Agenda item number: 6

COMMITTEE	**HEALTH AND COMMUNITY SERVICES OVERVIEW AND SCRUTINY COMMITTEE**
DATE	**13 SEPTEMBER 2005**
TITLE OF REPORT	**OBESITY STRATEGY**
RESPONSIBLE OFFICER	**Anita Sims, Director of Public Health**

1 PURPOSE OF THE ITEM

1.1 To present a report to the committee on the Obesity Strategy for Medway.

2 RECOMMENDATIONS

2.1 That the committee consider and comment on the Obesity Strategy.

3 BACKGROUND

3.1 The Public health White Paper, 'Choosing Health', the NSFs (National Service Frameworks) for CHD (Coronary Heart Disease), diabetes and the NHS cancer plan state the need to prevent and reduce obesity in order to reduce morbidity and mortality related to heart disease, diabetes and cancer. Stakeholders from statutory and voluntary agencies have worked together on the development of a strategy for tackling obesity in Medway. The Medway Obesity Strategy was presented to Primary Care Trust board in March, it was agreed that a consultation would be undertaken and an implementation plan developed. This report incorporates the results of this consultation and presents a plan for taking forward the strategy in Medway, being led by an 'Obesity Action Group'-a Choosing Health subgroup.

4. THE OBESITY STRATEGY

4.1 Obesity is undoubtedly the major nutritional disorder of the western world. Moreover as the problem appears to be increasing rapidly in children as well as in adults the true health consequences may only become apparent in the future. England is facing an epidemic of obesity and on present trends obesity will soon surpass smoking as the greater cause of premature loss of life. It will bring levels of illness that will put significant strains on the local NHS. Medway is experiencing this epidemic locally and local survey data suggests that up 50% or more of the adult population of Medway may be overweight, 15% obese.

4.2 Choosing health, the Public Health White paper, November 2004, describes the need to support people to make healthy choices and the process for doing so, this strategy takes forward the impetus of this White Paper in Medway, outlining a way forward for supporting people in Medway to Choose Health by preventing obesity.

4.3 We need a coordinated and planned approach throughout Medway to obesity prevention and treatment and general weight management. This strategy summarises the issues and evidence relating to obesity and suggests a number of options, which would contribute to improving health in Medway.

4.4 An Executive Summary of the Obesity Strategy is attached as Appendix A. A full copy of the Strategy (70 pages) can be obtained via the report author or the Overview and Scrutiny Co-ordinator by request.

5. BACKGROUND DOCUMENTS

- Medway Obesity Strategy, March 2004
- The Public Health White Paper, Choosing Health, making healthy choices easier, Department of Health, November 2004
- Choosing Health Delivery Plans, Department of Health, March 2005

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APPENDIX A

INTRODUCTION AND VISION

Following the Medway PCT obesity strategy being presented to board and PEC in March 2005 it was agreed that a consultation should be undertaken to inform the development of an implementation plan for the strategy.

The consultation was focussed on an 'Obesity Conference' which took place at the Sunlight Centre in Gillingham on June 10th, providing an opportunity for stakeholders to explore and feedback on some of the issues raised by the strategy. The conference was attended by over 100 people and there were 5 plenary presentations and 12 workshops, providing a great deal of opportunity for stakeholders from many backgrounds to participate in the consultation. Forty-two written feedback submissions on the strategy were received; these and many of the issues raised at the conference have been incorporated into the implementation plan.

The publication of the Public Health White Paper, Choosing Health has pushed forward the obesity agenda and is the key policy driver for tackling obesity, particularly childhood obesity at the local level. The local Medway obesity strategy brought to board in March shows a strong focus to design and develop services for:

- Dietary improvement
- Increasing physical activity
- Provision of services around obesity care pathways for adults and children
- Increasing the health improvement workforce

The overall aim of the local Medway obesity strategy is to:
To reduce the burden of death, disability and distress due to overweight and obesity in the population of Medway by, preventing overweight and obesity developing in the community, and managing existing cases of obesity.

This focus and aim has been endorsed by the consultation on the strategy.

