**Assessment for Relevance Form**

**Appendix 1 - Form A**

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

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| **What is being assessed:** | JumpStart Child Healthy Weight programme |
| **Named Officer / Directorate:** | Dr Ruth Campbell, Consultant Dietitian in Public Health Nutrition  Alan Brown, Health Improvement Officer |

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| **Protected Characteristics** | **Impact Rating**  Positive, Adverse or Neutral Impact | | **Rationale (provide evidence for your rating)** |
| **Socio-economic factors such as poverty, unemployment, discrimination, poor working conditions and a lack of education can all affect an individual‘s ability to access services. This can also be further broken down depending on protected characteristics (listed below).** | | | |
| **Age**   * Infants, children and young people * Adults | Positive  Positive | | Referrals accepted for children aged 2-17 with BMI on or above the 91st centile. Programme adopts a whole family approach therefore any siblings would benefit.  Programme includes all family members making positive health behaviour changes. Signposting to adult weight management programme also available. |
| **Disability** (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment, mental health) | Positive | | During screening and pre assessment participants are asked to detail any disabilities, this allows the provider to adopt a person centred approach by adapting the delivery route of the programme to suit individual needs. Programme also takes cognisance of disability and needs of parents, carers and family members.  Programme is adapted to meet needs of any child with any form of specific need.  We have a specific programme for children aged 5 – 17yrs with learning difficulties (JumpStart Plus) should the family feel their child’s needs are most suited to this programme. |
| **Gender** **Reassignment (trans)** | Neutral | | Referrals accepted for all children ages 2 – 17 years; programme is inclusive with no differential impact on gender reassignment. |
| **Marriage and Civil Partnership** | Neutral | | Referrals accepted for 16 and 17 year olds; programme is inclusive with no differential impact on marriage or civil partnerships. |
| **Pregnancy and Maternity** | Neutral | | Referrals accepted for those prior to conception and postpartum.  Programme would not be suitable to young women who are pregnant; other support is available from maternity services. |
| **Race / Ethnicity** | Neutral | | Referrals accepted; programme is inclusive. Programmes can be tailored to cultural beliefs. |
| **Religion / Faith** | Neutral | | Referrals accepted, programme is inclusive. Programmes tailored to religious beliefs. |
| **Sex (male/female/non binary)** | Neutral | | Referrals accepted, programme is inclusive. |
| **Sexual orientation** | Neutral | | Referrals accepted; programme is inclusive. |
| **If you have answered positive or adverse impact to any of the groups, an equality impact assessment should be carried out (see flowchart on page 4).** | | | |
| **Impact on socio-economic disadvantage?** | | **Rationale (provide evidence for your rating)** | |
| People living on a low income compared to most  others in Scotland | | Positive  At initial Well Chat, a range of options for delivery of programme is discussed and families choose which suits their needs best.  Face to Face delivery can be provided in the family home or within communities local to the individual and will be available during the day and at twilight sessions. Taxi provision can also be provided when required for those aged 5 – 17.  The option of digital programmes are available and can reduce financial burden of travelling to sessions. There may be potential negative impact of this option on families’ data usage and cost.  All children aged 5 – 17yrs are provided with a free pass to local health facilities such as swimming pools, gyms or sport centres for a limited period of time.  Families of children aged 2- 4 yrs are offered a leisure pass for a limited period of time.  As the programme advocates healthy eating and physical activity, consideration is given to the accessibility of healthy food and physical activity options i.e. families may be experiencing food insecurity or food poverty and access community supports where food provision can be limited. | |
| People living in deprived areas | | Positive  Programmes venues are often targeted within areas of higher deprivation.  At initial Well Chat, a range of options for delivery of programme is discussed and families choose which suits their needs best.  Face to Face delivery can be provided in the family home or within communities local to the individual and can be available during the day and at twilight sessions. Taxi provision can also be provided when required.  Digital programmes are also available, this form of delivery reduces financial burden of attending appointments, reduces the environmental impact due to a reduction in the need to travel.  All children aged 5 – 17 yrs are provided with a free pass to local health facilities such as swimming pools, gyms or sport centres for a limited period of time. Families of children aged 2- 4 yrs are offered a leisure pass for a limited period of time.  As the programme advocates healthy eating and physical activity, consideration needs to be given to the accessibility of healthy food and physical activity options i.e. families may be using food banks so there may be a lack of choice in content of parcels – Cheap & Nutritious (CAN) toolkit is available. | |
| People living in deprived communities of interest | | Positive  Programmes venues are often targeted within areas of higher deprivation.  At initial Well Chat, a range of options for delivery of programme is discussed and families choose which suits their needs best.  Face to Face delivery is provided in the family home or within communities local to the individual and will be available during the day and at twilight sessions. Taxi provision can also be provided when required.  Digital programmes are also available, this form of delivery reduces financial burden of attending appointments, reduces the environmental impact due to a reduction in the need to travel.  All children participating in the Jumpstart Tots programme are provided with a free pass to local health facilities such as swimming pools, gyms or sport centres for a limited period of time.  As the programme advocates healthy eating and physical activity, consideration needs to be given to the accessibility of healthy food and physical activity options i.e. families may be using food banks so there may be a lack of choice in content of parcels – Cheap & Nutritious (CAN) toolkit is available. | |
| Employment | | Positive  Programmes and classes can be scheduled to allow attendance out with parental/carer working hours and options for individual programmes are available. | |
| **If the policy involves a strategic decision you should carry out a** [**Fairer Scotland Duty**](https://www.gov.scot/publications/fairer-scotland-duty-interim-guidance-public-bodies/) **Assessment.** | | | |

