D Resources for commissioners

This section contains tools for commissioners in primary care trusts (PCTs) and local authorities developing local plans for tackling obesity, with a focus on children. It follows the framework for local action outlined in *Healthy Weight, Healthy Lives: Guidance for local areas*[2], so it is divided into the five sub-sections:

Understanding the problem in your area and setting local goals

There are four tools in this sub-section that will help local areas understand the problem in their area and set local goals. **Tools D2** and **D3** will give areas a sense of the scale of the problem in terms of prevalence of obesity and cost to the NHS. **Tool D4** will enable areas to identify priority groups using the national segmentation analysis undertaken by the Department of Health. **Tool D5** gives the advice provided to PCTs and local authorities on how to use local data from the National Child Measurement Programme (NCMP) in setting child obesity goals to achieve an improvement on current prevalence of child obesity in each of the three years (2008/09 to 2010/11) as part of the Vital Signs and the National Indicator Set (NIS).

Local leadership

The Department of Health advises that a multi-agency approach is key to tackling obesity. Success looks like clearly identified responsibility for actions, with overall leadership and governance agreed by all partners. **Tool D6** identifies key local leaders, the rationale for their involvement, their role in promoting a healthy weight, and ways to engage them.

Choosing interventions

This sub-section is about changing individual behaviour to reach the local goal of tackling obesity and promoting healthy weight. The seven tools in this sub-section will help local areas deliver behaviour change. **Tool D7** gives areas an idea of what changes in behaviour are desired at the end of the process. These outcomes or successes were outlined in *Healthy Weight, Healthy Lives: Guidance for local areas*.[2] **Tool D8** provides details of how to deliver the desired behaviour change through various interventions, divided into the Department of Health's five core themes set out in *Healthy Weight, Healthy Lives*.[1] This tool is based on evidence of effectiveness and cost-effectiveness adapted from the NICE guideline on obesity.[6] **Tool D9** moves on to provide behavioural insight among families with children aged 2-11 years and minority

ethnic communities. This tool gives a sense of the difficulties of achieving the desired behaviours but also can be useful in the initial design of interventions. **Tool D10** gives details of how to reach the priority clusters 1, 2 and 3 (as detailed in Tool D4), by communicating using the right language and key messages. **Tools D11, D12** and **D13** all provide details on procuring outside services to deliver behaviour change. Tool D11 provides a guide to procurement, Tool D12 provides a guide to commissioning weight management services, and Tool D13 provides details of how to procure a social marketing agency.

Monitoring and evaluation

Evaluating the effectiveness of local initiatives is key to understanding which services to continue to commission in the future. **Tool D14** provides a framework for monitoring and evaluating local interventions. It presents a 12-step guide on the key elements of monitoring and evaluation, an evaluation and monitoring checklist, and a glossary of terms.

Building local capabilities

Tool D15 provides a list of training programmes, publications, useful organisations and websites, and tools for healthcare professionals.

Tools

TOOL D1 Commissioning for health and wellbeing: a checklist

For:	Commissioners in primary care trusts (PCTs) and local authorities
About:	This tool provides details of World Class Commissioning including information on the organisational competencies. It also provides a checklist for commissioners to ensure that their obesity strategies are developed using the best available resources.
Purpose:	To provide an understanding of how World Class Commissioning can help local areas reach their goal of reducing the prevalence of obesity.
Use:	Can be used in the development of local obesity strategies.
Resource:	*World Class Commissioning: Competencies.*[145] www.dh.gov.uk *A vision for World Class Commissioning: Adding life to years and years to life*[146] www.primarycarecontracting.nhs.uk

World Class Commissioning: organisational competencies

The World Class Commissioning programme is designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way anywhere in the world. World Class Commissioning is about delivering better health and wellbeing for the population, improving health outcomes and reducing health inequalities. In partnership with local government, practice-based commissioners and others, primary care trusts (PCTs), supported by strategic health authorities (SHAs), will lead the NHS in turning the world class commissioning vision into a reality.

World class commissioning PCTs will need to develop the knowledge, skills, behaviours and characteristics that underpin effective commissioning. The organisational competencies are set out below. They have been divided into four of the five themes of *Healthy Weight, Healthy Lives*[1] – understanding the problem, local leadership, choosing interventions, and monitoring and evaluation – in order that local areas can use these competencies to develop their local obesity strategies.