ESTABLISHING AN OBESITY ACTION GROUP FOR MEDWAY

'Choosing Health' emphasises the importance of partnership working. It is particularly important for the group that is formed to implement the obesity strategy to be able to demonstrate stakeholder involvement and subsequent input into the Local Strategic Partnership.

Establishing the 'obesity action group': identifying key partners

Tackling overweight and obesity at local level requires a 'whole systems' approach to increase physical activity levels and to promote a balanced diet. This involves a range of partners in ensuring that it meshes appropriately with related strategies and policies.

Feedback from the conference suggested that it was important to have stakeholders on the group who:

- Are affected by, or significantly affect the issue
- Have information, knowledge and expertise about the issue
- Control or influence implementation instruments relevant to the issue.

Key membership of the 'obesity action group' will include representation from the following:
Public health, health visiting, school nursing, dietetics, primary care, education, leisure services, planning and parks, police and community safety partnerships, secondary care, community groups and voluntary bodies, local employers, local media.

The strategy and consultation provides a clear remit and the initial task of the action group is to develop a work plan for action. The obesity action group will be created specifically to coordinate action relating to the elements most relevant to tackling overweight and obesity.

TASKS FOR ACTION GROUP: REVIEW CURRENT ACTIVITY AND GAPS

This will involve an audit of local services, initiatives and infrastructure including protocols, procedures, pathways and practice, to find out:

- What is currently happening?
- Where are the gaps?
- What are the priorities?
- What are the opportunities for development?

The implementation of the strategy is most practically constructed around the main settings for the various interventions. These are likely to include home (including pre-school), school, workplace, community, primary care and media. **Appendix 1** provides a checklist for the three areas where action will be focused, i.e. prevention, management and infrastructure. This checklist will be used when reviewing current activity and assessing how well services and initiatives are delivering in the various settings.

PRIORITIES

A wide range of possible initiatives and interventions, both in terms of prevention and management, decisions will have to be made about where to focus efforts. For any proposed initiative or infrastructure component, the following questions should be addressed:
• How well does it meet needs?
• Which groups are missing out?
• What development or further action is needed?

INTERVENTIONS

A fundamental aspect of planning the work of Obesity Action Group is to consider which of the many possible interventions or actions should be undertaken locally. Decisions will be based on various factors, including:

- Evidence of effectiveness
- Cost-effectiveness
- Available resources
- Timeframes
- Organisational and political pressures.

PREVENTING OBESITY

Obesity prevention does not simply mean preventing normal weight individuals from becoming obese. Rather, it encompasses a range of approaches that aim to prevent the:

- Development of overweight in normal weight individuals
- Progression of overweight to obesity in those who are already overweight
- Weight regain in those who have been overweight or obese in the past but who have since lost weight.

The prevention part of the strategy implementation will be is based on a 'healthy lifestyles' and 'life course' approach and will include interventions starting from childhood to:

- Improve diet and nutrition
- Increase community-wide levels of physical activity

A practical framework for local programmes is the 'healthy settings' approach, which focuses on interventions in a number of key settings to develop a coordinated programme for obesity prevention. There are many possible settings to develop: from home to hospital, from park to prison, and from community group to club or pub. Each provides a particular opportunity to influence people's eating, drinking and physical activity habits. A simple range of settings for preventing overweight and obesity in line with the obesity strategy and the resulting consultation are in **Appendix 2**.

MANAGING OBESITY

The complementary strand to the wider community based approach to implementing the obesity strategy is assessing and managing overweight and obese patients, appropriately in primary care and also in the community and hospital setting.

Tackling overweight and obesity by improving diet and nutrition and increasing physical activity in primary care

Effective weight control involves multiple techniques and strategies including improving diet and nutrition, increasing physical activity, behaviour therapy, pharmacotherapy and surgery. However, before any treatment is proposed, the possible reasons for the excess weight in an overweight or obese person and possible metabolic co-morbidities should be comprehensively assessed. National clinical guidance and general guidance has been established to ensure that there is a systematic approach to the assessment and management of overweight and obesity. Examples of guidance are available but as yet, England does not have clinical guidance but NICE are developing guidelines to be published in 2007. The Department of Health is producing a care pathway later in 2005 for the prevention and management of overweight and obesity in adults and children ahead of the NICE guidance.

