A higher proportion of women (70%) had an increased health risk compared to men (58%) (<u>Scottish Health Survey 2023</u>). We would therefore expect to see more women on the waiting list than men.</p> <p>Lothian population wide data In the Lothian population, the sex split is approx. 52% female and 48% male. There are disproportionately more women on the waiting list than in the local population. Men are under-represented compared to the local population.</p> <p>WM Tier 2, 23/24 data: 74% female, 26% male WM Tier 3, 23/24 data: 70% female, 30% male</p> <p>Across Lothian, the proportion of males and females in each age group is similar except in the oldest age group, where 10.6% of females are aged 75 or over compared to 8.4% of males.</p> <p>Barriers facing women</p> <ul style="list-style-type: none"> • Symptoms in women are often under-recognised or misdiagnosed, particularly in areas like heart disease, chronic pain and autoimmune disorders. • Medical research and clinical trials have historically focused more on men, leading to gaps in understanding women's health needs. • Women, particularly single mothers and carers, are more likely to experience poverty and time poverty, making it harder to attend appointments or afford transport and childcare. • Women from ethnic minority communities may face additional challenges due to language barriers, cultural stigma or lack of culturally competent care. • Issues like domestic abuse, sexual violence and reproductive choices can carry stigma, discouraging women from seeking help

Relevant group	<p>What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?</p>
	<ul style="list-style-type: none"> • Trans and non-binary people assigned female at birth may also face discrimination or lack of inclusive services. <p>Barriers facing men</p> <ul style="list-style-type: none"> • Many men delay seeking medical help due to social norms around masculinity, which discourage showing vulnerability or admitting to health concerns. • Men are less likely to attend routine check-ups, screenings and health promotion activities, leading to later diagnoses of conditions like cancer and heart disease. • Men often face stigma around mental illness, which can prevent them from accessing timely support. • Traditional work patterns and lack of flexible appointment times can make it harder for men – especially those in manual or shift work – to attend healthcare appointments. • Some men may have lower health literacy, making it harder to understand symptoms, navigate healthcare system or engage with health information. • Men in deprived areas face barriers to accessing care, including transport, digital exclusion and financial stress. <p>Inequalities facing women</p> <p>Evidence in the Women’s Health Plan tells us:</p> <ul style="list-style-type: none"> – An estimated 1.5 million (1 in ten) women in the UK of reproductive age are affected by endometriosis, and it takes an average of 8.5 years to diagnose. – Almost 1 in 10 deaths in women in Scotland each year are caused by ischaemic heart disease. – It is estimated there are currently 300,000 people in Scotland living with osteoporosis, a condition which is more common in women than men. – Heart disease is the leading cause of maternal death in the UK. – Around 400,000 women in Scotland are of menopausal age. The average age at which a woman will reach menopause is 51.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<p>Inequalities facing men</p> <ul style="list-style-type: none"> • Men in the most deprived areas have significantly lower life expectancy than those in the least deprived areas. • Men are more likely to die by suicide, especially in middle age, which is linked to underdiagnosis and underuse of mental health services. • Men are more likely to experience cardiovascular disease at a younger age, but women often have worse outcomes post-diagnosis due to later detection.
<p>People who are heterosexual, lesbian, gay or bisexual</p>	<p>Lothian Weight management data Do not currently collect information within service</p> <p>NHS Lothian population (2022)</p> <ul style="list-style-type: none"> • Within the Lothian population, the majority of the population identifies as straight or heterosexual (88.2%). • Gay or lesbian (1.9%) and bisexual (1.8%) people each make up small but similar proportions of the population. • A further 0.6% identify as having another sexual orientation. • Sexual orientation was not stated for 7.5% of the population. <p>Barriers accessing health services</p> <ul style="list-style-type: none"> • One in five LGB people conceal their sexual orientation when seeking care. • One in seven LGB people avoid treatment altogether due to fear of discrimination. • LGB people report negative experiences in healthcare that can discourage disclosure or engagement with services, including: <ul style="list-style-type: none"> – Heteronormative assumptions – Lack of inclusive language – Microaggressions and insensitivity.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<p>Health Inequalities</p> <ul style="list-style-type: none"> • LGB adults are twice as likely to report symptoms of anxiety and depression compared to heterosexual adults. • Bisexual adults, especially young bisexual women, experience highest rates of chronic mental health problems. • LGB people have higher rates of chronic conditions including cardiovascular disease, neurological conditions and obesity. • Lesbian and bisexual women are less likely to attend cervical cancer screenings • Higher rates of sexually transmitted infections are reported among some LGB groups, particularly gap and bisexual men. • Lesbian and bi-sexual women may receive less frequent sexual health screening due to assumptions about risk. • LGB people are more likely to engage in unhealthy behaviours, often as a coping mechanism for stress and discrimination
<p>People who are married or in a civil partnership</p>	<p>Do not currently collect information within the service</p>
<p>Care-experienced people</p>	<p>Weight management data Do not currently collect information within service. No data available at board level from The Promise</p> <p>Barriers accessing health services</p> <ul style="list-style-type: none"> • Mistrust of professionals, including healthcare, making it harder to seek help or engage with services. • Frequent placement moves can disrupt continuity of care, GP registration, access to mental health or specialist services. • Lacking a consistent adult advocate to help them navigate the healthcare system, attend appointments and understand treatment options. • Feeling judged or stereotyped that can led to avoidance of services or reluctance to disclose personal information.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<ul style="list-style-type: none"> • The cliff edge when transitioning from children's to adult services. Adult services may not be equipped to support care leavers. • Digital exclusion making it harder to access online health services or book appointments. • Struggling with transport, housing instability or financial barriers that affect their ability to prioritise health. <p>Health inequalities</p> <p>The Promise found care experience people in Scotland face significant health inequalities, particularly in mental health and called for trauma informed, lifelong support.</p> <ul style="list-style-type: none"> • Are more likely to experience mental illness, substance abuse and early mortality. • Are more likely to report poorer general health, long term conditions and face barriers accessing consistent healthcare.
<p>People experiencing health or employment inequalities caused by socio-economic disadvantage [This may include people living in different or difficult circumstances</p>	<p>Waiting lists, Tier 2 and Tier 3</p> <p>Disproportionately more people from the worst deprived areas on waiting lists compared to the local population.</p> <p>Tier 2, 41% combined are within SIMD 1-2 Tier 3. 47% combined are within SIMD 1-2, and the lowest proportion is within SIMD 5, 17%.</p> <p>National data: number of referrals, SIMD and Tier- October 2019-September 2022</p> <p>Tier 2</p> <ul style="list-style-type: none"> • Referrals were highest from SIMD 1 (most deprived) in every year, rising markedly to 3,499 in 2021–22. • Referrals gradually decreased across quintiles, with SIMD 5 (least deprived) consistently having the lowest numbers.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
such as people experiencing homelessness, who are in prison or are ex-offenders, people with addictions and people involved with prostitution.]	<p>Tier 3</p> <ul style="list-style-type: none"> • SIMD 1 and 2 accounted for the largest share of referrals, particularly in 2021–22. • 2021: 2,130 referrals SIMD 1 and 1,876 referrals SIMD 2. • Referral numbers declined with decreasing deprivation, with SIMD 5 consistently lowest. <p>Barriers to accessing services</p> <ul style="list-style-type: none"> • People who lived in the most deprived parts of England were twice as likely to wait more than a year for elective treatment as people who lived in the most affluent areas. • Limited public transport options, making it difficult to attend appointments • Rural or peripheral urban areas may lack nearby GP practices or hospitals, increasing travel time and cost. • Increase reliance on online appointment systems and digital health services can disadvantage people without internet access or digital literacy. • Waiting longer for GP or specialist appointments. • Missed appointments due to inflexible work or caring responsibilities • Low levels of health literacy • Feeling judged or dismissed due to their status, lifestyle or appearance. • Historical mistrust of institutions. • Data suggests that for older people living within prisons, the infrastructure may not be equipped to meet these changing needs. <p>Health inequalities</p> <ul style="list-style-type: none"> • Higher mortality rates (more premature deaths) • Lower life expectancy (up to 13 years than those in least deprived areas) • Higher rates of emergency hospital admissions, particularly for conditions that are preventable with timely and effective primary care. • Prescribed medication for anxiety, depression or psychosis reflecting higher levels of mental ill health. • Hospital stays related to alcohol and drug misuse. • Low birth weight, which is associated with poorer long-term health outcomes.