Understanding the problem in your area and setting local goals

Manage knowledge and undertake robust and regular local health needs assessments that establish a full understanding of current and future local health needs and requirements

- Commissioning decisions should be based on sound evidence. They capture high-quality and timely information from a range of sources, and actively seek feedback from their populations about services. By identifying current needs and recognising future trends, World Class Commissioners will ensure that the services commissioned respond to the needs of the whole population, not only now, but also in the future.
- In particular, World Class Commissioning will ensure that the greatest priority is placed on those whose needs are greatest. To prioritise effectively, commissioners will require a high level of knowledge management with associated actuarial and analytical skill.

- The PCT is able to anticipate and address the needs of the whole population, including people with long-term conditions. A joint strategic needs assessment (JSNA) carried out by PCTs and local authorities, provides a rich picture of the current and future needs of their populations. This results in comprehensive and better-managed care.

Prioritise investment according to local needs, service requirements and NHS values

- By having a thorough understanding of the needs of different sections of the local population, World Class Commissioners, along with their partners, will develop a set of clear, outcome-focused, strategic priorities and investment plans. This will require taking a long-term view of population health and changing requirements. Their priorities are formally agreed through the local area agreement (LAA). Strategic priorities should include investment plans to address areas of greatest health inequality.
- PCTs make confident choices about the services that they want to be delivered, and acknowledge the impact that these choices may have on current services and providers. They have ambitious but realistic goals for the short, medium and long term, linked to an outcomes framework. They work with providers to ensure that service specifications are focused on clinical quality and based on the outcomes they want to achieve, and not just on processes and inputs.

Local leadership

Lead and steer the local health agenda in the community

- World Class Commissioners will actively steer the local health agenda and will build their reputation within the community so that they are recognised as the leader of the local NHS. They will seek and stimulate discussion on health and care matters and will be respected by community and business partners as the primary source of credible and timely advice on all matters relating to health and care services.

Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities

- World Class Commissioners will take into account the wider determinants of health, when considering how to improve the health and wellbeing of their local community. To do this effectively, they will work closely and develop a shared ambition with key partners including local government, healthcare providers and third sector organisations. These relationships are built up over time, reflecting the commitment of partner organisations to develop innovative solutions for the whole community. Together, commissioners and their partners will encourage innovation and continuous improvement in service design, and drive dramatic improvements in health and wellbeing.

Choosing interventions

Engage with patients and the public to shape services and improve health

- Commissioners act on behalf of the public and patients. They are responsible for investing funds on behalf of their communities, and building local trust and legitimacy through the process of engagement with their local population. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, World Class Commissioners will engage with the public, and actively seek the views of patients, carers and the wider community. This new relationship with the public is long-term, inclusive and enduring and has been forged through a sustained effort and commitment on the part of commissioners. Decisions are made with a strong mandate from the local population and other partners.

Engage with clinicians to inform strategy and drive quality, service design and resource utilisation

- Clinical leadership and involvement is a critical and integral part of the commissioning process. World class commissioners will need to ensure demonstrable clinical leadership and engagement at all stages of the commissioning process. Clinicians are best placed to advise and lead on issues relating to clinical quality and effectiveness. They are the local care experts, who understand clinical needs and have close contact with the local population. By encouraging clinical involvement in strategic planning and service design, World Class Commissioners will ensure that the services commissioned reflect the needs of the population and are delivered in the most personalised, practical and effective way possible.
- World class PCTs need world class practice based commissioners with whom they work in demonstrable partnership to drive improvements across the highest priority services and meet the most challenging needs identified by their strategic plans. To support this drive towards World Class Commissioning, Professional Executive Committees (PECs) have a crucial role to play in building and strengthening clinical leadership in the strategic commissioning process.

Stimulate the market to meet demand and secure required clinical, and health and wellbeing outcomes

- Commissioners will need a choice of responsive providers in place to meet the health and care needs of the local population.
- Employing their knowledge of future priorities, needs and community aspirations, commissioners will use their investment choices to influence service design, increase choice, and drive continuous improvement and innovation.
- World Class Commissioners will have clear strategies for dealing with situations where there is a lack of provider choice, in particular in areas where there is relatively poor health and limited access.