##### EQUALITY IMPACT ASSESSMENT

**Appendix 2 - Form B**

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

**If you require advice on the completion of this EQIA, contact** [**elaine.savory@aapct.scot.nhs.uk**](mailto:elaine.savory@aapct.scot.nhs.uk)

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

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| **Name of Policy** | Ayrshire & Arran Jumpstart Programme | | |
| **Names and role of Review Team:** | Initial review team:  Alan Brown, Health Improvement Officer – Child Healthy Weight  Elaine Jocelyn, Dietetic Health Improvement Team Lead  Donna Gilgallon, Dietitian, Dietetic Health Improvement Team  Carol McGregor Service Manager, Early Years Development, East Ayrshire Council  Reviewed by:  Alan Brown, Health Improvement Officer – Child Healthy Weight  Elaine Jocelyn, Dietetic Health Improvement Team Lead | Date(s) of assessment: | 01/11/2021  Updated 31/08/23 |
| **SECTION ONE** | AIMS OF THE POLICY | | |
| * 1. **Is this a new or existing Policy :**   x  **Please state which: Policy Strategy Function Service Change Guidance Other**  Continuation of NHS Ayrshire & Arran’s Child Healthy Weight programme aimed at children and young people on or above 91st BMI centile | | | |
| **1.2 What is the scope of this EQIA?**  x  **NHS A&A wide Service specific Discipline specific Other (please detail)**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **1.3a. What is the aim?**  Continuation of implementation of the minimum standards delivery of Tier 2 weight management services for children and young people in Ayrshire.  The aim of this programme is to help children and young people move towards achieving a healthier weight by providing support, advice and education, which in turn will reduce the long term physical and psychological complications for the individual, family and population, and reduce the impact on health care services in relation to demand and overall cost**.**  It is estimated that, without action, by 2050 obesity related diseases will cost society £50billion per year. The NHS costs attributable to overweight and obesity are predicted to increase in the UK to £10billion per year by 2050 (Tackling Obesity: Future Choices – Modelling Future Trends in Obesity and Their Impact on Health, 2007).  Being overweight or obese has a significant impact on health (SIGN, 2010). Those who are overweight or obese are more likely to suffer from physical and psychological comorbidities. Given the clear health and financial implications of obesity, NHS Ayrshire and Arran’s Healthy Weight Strategy (2014-2024) states that supporting the population to achieve a healthy weight is a priority. It describes promoting healthy weight as a challenge that requires commitment, expertise, effective practice and strong leadership. The Ayrshire Healthy Weight strategy aims to utilise these qualities to work towards reducing overweight and obesity among children and adults living in Ayrshire and support maintenance of a healthy weight across the population. | | | |
| **1.3b.What is the objective?**  Deliver targeted Tier 2 family centred programme to families with children on or above the 91st BMI centile in Ayrshire and Arran by ensuring a consistent, equitable and evidence-based approach to the treatment of overweight and obesity for children and young people. The programme provides initial consultation, structured group or 1:1 interventions up to eight weeks initially with person centred support and ongoing maintenance support for one year. Each session includes an exercise/play component, nutrition education and health behaviour change element. Referrals are accepted via self-referral, GPs, education, third sector and other Health and Social Care Professionals for school aged children. Referrals for children under 5 are accepted via request for assistance.  Please see attached ‘NHS Health Scotland (2019). Standards for the Delivery of Tier 2 and Tier 3 Weight Management Services for Children and Young People.in Scotland.’  <http://www.healthscotland.scot/media/2658/standards-for-the-delivery-of-tier-2-and-tier-3-weight-management-services-for-children-and-young-people-in-scotland-english-oct2019.pdf> | | | |
| **1.3c. What are the intended outcomes?**  National outcomes   * Improved consistency, equitability and effectiveness of weight management services to support better outcomes for children and young people across Scotland. * Improved early identification of child and family needs, allowing timely and appropriate responses. * Improved long-term resource planning to support the development, implementation and delivery of these services. * Services designed for and delivered to those who need it most – focused on reducing health inequalities, improving health equity and health literacy. * Children, young people and families are supported and empowered to make positive and sustainable changes to their health and wellbeing. * Improved monitoring and evaluating of weight management services for children and young people. * Promotion and facilitation of continual improvement, forward planning and shared learning across NHS Boards.   