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
Carers	<p>Weight management service Do not currently collect information within Lothian WM service or national WM data.</p> <p>Lothian whole population data- 2023 public health survey Those living in City of Edinburgh were less likely to provide regular care compared with people living elsewhere in Lothian. Around one in five (19.3%) of those living in City of Edinburgh reported being carers, whilst this ranged from 24.8% in Midlothian to 26.7% in East Lothian. A higher proportion of white people (22.5%) provide regular care compared to African (11.0%) and mixed/multiple (14.8%) ethnic groups. There were small differences in caring status by SIMD decile with those living in the second-most deprived areas (26.6%) being more likely to provide regular care than those living in the fifth-most (19.0%), seventh-most (19.3%) and least deprived areas (21.2%).</p> <ul style="list-style-type: none"> • Around one in five (22.0%) said they provided weekly care to someone for long-term physical or mental ill-health, disability or problems relating to old age, with 5.4% of reporting that they provided 20 or more hours of weekly care. • More females (23.6%) than males (20.2%) reported that they provided any level of weekly care. • The proportion providing regular care was greater in older age groups, peaking at 35.0% in the 55–64 years age group before decreasing again in those aged 65 or over. <p>Barriers</p> <ul style="list-style-type: none"> • Carers often neglect their own health due to time constraints or prioritising the needs of the person they care for. • Many carers report difficulty attending medical appointments for themselves due to lack of respite care or rigid appointment systems. • Some carers face digital exclusion, making it harder to access online health services. <p>Health Inequalities</p> <ul style="list-style-type: none"> • 36% of unpaid carers reported their mental health as “bad” or “very bad”

Relevant group	What you found e.g. who uses your service, What inequalities do they experience? What barriers do they have accessing your service?
	<ul style="list-style-type: none"> • Many carers experience chronic stress, anxiety and depression often due to the emotional and physical demands of caregiving without adequate support. • More likely to experience financial hardship, reduced income, limited employment opportunities and extra costs related to caring. • Demands of caring can lead to social withdrawal. • Can lack time or energy to maintain social relationships or engage in community activities.