Promote improvement in quality and outcomes through clinical and provider innovation and configuration

- World Class Commissioners will drive continuous improvement in the NHS. Their quest for knowledge, innovation and best practice will result in better quality local services and significantly improved health outcomes.
- By working with partners to clearly specify required quality and outcomes, and influencing provision accordingly, World Class Commissioners will facilitate continuous improvement in service design to better meet the needs of the local population. This will be supported by transparent and fair commissioning and decommissioning processes.

Secure procurement skills that ensure robust and viable contracts

- Procurement and contracting processes will ensure that agreements with providers are set out clearly and accurately. By putting in place excellent processes, commissioners can facilitate good working relationships with their providers, offering protection to service users and ensuring value for money.

Make sound financial investments to ensure sustainable development and value for money

- World Class Commissioners ensure that their commissioning decisions are sustainable and that they are able to secure improved health outcomes, both now and in the future. Excellent financial skills and resource management will enable commissioners to manage the financial risks involved in commissioning and take a proactive rather than reactive approach to financial

management. The financial strategy will ensure that the commissioning strategy is affordable and set within the organisation's overall risk and assurance framework.

Monitoring and evaluation

Manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes

- Commissioners must ensure that providers are given the support needed to deliver the highest possible quality of service and value for money. This involves working closely with partners to sustain and improve provision, and engaging in constructive performance discussions to ensure continuous improvement.
- By having timely and continuous control over contracts, World Class Commissioners deliver better value to service users and taxpayers. PCTs use a range of approaches, including collecting and communicating performance data and service user feedback, working closely with regulators, and intervening when necessary to ensure service continuity and access. PCTs ensure that the commissioning process is equitable and transparent, and open to influence from all stakeholders via an ongoing dialogue with patients, service users and providers.

Checklist

In order that commissioners develop a successful obesity strategy in terms of the outcome being a reduction in obesity, particularly in children, commissioners should go through the checklist below and check whether they are using the best available resources in their area to achieve this outcome.

Understanding the problem in your area and setting local goals

Competency	Yes	No	Action
Manage knowledge and undertake robust and regular local health needs assessments that establish a full understanding of current and future local health needs and requirements			
Do you have strategies to further develop and enhance the needs assessment data sets and analysis with your partners?			
Are you routinely acquiring knowledge and intelligence of the whole community through well-defined and rigorous methodologies, including data collection with local partners, service providers and other agencies?			
Do you identify and use the relevant core data sets required for effective commissioning analysis? Are you demonstrating this use?			
Are you routinely seeking and reporting on research and best practice evidence, including clinical evidence that will assist in commissioning and decision making?			
Do you share data with current and potential providers and with relevant community groups?			
Can you demonstrate that you have sought and used all relevant data to work with communities and clinicians, prioritising strategic commissioning decisions and longer-term workforce planning?			

	Yes	No	Action
Prioritise investment according to local needs, service requirements and NHS values			
Do you identify and commission against key priority outcomes, taking into account patient experiences, local needs and preferences, risk assessments, national priorities and other guidance, such as National Institute for Health and Clinical Excellence (NICE) guidelines?			
Are the selected clinical, health and wellbeing outcomes desired, achievable and measurable? Do the outcomes align with partners' commissioning strategies?			
Are you developing short-, medium- and long-term commissioning strategies enabling local service design, innovation and development?			
Are you identifying and tackling inequalities of health status, access and resource allocation?			
Are you routinely using programme budgeting to understand investment against outcomes?			
Can you complete comprehensive risk assessments to feed into the wider decision-making process and all investment plans?			
Are you using financial resources in a planned and sustainable manner and investing for the future, including through innovative service design and delivery?			
Do you seek and make available valid benchmarking data?			
Do you share data with partner organisations, including practice-based commissioners and current and potential providers?			
Are you monitoring the performance of commissioned strategic health outcomes, using patient-reported clinical outcome measures and measures related to patient experience and public engagement?			

Local leadership

Competency	**Yes**	**No**	**Action**
Lead and steer the local health agenda in the community			
Are you the primary source of credible, timely and authoritative advice on all matters relating to the NHS?			
Do you apply NHS values (fair, personal, effective and safe) to strategic planning and decision making?			
Do you work closely with partner NHS organisations and other providers?			
Do you engage with and involve the public, community and patients?			
Do you communicate local NHS priorities to diverse groups of people?			
Do you develop the competences and capabilities of local NHS organisations?			
Do you effectively manage contracts?			
Do you have a clear communications policy? Can you respond effectively to individual, organisational and media enquiries regarding the NHS?			