Local outcomes   * There is collective leadership and commitment to childhood obesity, including consistency of messaging about good nutrition and healthy eating habits across the age group criteria (2 – 17) * Practitioners have the skills, confidence and knowledge to support children and families to eat well, be active and have a healthy weight. * Parents feel better equipped and confident to provide their children with a healthy lifestyle including positive physical activity and healthy eating habits. * More families at risk of diet-related health inequalities are engaging with services and accessing support. * Children and families eat more fruit and vegetables and less energy-dense foods. * Children and families are more active. * Children and families adopt positive health behaviours such as less screen time and positive sleeping habits. | | | |
| **1.4. Who is this policy intended to benefit or affect? In what way? Who are the stakeholders?**  The beneficiaries of the policy are children aged 2 to 17 years who are on or above the 91st centile with engagement from wider family members/care givers who will receive direct input from programme staff in the form of information, education and direct support.  There are a wide range of stakeholders; children and families, Public Health, NHS services, education services, third sector, local authority leisure services, nutrition and dietetic services. | | | |
| **1.5. How have the stakeholders been involved in the development of this policy?**  Consultation with providers of the service  Consultation with Public Health  National Advisors at Scottish Government allow for feedback between the organisations  We have a robust governance structure in place in order to support the implementation of the standards. | | | |
| **1.6 Examination of Available Data and Consultation –**  Data on the prevalence of overweight and obesity among children in Primary 1 is published annually by Public Health Scotland. Data for school year 2020/21 showed that 66.3% of children in NHS Ayrshire & Arran were a healthy weight, 14% were at risk of overweight and 18.5% were at risk of obesity. Data for the previous school year (2019/20) showed that 76.2% children were a healthy weight, 12.2% were at risk of overweight and 10.5% were at risk of obesity.  Data on children’s BMI at 27-30 months is not published nationally however an annual data request is submitted to Public Health Scotland for NHS Ayrshire & Arran’s data. This data showed that in 2020/21, 61.3% of children at this age were a healthy weight, 18% were at risk of overweight and 19.9% were at risk of obesity. Data for the previous year (2019/20) showed that (64.9%) were a healthy weight, 18.3% were at risk of overweight and 16.1% were at risk of obesity.  We utilised the professional publication: Standards for the delivery of tier 2 and tier 3 weight management services for children and young people in Scotland.  Prior to 2019, there was a lack of standardised information collected by NHS boards in relation to provision of weight management services. Approved by the Scottish Type 2 Diabetes Framework Oversight Group, the core dataset was developed in collaboration with the Scottish Government (SG), Public Health Scotland (PHS) and NHS boards.  NHS boards commenced data collection on new referrals from 1 October 2019 and agreed to make their data available to PHS for the purposes of this report (Referrals to NHS Board Commissioned Weight Management Services Tier 2 and Tier 3, May 202). The core dataset was introduced to support the evaluation of the Type 2 Diabetes Prevention, Early Detection and Early Intervention Framework and Standards for the Delivery of Tier 2 and Tier 3 Weight Management Services for Children, Young People and Adults in Scotland. It also assists local evaluation and service planning. The first report was published in May 2021.  The core dataset applies to all NHS board commissioned services (Tier 2 and Tier 3) for children and young people and adults, whether provided by the NHS, local authorities, commercial organisations or voluntary/third sector organisations. | | | |
| **Name any experts or relevant groups / bodies you should approach (or have approached) to explore their views on the issues.**  We are involved with the Scottish Healthy Weight Leads network.  Locally, we have a robust governance structures and have feedback strategies in place for example Dietetic Governance and Paediatric Governance. | | | |