Part 2: Assessing the impact

Impact on equality & socio-economic inequalities

Negative impacts - Disadvantage and discrimination

Using the evidence, explain if your proposal could be discriminatory and/ or put a group of people sharing a characteristic at a disadvantage for a reason connected to that characteristic.

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
<p>People in different age groups</p>	<p>Potentially.</p> <p>People under 40 less likely to have comorbidities.</p> <p>Most people accessing the service are age 30-60.</p> <p>Trend towards higher BMI with increasing age, likely to have high blood pressure and other conditions.</p> <p>Complexities for people with multiple co-morbidities – require a lot of support and their BMI / weight impacts on other conditions and vice versa.</p>	<p>No.</p>	<p>Prevention work with younger people before it becomes a disease.</p> <p>Could establish links with NHS staff that will see people at a younger age e.g. MH nurses, and providing training for NHS Lothian staff about how to talk about weight with parents and carers.</p> <p>Support needed for parents to engage effectively with CYP. Supporting the families how to support CYP who may have internalised weight stigma, fear, anxiety and shame.</p>

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
	<p>Risks for older people, who get support too late – overall life expectancy of people who develop type 2 diabetes at younger age group is significantly reduced.</p> <p>Young people can be harder to engage. If they are not going to GP, then unlikely to get information or referral.</p>		<p>Understand why children with complex medical conditions engaged with Child Healthy Weight (CHW) service can find it more difficult to engage. Including getting feedback on what the referral process is like and how to improve conversations.</p> <p>Consider focusing prevention work on children and young people with clinical conditions in addition to obesity, such as asthma.</p> <p>New WM and T2D oversight group to consider what other services or prevention work could be available for those who do not meet specialist service criteria.</p> <p>NHS Inform Weight Loss Hub is live so make sure signposts to local services.</p>

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
	<p>Who have a diagnosis of current eating disorder or potential binge eating disorder.</p> <p>Who have uncontrolled hypothyroidism.</p> <p>Who have psychosis or severe and unstable personality disorder.</p> <p>Those living with significant learning disabilities being supported by specialist LD teams in community.</p>	<p>under control then people can be accepted. In case of learning disability population, their holistic health care is managed within their specialist team and this is the most appropriate place for their obesity care.</p>	<p>Check for mild to moderate LD at triage as these individuals can be safely managed within the WM service.</p> <p>Continue to offer home and online visits.</p> <p>Explore whether Rockford score could be a prompt on referral form. Could be helpful as part of new digital triage tool.</p> <p>Explore links to NHS Lothian mental health services e.g. people on anti-psychotics will have reviews annually.</p> <p>Explicitly tell patients and referrers that service will make reasonable adjustments for people who cannot access the digital programme due to disability.</p>

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
			<p>Referral processes need to be accessibility checked – forms need to be easy, self populated where possible and consider methods for self-referral.</p> <p>Explore producing a demo of digital service for primary care.</p> <p>Technical support is provided by the external provider to support people who may struggle with IT.</p> <p>Measure success of tier 2 digital service using</p> <ul style="list-style-type: none"> – Realistic clinical outcomes – Patient satisfaction and perception
Trans and non-binary people	In general trans and non-binary are less likely to access health services than non-trans and binary people.	No	Consider how to demonstrate WMS are gender inclusive , including ensuring staff have done NHS Lothian education and training on trans inclusive healthcare.

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
<p>People who are pregnant or on maternity leave</p>	<p>No.</p> <p>If someone is pregnant they cannot be referred to WMS due to health reasons.</p> <p>There is a specialist antenatal metabolic clinic if BME is greater than 40.</p> <p>Women and people on maternity leave will not be excluded.</p>	<p>NA</p>	<p>Women and people who are pregnant will stay on waiting list until they have had their baby. The waiting time clock will be paused.</p> <p>Continue to offer virtual and home appointments to support childcare arrangements.</p>
<p>People from different ethnic backgrounds</p>	<p>No.</p> <p>Proposed new adult criteria takes into account NICE evidence and recommendations about people from some ethnic minority backgrounds are prone to central adiposity and so are at an increased risk of chronic weight related health conditions at a lower BMI. Ethnic groups are:</p>	<p>No.</p> <p>The proposed lower BMI criteria for particular ethnic groups relates directly to evidence of increased risk of chronic weight related health conditions at a lower BMI. Any potential indirect race discrimination can be objectively justified as a proportionate way of</p>	<p>Use information in the MEHIS T2 Diabetes report to identify actions to reduce barriers and meet different needs.</p> <p>Continue to work with MEHIS and other community organisations to share information on the increased risks for people from these minority ethnic backgrounds in an inclusive and non-stigmatising way.</p>