	Yes	No	Action
Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities			
Do you actively seek partnership with appropriate agencies both within health and beyond using defined legal agreements and frameworks?			
Do you create informal and formal partnering arrangements as appropriate to different relationships?			
Do you identify key local participants and potential partners (both statutory and non-statutory) to optimise improvements in outcomes?			
Do you advise and develop local partner commissioning capabilities where there will be a direct impact on joint commissioning goals?			
Do you share with the local community its ambition for health improvement, innovation, and preventive measures to improve wellbeing and tackle inequalities?			
Do you influence partner commissioning strategies reflecting NHS core values?			
Do you use the skills and knowledge of partners, including clinicians, to inform commissioning intentions in all areas of activity?			
Do you actively share relevant information so that informed decisions can be made across the commissioning community?			
Do you monitor and evaluate the effectiveness of partnerships?			

Choosing interventions

Competency	Yes	No	Action
Engage with patients and the public to shape services and improve health			
Can patients and the public share their experiences of health and care services? Do you use these experiences to inform commissioning?			
Do you have an understanding of different engagement options, including the opportunities, strengths, weaknesses and risks?			
Do you invite patients and the public to respond and comment on issues in order to influence commissioning decisions and to ensure that services are convenient and effective?			
Do patients and the public understand how their views will be used? Do they know which decisions they will be involved in, when decisions will be made, and how they can influence the process? Do you publicise the ways in which public input has influenced decisions?			
Do you proactively challenge and, through active dialogue, raise local health aspirations to address local health inequalities and promote social inclusion?			
Do you create a trusting relationship with patients and the public? Are you seen as an effective advocate and decision maker on health requirements?			
Do you communicate the PCT's vision, key local priorities and delivery objectives to patients and the public, clarifying its role as the local leader of the NHS?			

	Yes	No	Action
Do you respond in an appropriate and timely manner to individual, organisational and media enquiries?			
Do you undertake assessments and seek feedback to ensure that the public's experience of engagement has been appropriate and not tokenistic?			
Engage with clinicians to inform strategy and drive quality, service design and resource utilisation			
Do you encourage broad clinical engagement through devolution of commissioning decisions? This includes maximising clinical impact through the development of practice-based commissioning (PBC).			
Do you engage and utilise the skills and knowledge of clinicians to inform commissioning intentions in all areas of activity, including setting strategic direction and formulating commissioning decisions?			
Do you build and support: • broad clinical networks, including across provider boundaries, to facilitate multidisciplinary input into pathway and service design? • informed clinical reference groups, such as Professional Executive Committees (PECs), ensuring that clinicians and practice-based commissioners have full and timely access to information, enabling local commissioning decisions to be made? • clinical engagement in strategic decision making and assure clinical governance structures via PECs? Do you oversee and support PBC decisions to ensure effective resource utilisation, reducing health inequalities and transforming service delivery?			
Do you work with clinical colleagues, such as PECs, along care pathways to spread best practice and rigorous standards to hold clinicians to account?			
Do you work in partnership with clinicians along care pathways in commissioner and provider organisations to facilitate and harness front-line innovation and drive continuous quality improvement?			
Stimulate the market to meet demand and secure required clinical, and health and wellbeing outcomes			
Do you map and understand the strengths and weaknesses of current service configuration and provision?			
Do you have an understanding and knowledge of methods for finding out what matters to patients, the public and staff? Are you able to respond to this when defining service specifications?			
Can you model and simulate the impact of commissioning decisions and strategies on the current configuration of provision?			
Can you promote services that encourage early intervention, to avoid unnecessary unplanned admissions?			
Do you have a clear understanding and knowledge of the abilities and role of the third sector, and of its ability to provide against service specifications?			
Can you translate strategy into short-, medium- and long-term investment requirements, allowing providers to align their own investment and planning processes with specified requirements?			