| **What do we know from existing in-house quantitative and qualitative data, research, consultations, focus groups and analysis?**  The school aged programme has been evaluated on three occasions (2011, 2014 and 2018) as well as initial evaluation of the pre five programme by the Public Health research team in NHS Ayrshire & Arran. Recommendations from the evaluations have been incorporated into the current delivery model**.** A range of programme stakeholders including referrers, families and programme staff (managers and Health Coaches) were interviewed to examine different views and experiences of the programmes. The intention was primarily to assess the strengths and limitations of the programme, to look for common themes in the views and experiences reported, and also to explore suggestions for programme improvement which were then taken into the latest format of delivery.  The most recent evaluation of the JumpStart programme aged 5 – 15 has emphasised that there were improvements to health and wellbeing during participation in the Jumpstart programme. Specifically, there were improvements in relation to reduction of BMI and BMI-SDS, total activity, days physically activity and child-rated health-related quality of life at the end of the 10 week programme, however, fruit and vegetable consumption, adult-rated health-related quality of life and BMI and BMI-SDS were not maintained at follow-up.  Initial evaluation of the pre five programme focused on the development process of the intervention and has highlighted generally positive changes in weighing and measuring practice of health visiting staff. | | | |
| **What do we know from existing external quantitative and qualitative data, research, consultations, focus groups and analysis?**  Scottish Government issued the core dataset to NHS Boards and asked that weight management services start collection in accordance with the common definitions on new referrals from 1 October 2019. A national report was published by Public Health Scotland (PHS) on 18 May 2021 after NHS Boards were asked to provide a central submission of their core dataset on new referrals between 1 October 2019 and 30 September 2020. The report can be accessed from the Public Health Scotland website (<https://publichealthscotland.scot/publications/referrals-to-nhs-board-commissioned-weight-management-services/referrals-to-nhs-board-commissioned-weight-management-services-1-october-2019-to-30-september-2020/>.)  Data was then produced for each individual NHS Board as a means to complement the national report and allow exploration of the breakdown of Ayrshire and Arran data in comparison with the Scotland totals. It also provides options to break down Ayrshire and Arran data at individual service level.  The establishment of NHS Health Scotland (2019). Standards for the Delivery of Tier 2 and Tier 3 Weight Management Services for Children and Adults in Scotland’ crucially supports ‘A Healthier Future – Framework for the Prevention, Early Detection and Early Intervention of Type 2 Diabetes’.  The purpose of these standards is to ensure a consistent, equitable and evidence-based approach to the treatment of overweight and obesity for children and adults across weight management services in Scotland. Informed by local discussion with NHS Boards and the issues highlighted by Logue and colleagues (Variations in weight management services in Scotland: A national survey of weight management provision 2016) NHS Health Scotland also carried out a mapping exercise of weight management services across Scotland in 2017–18, which provided a more up-to-date overview of current services. Again, this exercise highlighted the need for a more consistent and equitable approach to the provision and delivery of weight management services for children and adults.  With broad consensus for the need for development of standards for weight management services, NHS Health Scotland convened an expert reference group which included representation from service leads, dietitians, clinical psychology, physical activity professionals, NHS Health Scotland staff, Scottish Government policy leads and academics. These standards have been informed by best available evidence including the National Institute for Health and Care Excellence (NICE) guidelines, Scottish Intercollegiate Guidelines Network (SIGN) guidelines, Public Health England (PHE) work on commissioning and delivering children and adult tier 2 weight management services, British Obesity and Metabolic Surgery Society (BOMSS) commissioning guide for weight assessment and management clinics (tier 3) British Dietetic Association (BDA) Dietetic Obesity management interventions in adults, learning from good practice across Scotland and emerging evidence. These standards have also been subject to peer review by the British Dietetic Association and are endorsed by the British Dietetic Association and the British Psychological Society (BPS). | | | |
| **1.7. What resource implications are linked to this policy?**  This programme requires a variety of resource including local authority and third sector accommodation e.g. early years centres, schools, leisure centres and sports clubs, resources in order to deliver the programme as intended include physical resource as well as time from dedicated CHW staff. | | | |