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
	<p>South Asian, Chinese Other Asian Middle Eastern Black African African-Caribbean</p> <p>Higher risk ethnic minorities with CVD risk could be underrepresented in service. However, we don't know the ethnicity of around 30% of patients on waiting lists so comparison with local population data not accurate. This means cannot tell is some groups are over or underrepresented compared to local population.</p>	<p>achieving a legitimate aim.</p>	<p>Continue to use NHS Lothian Interpretation and Translation Service (ITS) and explore if could do some awareness raising with interpreters so they have knowledge and language around health prevention.</p> <p>Encourage staff when contacting people to ask about their ethnicity and update TRAK. Can provide standard phrases for teams to use. Make sure if people say they prefer not to share this information that this is marked on TRAK as prefer not to say, rather than unknown.</p> <p>Continue to deliver culturally competent advice and information as part of treatment.</p>
<p>People with religious or protected beliefs</p>	<p>None identified.</p>	<p>NA</p>	<p>NA</p>

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
Men and women [This may include carers, because many are women.]	No. However, waiting list data shows that people accessing service are 70/30 female/ male but the population is around 50/50. It is predicted that obesity in women is likely to increase as they are likely to live longer.	No.	Consider preventative work to improve referrals of men. Government CVD funding for GP health checks may increase proportion of men accessing the service. Consider adding info to ref help that recognises gender differences and impact.
People who are heterosexual, lesbian, gay or bisexual	None identified	NA	NA
People who are married or in a civil partnership [only in employment situations]	NA	NA	NA
Care experienced people	No. However, care experienced people more likely to have mental health conditions and trauma.	Note – there is no legal protection from discrimination in relation to care experience	

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
	<p>May miss out accessing services if moving across local authority / health board boundaries.</p>		
<p>People experiencing health inequalities caused by socio-economic disadvantage [This may include people living in different or difficult circumstances such as people experiencing homelessness, who are in prison or are ex-offenders, people with addictions and people involved with prostitution. Note – travel costs have a particular impact on people experiencing poverty.]</p>	<p>Potentially.</p> <p>Over representation of those in deprived areas but this is in keeping with population data, higher deprivation linked to higher levels of obesity.</p> <p>Those living in poverty – can find lifestyle changes overwhelming and unable to put changes into practice and puts people off accessing support. More likely to have a disabled person living with them and caring responsibilities.</p> <p>Digital poverty could impact ability to access tier 2 service.</p>	<p>NOTE - there is no legal protection from discrimination on basis of socio-economic disadvantage</p>	<p>If patient DNA then referrer is told at the same time as the patient.</p> <p>Explore with referrers whether there is a key worker that could support people who frequently DNA and help to support patient's relationship with the WMS.</p> <p>Continue to phone and text people to remind them about appointments.</p> <p>Continue to ask people to inform us if their contact details change and explain why this is important so we can support them to attend their appointments.</p>

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
	<p>Higher DNA rates and Waiting Times Guidance requires us to move DNA patients to the bottom of the waiting list/ reset the clock.</p> <p>Yes - people with alcohol or drug dependency will not be accepted until this is under control.</p>		<p>Record on patient records if they have an advocate or key worker and their contact details. Need to make sure have consent of patient to do this and to share information with them.</p>
<p>People experiencing employment inequalities caused by socio-economic disadvantage [This may include people living in different or difficult circumstances, such as people experiencing homelessness, who are in prison or ex-offenders, people with addictions, ex-service personnel/veterans and people involved with prostitution. Note – travel costs have a particular impact on people experiencing poverty.]</p>	<p>NA</p>	<p>NOTE - there is no legal protection from discrimination in employment on basis of socio-economic disadvantage.</p>	<p>NA</p>

Relevant group	Will your proposal put people at a disadvantage/ make their lives worse?	Could this be unlawful?	What can you do to reduce/remove this?
Carers	<p>Potentially</p> <p>More women and more older people are carers and disproportionately more people on WMS waiting lists in these groups. More likely to be time poor and find it difficult to get to the GP for referral or attend WMS appointments.</p>	No	Explore whether there are different ways people can access the services.

Positive impact - Advancing equality, reducing inequalities and disadvantage and meeting different needs. Fostering good relations, reducing prejudice and increasing tolerance

Using the evidence, explain if your proposal could reduce inequalities experienced by groups of people sharing certain characteristics.

Relevant group	Can your work advance equality of opportunity? e.g reduce disadvantage, meet needs, increase participation	Can your work foster good relations? e.g. reduce prejudice + increase tolerance
People in different age groups	Yes - Scottish Government CVD funding means that people age 30-60 years old will be invited into GP for health checks and this may result in referral to WMS.	Neutral
Disabled people	Yes – if proactively ensure people know services will make reasonable adjustments to remove or reduce any barriers related to disability and reasonable adjustments are made.	Neutral
Trans and non-binary people	Yes - Staff training and awareness raising on gender inclusive services may build trust and confidence in the service, encouraging more trans and non-binary to access.	Neutral
People who are pregnant or on maternity leave	Yes – specialist services available.	Neutral
People from different ethnic backgrounds	Yes – proposed criteria recognises some ethnic groups at increased risk at lower BMI. Yes – prevention work with particular ethnic minority communities based on evidence of health inequalities.	Neutral

Relevant group	Can your work advance equality of opportunity? e.g reduce disadvantage, meet needs, increase participation	Can your work foster good relations? e.g. reduce prejudice + increase tolerance
	Yes – interpretation services provided.	
People with religious or protected beliefs	Neutral	Neutral
Men or women [This may include carers, because many are women]	Yes – if prevention work with men from particular communities.	Neutral
People who are heterosexual, lesbian, gay or bisexual	Neutral.	Neutral
Care experienced people	Yes – staff will continue to take trauma informed approach.	Neutral
People who experience health inequalities caused by socio-economic disadvantage	Yes – if steps taken to recognise barriers and different needs identified.	Neutral
People who experience employment inequalities caused by socio-economic disadvantage.	NA	NA
Carers	Yes – if service continued to be provided in ways accessible to carers.	Neutral

Impact on UNCRC rights

If your proposal does not affect children and young people do not complete this section.