An example of an intervention to manage overweight and obesity is weight control groups and more recently, slimming on referral schemes, (This option received a lot of support from consultation respondents). A number of PCTs are

working with the commercial sector, most notably, Slimming World and Weight Watchers, to support patients whose weight is threatening their health.

ROLES OF HEALTH PRACTITIONERS

Roles of health practitioners are extremely important for ensuring that interventions can be developed and actioned effectively. There is evidence to support the improving role of health professionals in the management of overweight and obesity in particular by:

- Reminders to GPs to prescribe diets
- A brief educational training intervention on obesity management delivered by behavioural psychologists to GPs
- Encouraging shared care between GPs and a hospital service
- Use of inpatient obesity treatment services
- Training for both health professionals and leaders of self-help weight loss clinics.

Some health professionals such as pharmacists are becoming more aware of the importance of their role in providing advice to overweight and obese patients. The Royal Pharmaceutical Society of Great Britain (2005) has produced guidance for community pharmacists that provide advice on overweight and obesity. Dietitians Working in Obesity Management (DOM UK) have produced a directory *Obesity Training Courses for Primary Care* that is a directory, which provides details of a range of training, which specifically targets obesity management and provides contact details of trainers.

MILESTONES

The following are proposed achievable milestones for local action to tackle overweight and obesity:

NO.	MILESTONE	DEADLINE
PARTNERSHIP		
1	The action team should have the explicit commitment of each partner organisation to develop a shared approach.	End of year 1
	Identified a named link person for each partner organisation.	
	Conducted a needs assessment (including equity profiles of access to services).	
	Developed a systematic approach to involving the community.	
	Agreed aims, targets, and an outline action plan.	
	Agreed each partner's lead responsibilities for each main component of the plan.	
	Built in a mechanism for reporting progress to the boards of each partner organisation.	
2	Each partner organisation should have a systematic approach to achieving the agreed objectives/changes.	End of year 2
	An agreed mechanism for assessing the impact of its policies on both healthy eating opportunities and physical activity opportunities.	
3	Each partner organisation should have recent quantitative data to monitor the above, integrated into its information strategy.	End of Year 3

	A systematic process for assessing performance and evaluating progress (see below).	
PRIMARY CARE		
1	Practices should have a systematically developed and maintained practice-based register of people who are also known to be overweight or obese	End of year 2
	Practices should have an agreed weight management protocol (describing the systematic assessment, goal setting, lifestyles advice, medication, referral criteria, follow-up arrangements, and auditing) for people in the priority groups who are known to be, or found to be, overweight/obese. Many practices will choose to deliver their structured care through nurse- or dietitian-led clinics.	
2	Practices should have clinical audit data no more than 12 months old describing items listed above.	End of year 3
SPECIALIST SERVICE		
1	The specialist service should have an effective systems of setting standards for obesity management A systematic approach to determining whether agreed clinical standards are being met.	End of year 1
2	The specialist service should have an agreed protocol for the assessment and management of people who have been referred for specialist management of their obesity.	End of year 2
3	The specialist service should have clinical audit data no more than 12 months old that describes key items concerning the above and that demonstrates that there is equitable access to the service.	End of year 3
	Clinical audit data no more than 12 months old that demonstrates that at least 85% of people referred for specialist management of their obesity have maintained some weight loss six months after their initial consultation, and that 30% have maintained a weight loss of at least 10% of their presenting weight	

INFRASTRUCTURE SUPPORT

The main issues concerning infrastructure support to implement the obesity strategy are around the need to:

- Involve the public, patients and carers
- Build capacity in terms of staff, equipment and facilities
- Set up appropriate education and training programmes
- Ensure effective IT systems to support information capture
- Ensure good communications, and
- Ensure that any planned new developments for services and interventions are prioritised within the funding processes
-

MONITORING AND EVALUATION

Evaluation of the strategies and current and new programmes for overweight and obesity is central for:

- Clinical governance
- Audit and quality improvement
- Providing information to the public
- Strategy and performance development
- Assessing value for money
- Assessing sustainability, and
- Increasing the evidence base.