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| **SECTION TWO** | IMPACT ASSESSMENT | | | |
| **Complete the following table, giving reasons or comments where:**  **The Programme could have a positive impact by contributing to the general duty by –**   * **Eliminating unlawful discrimination** * **Promoting equal opportunities** * **Promoting relations within the equality group**   **The Programme could have an adverse impact by disadvantaging any of the equality groups. Particular attention should be given to unlawful direct and indirect discrimination.**  **If any potential impact on any of these groups has been identified, please give details - including if impact is anticipated to be positive or negative.**  **If negative impacts are identified, the action plan template in Appendix C must be completed.** | | | | |
| Equality Target Groups – please note, this could also refer to staff | | | | |
|  | Positive impact | Adverse impact | Neutral impact | Reason or comment for impact rating |
| **2.1. Age**   * Infants, children and young people * Adults * Older People | √  √  √ |  |  | This programme specifically targets interventions at this age group.  Parents, carers and family members attend and benefit from advice and support to change their own behaviours towards a healthy lifestyle.  Older family members may attend the programme. Children maybe in kinship with grandparents or older family relatives as the main carers at that time. |
| **2.2. Disability** (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment, mental health) | √ |  |  | As part of the screening process and pre assessment paperwork participants are asked to detail any additional needs or highlight any disabilities. This allows the providers to adopt a person centred approach by adapting the delivery route of the programme to suit individual needs. The providers can adopt a person centred approach by adapting the delivery route of the programme to suit the individual.  The team is aware that there are numerous hidden disabilities and that through communication the individual can successfully engage with the programme e.g. asking what support is needed to engage with an individual i.e. assist with completion of paperwork, option of remote access or to bring a significant other to allow the person to have a buddy/carer available to support them during the programme etc.  Referrals for those with sensory impairment are accepted.  If the child or young person is registered with Contact Scotland (<https://contactscotland-bsl.org/> ) they can be supported to participate, if not registered BSL interpreters can also be sourced.  NHS Ayrshire & Arran with RNIB provides an Eye Clinic Liaison Officer Service and support for people with sight loss can be sourced from this service.  For school aged children who present with learning disabilities there is an adapted JumpStart programme – JumpStart Plus. |
| **2.3. Gender** **Reassignment** |  |  | √ | Referrals are accepted for all children under 18 and there would be no differential impact on gender re-assignment. |
| **2.4 Marriage and Civil partnership** |  |  | √ | Referrals are accepted for young people aged 16 and 17 and there would be no differential impact on marriage and civil partnership. |
| **2.5 Pregnancy and Maternity** |  |  | √ | Referrals are accepted for young people prior to conception or postnatally. Pregnant young women would be under the care of a midwife and as their main health care practitioner, would give person centred advice. |
| **2.6 Race/Ethnicity** |  |  | √ | Children and young people of any race or ethnic backgrounds are able to be referred to the programme.  Information is be tailored to ensure it is culturally appropriate. We are able to utilise additional resources as and when required.  Where language barriers exist information is provided in a format or language suitable to their needs to make sure they are fully informed of the programme and communications relating to it through NHS Ayrshire & Arran’s Communication team. For those who require additional language support, existing organisational processes will be implemented to support clear communication between the individual and the health care practitioner. |
| **2.7 Religion/Faith** |  |  | √ | Referrals are accepted from all children aged 2 to 17 and there would be no differential impact on this client group.  However we recognise that some religions may not accept some or all interventions offered. |
| **2.8 Sex (male/female)** |  |  | √ | Referrals are accepted from all children aged 2 to 17 and there would be no differential impact on this client group. |
| **2.9 Sexual Orientation**   * Lesbians * Gay men * Bisexuals |  |  | √ | Referrals are accepted from all children aged 2 to 17 and there would be no differential impact on this client group. |
| **2.10 Carers** |  |  | √ | Referrals are accepted from all children aged 2 to 17 and there would be no differential impact on this client group.  **Mitigation** All children/young people are offered a variety of appointment times which would provide flexibility in attendance. If the child/young person is attending with a carer we are able to facilitate this and have an adaptable and flexible process for this. Likewise any children/young people who are carers are offered flexibility to attend the sessions. |
| **2.10 Homeless** |  |  | √ | Referrals are accepted from all children aged 2 to 17 and there would be no differential impact on this client group. |
| **2.12 Involved in criminal justice system** |  |  | √ | Referrals are accepted from all children aged 2 to 17 and there would be no differential impact on this client group. |
| **2.13 Literacy** |  |  | √ | Referrals are accepted from all children aged 2 to 17 and there would be no differential impact on this client group.  **Mitigation:** Delivery route/programme can be altered to meet the needs of the child/young person e.g. information in alternative formats, 1:1 programme. |
| **2.14 Rural Areas** |  |  | √ | Referrals are accepted from all children aged 2 to 17 and there would be no differential impact on this client group.  **Mitigation:** Services can be delivered face to face in local communities however the COVID-19 pandemic enabled us to utilise digital platforms which has reduced access issues in rural communities where travel may have been a barrier previously. |
| **2.15 Staff**   * Working conditions * Knowledge, skills and learning required * Location * Any other relevant factors |  |  | √ | Staff delivering the Child Healthy Weight Programmes have received training in order to deliver the programme. In addition, they are also supported to attend additional training to deliver and facilitate the programme as required and have competencies reviewed annually.  Locations in which staff are asked to deliver the programme have been appropriately risk assessed. |