If your proposal affects children and young people up to age 18, use the evidence you have collected to explain how your proposal could impact Children's Rights. Not all UNCRC rights may apply to your proposal. If this is the case, simply say 'Neutral.'

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
1 – we must make sure everyone under 18 years old can enjoy all UNCRC rights	Yes	WMS works closely with women and children's young person's board, have 5-year plan linked to development framework.	
2 – we must make sure all UNCRC rights apply to every child without discrimination.	Yes	Any exclusion from the service is proportionate, balanced against right to health and only under other conditions are under control.	Children under 2 years of age are referred to paediatric endocrinology to exclude an underlying cause. Children who require alternative support prior to being ready to attend CHW.
3 – we must make sure the best interests of the child are a top priority in all decisions and actions that affect the child.	Yes	Ask for views of child – put at the centre of treatment if they don't want to attend or can't attend – parent and guardian on their own.	

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
		<p>Can offer appointment on their own if they want and have capacity. Decisions on capacity are based on individual child.</p> <p>Holistic service – all their needs are taken into account.</p> <p>Child protection in place</p>	
<p>4 - we must create systems that promote and protect UNCRC rights.</p>	<p>Yes</p>	<p>Adhere to GIRFEC and feed into child planning meetings and child protection, secure electronic records, adhere to NHS Lothian Information Governance procedures.</p> <p>Getting children and young people's views heard in decision-making and feedback.</p>	
<p>5 – we must respect the rights and responsibilities of parents and carers to provide guidance and direction to their child as they grow up, recognising the child's capacity to make their own choices.</p>	<p>Yes</p>	<p>1st appointment is with parents/carers.</p> <p>No blanket age policy/ rule around patient/ carer attendance at appointments.</p>	

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
<p>6 – we must do everything we can to ensure that children survive and develop to their full potential.</p>	<p>Yes, but there may be more we could do.</p> <p>How do we get to know about children with known clinical condition who could benefit from service.</p> <p>Prevention – supporting educators to have conversations about healthy weight.</p> <p>Work with secondary care colleagues managing specialist paediatric conditions to make sure they're aware of service and referrals.</p> <p>Obesity training in paediatrics.</p> <p>Awareness, information for self-</p>	<p>CHW is focused on supporting child and parents.</p> <p>Provide holistic assessments.</p>	

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
	<p>referrals, how to we make sure that it's high quality, accessible. Training and advice about having good conversations.</p> <p>Running a helpline type service to allow specialist advice and consultation for those who don't meet criteria.</p> <p>Revalidating of waiting list – question is yes or no and should we have a don't know</p>		
<p>7 – we must respect the right to be registered at birth, to have a name and nationality and as far as possible for children to know and be cared for by their parents.</p>	<p>Neutral</p>		

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
8 – we must respect and protect children's right to an identity and prevent a child's name, nationality or family relationships from being changed unlawfully.	Neutral		
9 – we must not separate children from their parents against their will unless it is in their best interests and uphold the right to stay in contact with both parents, unless this could cause them harm.	Neutral		
10 – we must respond quickly and sympathetically if a child or their parents apply to live together in the same country. The right to visit and keep in contact with both parents if they live in different countries.	Neutral		
11 – we must do everything we can to stop children being taken out of their own country illegally by their parents or other relatives, or being prevented from returning home.	Neutral		
12 – we must respect the right for children to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously.	Yes but there may be more we could do: Developing new resources and short videos to help set	Shared decision making is part of clinical practice. Feedback form – on JISC and offer hard copy.	

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
	<p>expectations for children</p> <p>Ref Help resources for children</p>	<p>Self-help – you don't quite fit the criteria – but provide information and advice. Signpost to national resource (Parent Hub)</p>	
<p>13 – we must make sure every child is free to express their thoughts and opinions and to access all kinds of information, as long as it is within the law.</p>	<p>Yes – see Art 12</p>	<p>Yes – see Art 12</p>	
<p>14 – we must respect children's right to think and believe what they choose and also to practise their religion as long as they are not stopping other people from their rights. We must respect the rights and responsibilities of parents to guide their child as they grow up.</p>	<p>Yes</p>	<p>We provided tailored advice to make sure it's culturally and religiously appropriate.</p>	
<p>15 – we must respect the right to meet with other children and join groups and organisations as long as this does not stop other people from enjoying their rights.</p>	<p>Neutral</p>		
<p>16 – we must respect the right to privacy and protecting the child's private, family and home life, including protecting children from</p>	<p>Yes</p>	<p>We adhere to GIRFEC and feed into child planning meetings and child protection, secure electronic records, adhere to</p>	