	Yes	No	Action
Are you aware of market trends and behaviours? Can you show knowledge of and act on current gaps in the market to provide patients with a choice of local providers?			
Can you create incentives where necessary for market entry, including understanding the requirements of full cost recovery?			
Can you stimulate provider development matched to the requirements and experiences accrued from user and community feedback (for example, timely and convenient access to services that are closer to home)?			
Can you specify the realistic time schedules that are needed to encourage and deliver innovation and change, providing direct support when required?			
Can you develop relationships with potential future providers whose services may be of interest and may be relevant to meeting need and demand?			
Do you communicate with the market as an investor, not a funder, using and specifying an approach based on quality and outcomes?			
Promote improvement in quality and outcomes through clinical and provider innovation and configuration			
Do you map and understand the strengths and weaknesses of current service innovation, quality and outcomes?			
Do you maintain an active database of best practice, innovation and service improvement?			
Do you analyse local and wider clinical and provider quality and capacity to innovate and improve?			
Do you share research, clinical and service best practice linked to clear specifications that drive innovation and improvement?			
Do you communicate with clinicians and providers to challenge established practice and drive services that are both convenient and effective?			
Do you set stretch targets? Do you challenge providers to come up with innovative ways to achieve them?			
Do you understand the potential of local community and third sector providers to deliver innovative services and increase local social capital?			
Do you catalyse change and help to overcome barriers, including recognising and challenging traditions and ways of thinking (for example in service design and workforce development) that have outlived their usefulness? Do you support providers that constructively break with these?			
Do you translate research and knowledge into specific clinical and service reconfiguration, improving access, quality and outcomes?			
Do you design and negotiate contracts that encourage provider modernisation, continued efficiency, quality and innovation?			
Are you creating incentives to drive innovation and quality?			
Do you secure and maintain relationships with improvement agencies and suppliers, brokering local knowledge and information networks?			

	Yes	No	Action
Are you developing relationships with current and potential providers, stimulating whole-system solutions for the greatest health and wellbeing gain?			
Secure procurement skills that ensure robust and viable contracts			
Are you procuring and contracting in proportion to risk and in line with the clinical priorities and wider health and wellbeing outcomes described in the commissioning strategy?			
Are you procuring and contracting in line with relevant Department of Health policies, such as patient choice, competition principles and rules, care closer to home and NICE guidelines?			
Do you work with commissioning partners to ensure that your procurement plans are consistent with wider local commissioning priorities?			
Are you continuously developing your range of procurement techniques and making effective use of them?			
Do you have a working knowledge of all legal, competition and regulatory requirements relevant to your role when tendering?			
Are you reflecting NHS values through clear and accurate service specifications?			
Are you assessing business cases according to financial viability, risk, sustainability and alignment with commissioning strategies?			
Do you design and negotiate open and fair contracts that provide value for money and are enforceable, with agreed performance measures and intervention protocols?			
Do contracts cover reasonable time periods, maximising the investment of both the provider and the PCT?			
Do you understand and implement standard national contracts as these become available?			
Do you create contingency plans to mitigate against provider failure?			
Make sound financial investments to ensure sustainable development and value for money			
Do you have a thorough understanding of the financial regime in which you operate?			
Do you prepare effective financial strategies that identify and take account of trends, key risks and potential high-impact changes in cost and activity levels? These strategies drive the annual budgeting process and support the commissioning strategy.			
Are you developing a risk-based approach to long-term financial planning and budgeting that supports relevant and proportionate analysis of financial and activity flows?			
Are you routinely using programme budgeting to understand investment against outcomes and relative potential shifts in investment opportunities that will optimise local health gains and increase quality?			
Do you use financial resources in a planned and sustainable manner and invest for the future?			

	Yes	No	Action
Do you analyse costs, such as prescribing, and identify areas for improvement?			
Do you have a clear understanding of the links between the financial and non-financial elements of the commissioning strategies?			
Are you developing a risk-based approach to annual financial management and budgeting? This is supported by the ongoing analysis of financial and activity flows and includes cash management plans to ensure an efficient use of allocated resources.			
Do you budget proactively rather than reactively, with large, high-risk or volatile elements being identified and cross-referenced to operational activity?			
Does the Board have clear governance structures in place that facilitate and ensure active management of all aspects of the PCT's business and planning functions? Are these transparent, easily understood and public-facing?			
Do you analyse the activity of the providers, PBC leads, and other budget holders through detailed comparisons of expected and actual costs and activity?			
Do you provide useful, concise and complete financial and activity information to the Board to aid decision making, highlighting significant variances where these are occurring?			
Do you have clear and understood processes for dealing with any areas which begin to show significant variance from budget during the financial year? Are these implemented effectively by all relevant staff and reported to the Board where necessary?			
Are you calculating, allocating and reviewing PBC budgets in a fair and transparent manner with effective incentive systems? Are you enabling PBC leads to fully understand and manage their devolved budgets?			
Are you developing short-, medium- and long-term strategic financial plans, highlighting areas suitable for local service redesign, innovation and development?			
Are you working effectively with all service providers by providing financial support and information to achieve the most clinically effective and cost-effective approaches?			
Do you have a well-developed system of governance that ensures financial risks are reported and managed at the appropriate level?			
Do you have strong financial and ethical values and principles that are publicly expressed and underpin the work of all staff and board members, including those working under contract? These values will also be expressed in all contracts entered into by the PCT.			
Do all staff have a clear understanding of their delegated commissioning budgets? Do all staff responsible for the management of budgets have access to relevant and timely activity and performance data that enable them to operate these budgets effectively?			