The evaluation process must be incorporated into obesity action group work plan and the milestones agreed, with expanded aims, objectives and targets. Evaluation of community projects is not easy but must be incorporated.

The key areas to evaluate will include:

- Measuring indicators of progress, including progress towards targets
- Assessing how well various aspects of the strategy were perceived to work from the viewpoint of professionals and communities
- Assessing whether the changes were a result of the intervention.

MAINSTREAMING AND SUSTAINABILITY

Effective changes in practice must be sustainable and 'mainstreamed' in terms of continued funding or service change. This is particularly true of preventive lifestyle initiatives, which often have less measurable, less attributable, and shorter-term outcomes than interventions to manage overweight and obesity- this endorses the need for effective monitoring and evaluation.

Appendix 1

For each service, initiative or infrastructure component, the following questions should be addressed:

• How well does it meet needs?
• Which groups are missing out?
• What development or further action is needed?

Each partner agency is usually best placed to undertake the mapping for its own sphere of influence and to feed its findings into the audit.

For each service or initiative listed/planned:

• How well does it meet needs? Measure using ranking scale 1, 2 or 3 (3 being the highest score)
• Specify which groups are missing out?
• Specify what development or further action is needed?

Service/initiative	How well does it meet needs? (1, 2 or 3)	Which groups are missing out?	What development or further action is needed?
PREVENTION			
Home			
School			
Workplace			
Community			
Primary care			
MANAGEMENT			
Community			
Primary care			
Hospital			
INFRASTRUCTURE			
Training			
IT systems			
Premises			
Workforce planning			
Sustainable funding			
…..and so on…..			

Appendix 2

SETTING	MAIN TARGET GROUP(S)
Home (including pre-school)	Infants, pre-school children and their parents or carers
School	School-age children, parents, teachers, school governors
Community groups and faith groups	Minority groups e.g. people with cultural or ethnic identities, refugees and asylum seekers, travellers, homeless people
Workplace	Employees and employers, and their families, catering providers
Leisure outlets	General public and specific sub groups (e.g. older people)
Retail and commerce outlets	General public and specific sub groups (e.g. younger people), food retailers, catering providers
Primary and community care including community pharmacies and community health services	Patients, carers, primary care staff
Hospital	Patients, carers, hospital staff including catering providers
Media	General public and specific sub groups (e.g. younger people, older people)

Source: Adapted from Maryon-Davis, 2005

SETTING	POTENTIAL PARTNERS and suggested programmes/interventions
Home	
Early life influences such as breastfeeding, child nutrition, and active play	Parents, midwives, health visitors, GPs, community dietitians, social workers, playgroup leaders, voluntary groups, food retailers, leisure services, health promotion and public health specialists.
Family eating habits and physical activity patterns Sure Start programmes and children's centres	Promotion of breastfeeding: healthy infant feeding: healthy eating and active lifestyles for young families; 'positive parenting' e.g. action to promote breastfeeding, appropriate weaning and infant feeding (one-to-one verbal advice by health visitors or lay workers (mother-to mother schemes); breastfeeding drop ins and cafes; written support materials;

	mass media features; Sure Start programmes; National Breastfeeding Awareness Week); and action to promote healthy eating and active living for young children (positive parenting advice/classes; training for child minders and playgroup leaders around healthy eating and active play; safe play areas)
School	
A whole school health promoting environment – curricular and non-curricular	Pupils and students, parents, school nurses, teachers, head teachers, school governors, local education authority, local communities, road safety officers, community dietitians, leisure services, health promotion and public health specialists
Healthy choices for school meals and snacks	
Developing food choice skills and cooking skills Creating opportunities for sports and physical activities	
Encouraging active travel to and from school Developing family and community involvement	• A whole school health promoting environment e.g. National Healthy School Standard; and Health Schools Partnerships. • Teaching healthy eating and cooking skills e.g. Slots for nutrition in the curriculum; and slots for teaching healthy cooking skills. • Healthy school meals, snacks and drinking water e.g. guidelines on minimum nutritional standards for school meals; school nutrition policy; replacement of sugared drinks and high calorie snacks (e.g. in vending machines) with healthier alternatives (e.g. fruit tuck shops); healthy catering guidelines written into catering contract; breakfast clubs; and drinking water provision. • Increased uptake of physical activity and sports e.g. enjoyable activities, physical education and sports sessions built into the curriculum and after school, including such non-traditional forms as dance in order to develop skills in enjoyable ways; safe routes to schools; and walking buses (children walking in supervised groups) and other forms of active travel to/from school.