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
unlawful attacks that harm their reputation.		NHS Lothian Information Governance procedures.	
17 – we must ensure children have access to reliable information from a variety of sources and help to protect children from materials that could harm them.	Neutral		
18 – we must support parents by creating support services for children and giving parents the help they need to raise their children.	Yes	Parents are involved and receive support direct from service.	
19 – we must do everything we can to protect children from all forms of violence, abuse, neglect and bad treatment by their parents or anyone else who looks after them.	Yes	We apply safeguarding policy and practice.	
20 – we must give children who cannot be looked after by their immediate family special protection and assistance, that is continuous and respects their culture, language and religion.	Neutral		

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
21 – the process of adoption must be safe, lawful and prioritises children's best interests.	Neutral		
22 – if a child is seeking refuge or has refugee status, we must provide them with appropriate protection and assistance (within our remit/ functions) to help them enjoy UNCRC rights.	Neutral		
23 – we must do all we can to support disabled children and their families to enjoy their right to live a full and decent life with dignity and as far as possible independence and to play an active part in the community.	Yes	<p>Maintain access to the psychology support.</p> <p>Looking at pilot for people who can't access T2 exercise specialist. So looking at if can access specialists support.</p>	
24 – we must provide good quality health care and education on health and well-being so that children can stay healthy.	Yes	<p>Signposting to third sector like ithrive for mental health.</p> <p>Change in referral criteria may reduce access to some children so need to keep this under review.</p>	

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
25 – we must make sure children who have been placed away from home for the purpose of care or protection (e.g. in hospital) can have a regular review of their treatment, the way they are cared for and their wider circumstances.	Neutral		
26 – Governments must provide social security, including financial support and other benefits to families in need of assistance.	Neutral		
27 – we must help families (within our remit, functions) who cannot afford to, to provide their child with a standard of living that is good enough to meet their physical and social needs and support their development.	Neutral		
28 – every child has the right to an education and discipline in schools must respect children's dignity and their rights.	Neutral		
29 – education must develop every child's personality, talents and abilities to the full and encourage child's respect for human rights, as well as respect for their parents, their	Neutral		

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
own and other cultures and the environment.			
30 – we must respect that every child has the right to learn and use their language, customs and religion of their family, whether or not these are shared by the majority of the people in the country where they live.	Neutral		
31 – we must respect the right of every child to relax, play and take part in a wide range of cultural and artistic activities.	Yes	Access to the service provides greater opportunity to enjoy this right.	
32 – we must protect children from economic exploitation and work that is dangerous or might harm their health, development or education.	Neutral		
33 – we must protect children from the illegal use of drugs and from being involved in the production or distribution of drugs.	Neutral		
34 – we must protect children from all forms of sexual abuse and exploitation.	Neutral		

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
35 – we must protect children from being abducted, sold or moved illegally to a different place in or outside their country for the purpose of exploitation.	Neutral		
36 – we must protect children from all other forms of exploitation (e.g. by the media, or for medical research)	Neutral		
37 – we must not torture or cause suffering or other cruel or degrading treatment or punishment. Children should be detained only as a last resort and for the shortest time possible. They must be treated with respect and care and be able to keep in contact with their family.	Neutral		
38 – we must do everything we can to protect and care for children affected by war and armed conflicts.	Neutral		
39 – we must provide special support to help children who have experienced neglect, abuse, exploitation, torture or who are victims of war to recover their health, dignity, self-respect and social life.	Neutral		

UNCRC right	Is your work compatible with this right?	How does this proposal respect this right?	Are any groups of children particularly impacted
40 – we must treat a child accused or guilty of breaking the law with dignity and respect.	Neutral		
41 – we must comply with national laws and standards that go further than UNCRC rights.	Yes	Proposed new criteria based on NICE guidance (Jan 2025)	
42 – we must actively work to make sure children and adults know about UNCRC.	Yes	Discussion with the Programme Board about how to do this across NHS Lothian and apply to service.	

Part 3: Next steps

Proposed mitigating action

Recommended mitigating action	Agreed/ not agreed	Responsibility	Due	Comment
Prevention work with younger people before complications of obesity arise	Agreed	NHSL T2D and WM oversight group	April 2026	Requires whole system approach, not single responsibility of one service or team
Consider focusing prevention work on children and young people with clinical conditions in addition to obesity, such as asthma.	Agreed	WM/diabetes service leads	April 2026	Referral and triage criteria to be changed to prioritise this group
Could establish links with NHS staff that will see people at a younger age e.g. MH nurses and providing training for NHS Lothian staff about how to talk about weight with parents and carers.	Not agreed			This would require investment to develop training materials and deliver a programme of work – funding not currently available so this will remain on a development list.
Support needed for parents to engage correctly with CYP. Supporting the families how to support CYP who may have internalised weight stigma, fear, anxiety and shame.	Agreed	CHW team	April 2026	Create video for public website to demonstrate and explain the CHW in a compassionate way
Understand why children with complex medical conditions engaged with Child Healthy Weight (CHW) service can find it more difficult to engage. Including getting feedback on what the referral process is like and how to improve conversations.	Agreed	CHW team	March 2027	Plan for patient feedback and evaluation over course of next 12 months