Monitoring and evaluation

Competency	Yes	No	Action
Manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes			
Do you monitor provider financial performance, activity and sustainability in accordance with its contractual agreements?			
Are you transparent about your relationships with other organisations that collect, publish, assess and regulate providers?			
Do you evaluate individual provider performance according to agreed provision measurements?			
Do you use benchmarking to compare performance between providers? Are you communicating performance evaluation findings with providers?			
Do you use performance evaluation findings to lead regular and constructive performance conversations with providers, working with them to resolve issues?			
Do you use agreed dispute processes for unresolved issues?			
Do you recognise an advocacy and expert role in service development for providers? Do you invite them to contribute in that role?			
Do you disseminate relevant information to allow current providers to innovate and develop to meet changing commissioning requirements?			
Do you understand the motivations of current providers? Are you fostering an environment of shared responsibility and development?			
Do you terminate contracts when necessary?			

TOOL D2 Obesity prevalence ready-reckoner

For:	Commissioners in primary care trusts (PCTs)
About:	This tool is a ready-reckoner which can be used to estimate the number of adults (aged 16 and above) or the number of children aged 1-15 years within a primary care trust who are obese or overweight.
Purpose:	To provide an understanding of the scale of the obesity problem in your PCT.
Use:	• Can be used for understanding the problem in your PCT – case for funding. • Can be used for evaluation and monitoring purposes. The data can be used as a baseline when calculating the success of interventions using performance indicators.
Resource:	An electronic version of the *Obesity prevalence ready-reckoner*, which can be completed online, can be found at www.heartforum.org.uk or www.fph.org.uk

Estimating the prevalence of obesity and central obesity

The ready-reckoner can be used to estimate:

- the number of adults aged 16 and over who are obese – measured by Body Mass Index (BMI) of more than 30kg/m^2.
- the number of adults aged 16 and over with central obesity as measured by a raised waist circumference. A raised waist circumference has been taken to be 102cm (40 inches) or more in men and 88cm (35 inches) or more in women. These levels have been used to identify people at risk of the metabolic syndrome, a disorder characterised by increased risk of developing diabetes and cardiovascular disease. Central obesity, as measured by waist circumference, is reported to be more highly correlated with metabolic risk factors (high levels of triglycerides and low HDL cholesterol) than is elevated BMI.[12]
- the number of children aged 1-15 years who are obese using the UK National BMI Percentile Classification as recommended by the National Institute for Health and Clinical Excellence (NICE) and the Department of Health.

How to use the ready-reckoner

1 In cells A1 to A7 and B1 to B7, enter the actual numbers of residents in each age group, based on latest population estimates for your area.
2 Calculate the other cell values according to the formulae.

Note:
The ready-reckoner uses national data and does not take into account local factors such as ethnicity, deprivation or other factors that might affect overweight and obesity prevalence.

Obesity prevalence ready-reckoner: adults aged 16 and over

		A	B	C	D	E	F
		PCT population (Enter actual numbers)		**Estimate of number of people who are obese** (BMI greater than 30kg/m^2)		**Estimate of number of people who have a raised waist circumference** (Male 102cm or above. Female 88cm or above)	
	Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
1	16-24	Enter actual number	Enter actual number	A1 x 0.09	B1 x 0.12	A1 x 0.10	B1 x 0.17
2	25-34	Enter actual number	Enter actual number	A2 x 0.21	B2 x 0.18	A2 x 0.21	B2 x 0.30
3	35-44	Enter actual number	Enter actual number	A3 x 0.25	B3 x 0.24	A3 x 0.30	B3 x 0.36
4	45-54	Enter actual number	Enter actual number	A4 x 0.28	B4 x 0.27	A4 x 0.38	B4 x 0.45
5	55-64	Enter actual number	Enter actual number	A5 x 0.33	B5 x 0.30	A5 x 0.46	B5 x 0.50
6	65-74	Enter actual number	Enter actual number	A6 x 0.31	B6 x 0.35	A6 x 0.51	B6 x 0.60
7	75+	Enter actual number	Enter actual number	A7 x 0.18	B7 x 0.27	A7 x 0.41	B7 x 0.57
8	Sub-total	Sum of A1-A7	Sum of B1-B7	Sum of C1-C7	Sum of D1-D7	Sum of E1-E7	Sum of F1-F7
9	Total	Sum of A8 and B8		Sum of C8 and D8		Sum of E8-F8	