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| **2.16. What is the socio-economic impact of this policy / service change? (The** [**Fairer Scotland Duty**](https://www.gov.scot/publications/fairer-scotland-duty-interim-guidance-public-bodies/) **places responsibility on Health Boards to actively consider how they can reduce inequalities of outcomes caused by socio-economic disadvantage when making strategic decisions)** | | | | |
|  | **Positive** | **Adverse** | **Neutral** | **Rationale/Evidence** |
| **Low income / poverty** | √ |  |  | Group sessions can be delivered face to face in a local, accessible venue to the child/young person. Sessions delivered at a variety of times.  Digital delivery reduces financial burden of attending centralised appointments and can be delivered at suitable to the group or family. Digital delivery also reduces the environmental impact as there is a reduction in the need to travel. However digital delivery may exclude people due to digital poverty/poor digital infrastructure and lack of digital skills.  **Mitigation:** Programme can be delivered by telephone if digital literacy/exclusion is highlighted or is a concern, or face to face if experiencing digital exclusion.  Programmes are considered and targeted to areas of lower SIMD data zones |
| **Living in deprived areas** | √ |  |  |
| **Living in deprived communities of interest** | √ |  |  |
| **Employment (paid or unpaid)** | √ |  |  |

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| **SECTION THREE** | **CROSSCUTTING ISSUES** | | | |
| **What impact will the proposal have on lifestyles? For example, will the changes affect:** | | | | |
|  | Positive impact | Adverse impact | No impact | Reason or comment for impact rating |
| **3.1 Diet and nutrition?** | √ |  |  | Education programme focussed on health and wellbeing including lifestyle factors such activity opportunity, nutrition, parental health behaviour.  As the programme advocates healthy eating and physical activity consideration needs to be given to the accessibility of healthy food and physical activity options i.e. families may be using food banks so there may be a lack of choice in content of parcels – Cheap & Nutritious (CAN) toolkit is available. |
| **3.2 Exercise and physical activity?** | √ |  |  | As above  School aged children and young people participating in the programme receive a free leisure pass for duration of programme, links are made to partner organisations such as Active Schools and local physical activity clubs. |
| **3.3 Substance use: tobacco, alcohol or drugs?** |  |  | √ | Not addressed within education programme however if disclosed onward referrals can be sought to appropriate services. |
| 3.4 Risk taking behaviour? |  |  | √ | Not addressed within education programme however if disclosed onward referrals can be sought to appropriate services. |