Recommended mitigating action	Agreed/ not agreed	Responsibility	Due	Comment
NHS Inform Weight Loss Hub in progress and make sure signposts to local services.	Agreed	WM team leads	Complete	Weight Loss Hub live with signposting in both directions
New WM and T2D oversight group to consider what other services or prevention work could be available for those who do not meet specialist service criteria.	Agreed	WM and T2D oversight group	Ongoing	This is work that will remain on the workplan of the oversight group as a rolling commitment
Referral criteria continues to ensure people with obesity related conditions will be referred to services.	Agreed		Complete	
Continue to offer home and online visits.	Agreed	WM Service	Ongoing	
Check for mild to moderate LD at triage.	Agreed		Complete	
Explore whether Rockford score could be a prompt on referral form. Could be helpful as part of new digital triage tool	Agreed	WM/Diabetes Service Leads	Await development work on digital triage tool 2026-2029	
Explicitly tell patients and referrers that service will make reasonable adjustments for people who cannot access the digital programme due to disability.	Agreed	WM Team Leads	Complete	Update website with this information
Referral processes need to be accessibility checked – forms need to be easy, self populated where possible and consider methods for self-referral.	Agreed	WM Team Leads	December 2026	Work will be undertaken as part of digital innovation programme 2026-2029

Recommended mitigating action	Agreed/ not agreed	Responsibility	Due	Comment
Explore producing a demo of digital service for primary care.	Agreed	WM Team Leads	August 2026	To discuss with Second Nature about access to bespoke video
Technical support is provided by the external provider to support people who may struggle with IT.	Agreed		Ongoing	
Measure success of tier 2 digital service using <ul style="list-style-type: none"> – Realistic clinical outcomes – Patient satisfaction and perception 	Agreed		Complete	TURAS data collection and reporting system now doing this
Consider how to demonstrate WMS are gender inclusive, including ensuring staff have done NHS Lothian education and training on trans inclusive healthcare.	Agreed		Ongoing	
Women and people who are pregnant will stay on waiting list until they have had their baby. The waiting time clock will be paused.	Agreed		Complete	
Use information in the MEHIS T2 Diabetes report to identify actions to reduce barriers and meet different needs.	Agreed		Complete	
Continue to work with MEHIS and other community organisations to share information on the increased risks for people from these minority ethnic backgrounds in an inclusive and non-stigmatising way.	Agreed	WM/T2D oversight group	Ongoing	Delivered through work of oversight group

Recommended mitigating action	Agreed/ not agreed	Responsibility	Due	Comment
Continue to use NHS Lothian Interpretation and Translation Service (ITS) and explore if could do some awareness raising with interpreters so they have knowledge and language around health prevention.	Agreed		Ongoing	
Encourage staff when contacting people to ask about their ethnicity and update TRAK. Can provide standard phrases for teams to use. Make sure if people say they prefer not to share this information that this is marked on TRAK as prefer not to say, rather than unknown.	Agreed		Complete	
Consider preventative work to improve referrals of men.	Agreed	T2D/WM oversight group		Requires whole system response
Government CVD funding for GP health checks may increase proportion of men accessing the service.	Agreed		Ongoing	
Consider adding info to ref help that recognises gender differences and impact.	Agreed	WM team leads	August 2026	
If patient DNA then referrer is told at the same time as the patient.	Agreed		Complete	
Explore with referrers whether there is a key worker that could support people who DNA and help to support patient's relationship with the WMS.	Not Agreed			This is currently not possible or aligned to national waiting times guidance

Recommended mitigating action	Agreed/ not agreed	Responsibility	Due	Comment
Continue to phone and text people to remind them about appointments.	Agreed		Ongoing	
Continue to ask people to inform us if their contact details change and explain why this is important so we can support them to attend their appointments.	Agreed		Ongoing	
Can we include specific information on KISS that could be extracted at triage.	Agreed	WM/Diabetes service leads	August 2026	Dependent on OPIP funding to develop digital tool
Record on patient records if they have an advocate or key worker and their contact details. Need to make sure have consent of patient to do this and to share information with them.	Agreed	WM team leads	August 2026	
Explore whether there are different ways carers can access the services.	Not Agreed			At this stage, this is not a significant priority as we are aiming to refine and simplify the referral process in the first instance.

Sharing with decision-makers

Once approved and signed off through NHS Lothian governance, this assessment will be disseminated to all relevant stakeholders, including service users and referring practitioners. NHS Lothian will publish the final document, and it will be made accessible through multiple platforms. Publication through these channels ensures transparency and enables informed decision-making across the organisation and wider system. It is planned that the changes be made with effect from 1st June 2026.

Communication to those who access the service

- **NHS Lothian Weight Management Service public website:** This will include clear step-by-step guidance for patients on how to measure their own waist-to-height ratio (WHtR) at home where required (BMI < 35), to avoid the need for Primary Care to collect this measurement.
- **NHS Inform (Weight Loss Hub):** cross-signposting ensuring consistency with local criteria, including information on how patients can self-measure WHtR before referral if applicable.
- **Patient-facing materials:** updated leaflets and education materials.
- **Direct communication:** inclusion of information in initial assessments, information seminars, any waiting list validation processes, and triage processes.