Source: The formulae for both obesity and waist circumference are based on the Health Survey for England 2006.[10]

Example – Southwark Primary Care Trust: adults aged 16 and over

The following is an example of how to use the ready-reckoner, based on 2001 census figures for Southwark Primary Care Trust, London.

		A	B	C	D	E	F
		Southwark PCT population		**Estimate of number of people who are obese** (BMI greater than 30kg/m^2)		**Estimate of number of people who have a raised waist circumference** (Male 102cm or above. Female 88cm or above)	
	Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
1	16-24	17,812	18,011	1,603	2,161	1,781	3,062
2	25-34	25,894	26,865	5,438	4,836	5,438	8,060
3	35-44	21,501	20,998	5,375	5,040	6,450	7,559
4	45-54	11,960	12,478	3,349	3,369	4,545	5,615
5	55-64	8,137	8,831	2,685	2,649	3,743	4,416
6	65-74	6,421	7,213	1,991	2,525	3,275	4,328
7	75+	4,286	7,434	771	2,007	1,757	4,237
8	Sub-total	96,011	101,830	21,212	22,587	26,989	37,277
9	Total	197,841		43,799		64,266	

Obesity prevalence ready-reckoner: children aged 1-15 years

		A	B	C	D
		PCT population (Enter actual numbers)		**Estimate of number of children who are obese** (UK National BMI Percentile Classification*)	
	Age	**Male**	**Female**	**Male**	**Female**
1	1	Enter actual number	Enter actual number	A1 x 0.173	B1 x 0.160
2	2	Enter actual number	Enter actual number	A2 x 0.174	B2 x 0.170
3	3	Enter actual number	Enter actual number	A3 x 0.171	B3 x 0.166
4	4	Enter actual number	Enter actual number	A4 x 0.165	B4 x 0.162
5	5	Enter actual number	Enter actual number	A5 x 0.166	B5 x 0.166
6	6	Enter actual number	Enter actual number	A6 x 0.166	B6 x 0.163
7	7	Enter actual number	Enter actual number	A7 x 0.163	B7 x 0.169
8	8	Enter actual number	Enter actual number	A8 x 0.171	B8 x 0.176
9	9	Enter actual number	Enter actual number	A9 x 0.180	B9 x 0.181
10	10	Enter actual number	Enter actual number	A10 x 0.183	B10 x 0.187
11	11	Enter actual number	Enter actual number	A11 x 0.193	B11 x 0.195
12	12	Enter actual number	Enter actual number	A12 x 0.192	B12 x 0.205
13	13	Enter actual number	Enter actual number	A13 x 0.208	B13 x 0.211
14	14	Enter actual number	Enter actual number	A14 x 0.206	B14 x 0.220
15	15	Enter actual number	Enter actual number	A15 x 0.216	B15 x 0.225
16	Sub-total	Sum of A1-A15	Sum of B1-B15	Sum of C1-C15	Sum of D1-D15
17	Total	Sum of A16 and B16		Sum of C16 and D16	

Source: The formulae for obesity are based on the Health Survey for England 2006.[11]

* The UK National BMI Percentile Classification defines obesity as a BMI of more than the 95th centile, and overweight as a BMI of more than the 85th centile of the UK 1990 reference chart for age and sex. (See Tool E4 in section E.)

Estimating the prevalence of obesity and central obesity among adults in ethnic groups

To model for ethnicity, using the results from the ready-reckoner as a base, apply the ethnicity breakdown for each age/gender group, and for each cell apply the following adjustment factors (derived from Table 1 on page 12) to calculate the prevalence of obesity and central obesity by age/gender/ethnicity. The resulting prevalence estimates can be summed whichever way you choose. These adjustment factors represent the national prevalence of obesity and central obesity in adults (aged 16 and over) by ethnic group compared to the general population (= 1.0).