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| **SECTION FOUR** | **CROSSCUTTING ISSUES** | | | |
| **Will the proposal have an impact on the physical environment? For example, will there be impacts on:** | | | | |
|  | Positive impact | Adverse impact | No impact | Reason or comment for impact rating |
| 4.1 Living conditions? |  |  | √ | Delivered within family homes or centres close to homes. Able to signpost to local services for those who require further specific input relating to poverty, housing and employment. |
| **4.2 Working conditions?** |  |  | √ | As above |
| **4.3 Pollution or climate change?** |  |  | √ | Digital methods of delivery of child healthy weight programmes have a positive impact on the environment. Delivery is flexible with face to face, telehealth and digital pathways available. Delivery in local communities at times that suit reduces the need for travel to centralised locations; this has also been positively impacted by the development of the digital pathways. |
| **Will the proposal affect access to and experience of services? For example:** | | | | |
|  | Positive impact | Adverse impact | No impact | Reason or comment for impact rating |
| **Health care** | √ |  |  | Improved access to relevant education relating to lifestyle and will aim to address health and wellbeing to reduce the risk of developing weight related health comorbidities and subsequent complications. |
| **Social Services** |  |  | √ | Referral procedure in place.  Close liaison and communication with child’s named person and participation in multi-disciplinary meetings as appropriate for pre fives. |
| **Education** |  |  | √ | Referral procedure in place. |
| **Transport** | √ |  |  | Delivery is flexible with face to face, telehealth and digital pathways available. Delivery in local communities at times that suit reduces the need for travel to centralised locations; this has also been positively impacted by the development of the digital pathways.  Taxi service available if need is requested for Jumpstart participants. |
| **Housing** | √ |  |  | Signpost to local services for those who require further specific input relating to poverty, housing and employment. |

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| **SECTION FIVE** | | **MONITORING** | | |
| **How will the outcomes be monitored?**  Weight, BMI – Standard Deviation Score, fruit and vegetable intake, Peds QL scores, physical activity levels | | | | |
| **What monitoring arrangements are in place?**  Pre and post assessments in place which collect measurements and complete paperwork. Weight, height, BMI taken, Peds Ql of child completed by parent. | | | | |
| **Who will monitor?**  Programme staff - Health Coaches, Dietitian, Dietetic Assistant practitioners. Reporting data uploaded to Public Health Scotland Core Data Set. | | | | |
| **What criteria will you use to measure progress towards the outcomes?**  Outcomes of the programme are measured externally against the Child Healthy Weight Standards. The Scottish Government report on the Child Healthy Weight programme using information provided in the core dataset which is externally evaluated by the Scottish Government. | | | | |
| **PUBLICATION** | | | | |
| Public bodies covered by equalities legislation must be able to show that they have paid due regard to meeting the Public Sector Equality Duty (PSED). This should be set out clearly and accessibly, and signed off by an appropriate member of the organisation.  Once completed, send this completed EQIA to the **Equality & Diversity Adviser** | | | | |
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| **Authorised by** | Ruth Campbell | | **Title** | Consultant Dietitian in Public Health Nutrition |
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| **Signature** | Ruth Sig | | **Date** | 03/08/23 |

**Appendix 3: Form C**

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| **Identified Negative Impact Assessment Action Plan** |

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| **Name of EQIA:** | JumpStart programme – Child Healthy Weight |

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| **Date** | **Issue** | **Action Required** | **Lead (Name, title, and contact details)** | **Timescale** | **Resource Implications** | **Comments** |
| 02/11/21 | Development of updated resources to support Child Healthy Weight Programme | Ask communications team to review all local resources associated with programme to ensure Plain English and literacy levels | Alan Brown  Health Improvement Officer  [Alan.brown2@aapct.scot.nhs.uk](mailto:Alan.brown2@aapct.scot.nhs.uk) | 21.01.23 | Resources used to support the programme may need to be updated – time and costs | Our latest information leaflet and poster is with our communications team being reviewed in line with best practice guides to Plain English and health literacy.  Development of a digital landing page on the external website, which will host information on CHW programmes is underway. |
| 02/11/21 | Psychological Care | Develop and implement a training strategy to enhance psychological skills in staff involved in weight management services. | Alan Brown  Health Improvement Officer  [Alan.brown2@aapct.scot.nhs.uk](mailto:Alan.brown2@aapct.scot.nhs.uk)  Develop and implement a training strategy to enhance psychological skills in staff involved in weight management services. | Ongoing |  | This is ongoing  CHW staff have attended Trauma Informed Practice session and completed advised Webinars. |
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| Further Notes: |  |

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| Signed: | Ruth Sig | Date: | 31/08/23 |