	• Provision of personalised support and a range of options for children and young people seeking help to control their weight e.g. school nursing service able to support children and parents, and refer to relevant community and specialist services when needed.
Workplace	
Providing healthy choices in catering Encouraging active transport and active team pursuits Developing family and community involvement Promoting employee health checks	Employees and their families, managers, human resources staff, occupational health, facilities managers, leisure services, catering providers, trade unions, health promotion and public health specialists Healthy lifestyles amongst staff including weight control, through healthy eating and increased physical activity e.g. healthy catering; cycle parking racks, shower facilities; fitness sessions; recreational facilities; occupational health checks; and workplace health programmes.
Community	
Developing awareness of overweight and obesity and its prevention and management among vulnerable, at risk communities	Community members and leaders, local charities, faith groups, voluntary groups, outreach workers, project workers, primary care staff, regeneration and neighbourhood renewal workers, community safety workers, road safety officers, local businesses, leisure providers , primary care staff, local media, health promotion and public health specialists
Engaging local people in healthy lifestyles initiatives Encouraging local advocacy for culturally appropriate, health promoting environments and facilities Fostering a culture of prevention and adherence to health checks	

	Free or inexpensive access to a wide range of activities e.g. use of subsidised access Schemes for less wealthy local residents. •Healthy catering at all leisure venues e.g. inexpensive healthy choices in leisure centre cafes; and removal of promotion of less healthy foods and drinks in leisure centres. • Coordinated outreach physical activities for specific groups e.g. healthy walks schemes; and exercise sessions for older people in care homes. • More users walking or cycling to the leisure venue e.g. cycle parking racks at all leisure venues. • Healthy eating campaigns e.g. media campaigns; work with local supermarkets; healthy eating accreditation schemes for restaurants and food outlets; and removal of promotion of high fat/sugar foods and drinks from leisure centres, schools and hospitals. • Strategies to minimise barriers to healthy eating by improving availability and access e.g. mapping of 'food deserts';

	supermarket pricing policies to encourage healthier choices; and town planning to site food shops selling fruit and vegetables close to areas of deprivation. • Group work on healthy eating for higher risk or disadvantaged groups e.g. identification and mapping of groups at risk; culturally sensitive group work; and peer education. • Physical activity and fitness campaigns e.g. physical activity for older people; home based exercise; and at risk groups targeted. • Increased use of leisure facilities e.g. improved leisure facilities at affordable prices. • Increased walking or cycling to school and workplace e.g. safe routes to school and workplace; and walking buses (supervised groups of schoolchildren walking to and from school). • Local transport policies which encourage walking and cycling e.g. provision of reliable, comfortable, frequent, safe and affordable public transport; restriction of use of cars in urban areas; batter traffic calming; creation of safe cycling and walking routes; and wider use of CCTV cameras. • Local planning to encourage physical activity e.g. more parks and open spaces; and better street lighting and safe, clean environments • Closer links with local schools e.g. collaboration with local schools to integrate sports and physical activity into curricula and after-school initiatives. •
Primary care	
Contributing to the primary prevention of hypertension by providing appropriate lifestyles advice and motivation	Patients and carers, practice staff, pharmacists, community dietitians, exercise facilitators, fitness coaches, leisure providers, secondary care providers, health promotion and public health specialists
Referring suitable patients for specialist dietetic advice or an exercise programme	
Setting up a weight control programme for the most ‘at risk’	

patients	
Setting up an overweight and obese case-finding and management programme	
Advertising, marketing and media	
Advertising using combination of various media including	Local journalists working in mass media, advertising agencies marketing companies, local businesses
broadcast television, cable networks, DVDs, video games, computers, Internet and mobile phones.	
Media campaigns - articles/features/interviews in local newspapers and radio/TV programmes	
Marketing – promotion of local health days and other events	