Communication to those who refer into the service

- **RefHelp:** updated referral guidance, criteria, FAQs and signposting for those who do not meet criteria.
- **Intranet:** publication of updated pathways and operational guidance for NHS Lothian staff.
- **GP & Primary Care communication channels:**
 - GP weekly distribution bulletin
- **Professional education & engagement:**

- Virtual bitesize sessions for GP practices, AHPs and community teams
- Short explainer video for referrers

No external communication will be published until the ECRIA and criteria are formally approved.

2. Stakeholders and written statements

Stakeholders

Stakeholders who need to be informed of the changes include:

- **Primary Care** (GP practices, ANPs, Practice Nurses, Pharmacy teams)
- **Secondary Care specialties**
 - Endocrinology
 - Diabetes
 - Bariatric
 - Renal
 - Cardiology
 - Respiratory (OSA pathways)
 - Gastroenterology (MASLD/NASH)
 - Fertility
 - Orthopaedics / Prehabilitation
 - Mental Health
 - Paediatrics & Child Health
- **Community and Third Sector partners:** MEHIS, interpreters, community health organisations
- **Public Health / Health Improvement teams**
- **NHS Lothian governance groups:**

- Weight Management & T2D Oversight Group
- Midlothian SMT
- Women's and Children's Board (CHW)
- Equality and Human Rights Team
- **Digital & data teams:** eHealth, TRAK, TURAS

Draft wording for stakeholder communication

Dear colleagues

NHS Lothian is implementing updated referral and eligibility criteria for adult and child Weight Management Services, effective 1st June 2026. These changes aim to ensure equitable access, improve waiting times and align local pathways with emerging evidence (including NICE NG246, Jan 2025).

The updated criteria strengthen links with cardiometabolic risk, reduce ambiguity for referrers, and support early intervention, particularly for people with clinical risk conditions and for children with obesity and comorbidities.

To further ensure that we reach the people most in need, we will now only accept referrals from healthcare professionals. Self-referral accounts for a small percentage of our referrals (less than 15%) so we predict the impact will be minimal; over 80% of referrals already come from GPs and GPNs. Healthcare professional referral assures that patients have a diagnosis of obesity by a medical professional and that relevant clinical conditions are detailed, allowing for more effective weight management triage and treatment.

Detailed information will be published on RefHelp, the NHS Lothian Weight Management Service website and the Intranet. We will also provide bitesize education sessions and support for implementation within Primary Care and partner services.

Thank you for your continued collaboration in supporting equitable and effective weight management across Lothian.

Kind regards

Gillian Walker & Laurie Eyles

Dietetic Service Leads for Weight Management and Diabetes Prevention

Monitoring the impact

How will you monitor the actual impact of this piece of work on equality, socio-economic disadvantage or children's rights?

The impact of this service change will be monitored on an ongoing basis through the routine collection and analysis of Weight Management Service data. Monitoring will include referral numbers, access, waiting times, assessment outcomes, programme uptake, completion rates, and clinical outcomes, disaggregated by protected characteristics where data is available. Monitoring will also include review of psychological screening outcomes, engagement levels across different programme components, and patterns of non-attendance, to identify whether any groups are disproportionately affected.

Qualitative feedback from service users will be gathered through patient experience surveys, verbal feedback, complaints, and informal comments received during appointments, groups, or telephone contacts. Particular attention will be paid to whether service users from any protected groups experience barriers related to communication, digital access, health literacy, physical access, cultural appropriateness, or mental-health-related needs.

Responsibility for monitoring rests with the Service Leads for Weight Management, supported by the Head of Dietetics and the Senior Management Team. Findings will be reviewed through established governance structures, including Weight Management leadership meetings, operational meetings, and relevant NHS Lothian governance forums. Where monitoring identifies emerging inequalities or unintended negative impacts, appropriate mitigating actions will be implemented and documented, and feedback will be provided to staff and stakeholders.

The ECRIA will be revisited if monitoring indicates a material change in how different groups are affected, or if new evidence suggests additional impacts that require consideration. The monitoring process will support continuous improvement,

ensure equitable access to the service, and inform future refinements to pathways, referral processes, and communication materials.

Primary care impact

- Increased clarity of criteria should reduce inappropriate referrals.
- Lower BMI thresholds for some minority ethnic groups may increase appropriate referrals.
- Primary care time may be needed for:
 - explaining new criteria to patients
 - collecting waist:height ratio where appropriate (although patients will be encouraged to do this themselves)
 - making referrals via SCI-gateway given the self-referral route will no longer be available.
- CVD funding for GP health checks (age 30–60) may increase detection & referrals.
- Improvement plans to support digital innovation within Weight Management Services may help to streamline referrer workload.

Systems that require to be altered

The following systems may require updates to reflect the new criteria:

- RefHelp: updated referral pages, flowcharts and criteria definitions
- TRAK Care:
 - updated referrals
- TURAS data dashboards: updated outcome tracking aligned to new criteria
- Website & intranet content management systems

No significant change is required to core patient administration systems beyond updates to referral criteria and triage guidelines.

What information will you start or continue to collect and report on?	What impact are you measuring
<p>Equality data on people accessing the service, with a focus on improving ethnicity data.</p>	<p>Understand if there is over or under-representation of population groups compared to health and local population data and use this to identify any actions to remove disadvantage or meet needs.</p>

It is planned that the revised criteria and associated documentation will go live on 1st June 2026, following final sign-off and completion of communication, training, and system updates.