Ethnic group	Obesity		Central obesity	
	Men	Women	Men	Women
Black Caribbean	1.11	1.38	0.71	1.15
Black African	0.75	1.66	0.61	1.29
Indian	0.61	0.87	0.65	0.93
Pakistani	0.67	1.21	0.97	1.17
Bangladeshi	0.26	0.74	0.39	1.05
Chinese	0.26	0.33	0.26	0.39

Estimating the prevalence of overweight among adults

A modified version of the ready-reckoner can be used to estimate the number of overweight people – those with a BMI more than 25kg/m^2 – using the data on prevalence of overweight in different age groups from the Health Survey for England 2006. To estimate the prevalence of overweight for ethnic groups, follow the same procedure as described above. Use Table 1 on page 12 to calculate the adjustment factors.

Primary care organisation (PCO) level model-based estimate of adult obesity

Another way of assessing local prevalence of adult (aged 16 and over) obesity is using model-based estimates produced by the NHS Information Centre for Health and Social Care. These estimates are calculated using pooled 2003-05 Health Survey for England (HSE) data. However, because statistical modelling was used, prevalence data should be applied with caution.[147]

Note:
Statistical modelling was used to produce the PCO-level model-based estimates because the sample size of national surveys is too small at local area level to provide reliable direct estimates. The model-based estimate for a particular local area is the expected prevalence for that area based on its population characteristics (as measured by the census/administrative data) and as such does not represent an estimate of the actual prevalence for the local area. Confidence intervals are provided in order to make the margin of error around the estimates clear.

To view the PCO-level model-based estimates for adult obesity, go to www.ic.nhs.uk

TOOL D3 Estimating the local cost of obesity

TOOL D3

For:	Commissioners in primary care trusts (PCTs)
About:	This tool provides estimates of the annual costs to the NHS of diseases related to overweight and obesity and obesity alone, broken down to PCT level. Estimated costs have been based on a disaggregation of the national estimates calculated by Foresight (for selected years 2007-2015). See *Setting local goals* in Section C.
Purpose:	To give an understanding of the scale of the problem to the NHS in PCTs if current trends continue.
Use:	• Can be used for understanding the problem in your PCT – case for funding. • Can be used for evaluation and monitoring purposes. The data can be used as a baseline and for monitoring interventions relating to reducing costs to NHS.
Resource:	*Modelling future trends in obesity and the impact on health. Foresight tackling obesities: Future choices.*[16] www.foresight.gov.uk

The estimated annual costs to the NHS of diseases related to overweight and obesity (BMI 25kgm^2 or more) and obesity alone (BMI 30kg/m^2 or more), by PCT, are provided below.

The costs have been estimated using the national estimates calculated by Foresight. A microsimulation model was used to forecast costs to the NHS of the consequences of overweight and obesity. No inflation costs, either of prices generally or healthcare costs in particular, were incorporated within the costs, so this allows for direct comparison to current prices. Future BMI-related costs were approximated by subtracting estimates of current NHS costs of obesity from projected costs derived from the model. Further information about the microsimulation model can be found at www.foresight.gov.uk

Estimated annual costs to NHS of diseases related to overweight and obesity (BMI 25kg/m^2 or more) and obesity alone (BMI 30kg/m^2 or more), by PCT

	Estimated annual costs to NHS of diseases related to overweight and obesity £ million			**Estimated annual costs to NHS of diseases related to obesity £ million**		
	2007	**2010**	**2015**	**2007**	**2010**	**2015**
Government Office for the North East						
County Durham PCT	156.7	162.7	173.9	81.3	88.1	101.1
Darlington PCT	27.6	28.6	30.6	14.3	15.5	17.8
Gateshead PCT	61.9	64.3	68.7	32.1	34.8	39.9
Hartlepool PCT	29.3	30.4	32.5	15.2	16.5	18.9
Middlesbrough PCT	45.8	47.5	50.8	23.7	25.7	29.5
Newcastle PCT	81.1	84.1	90	42.1	45.6	52.3
North Tees PCT	51.9	53.9	57.6	26.9	29.2	33.5
North Tyneside PCT	58.9	61.2	65.4	30.6	33.1	38
Northumberland Care Trust	85.7	88.9	95.1	44.4	48.1	55.3

	Estimated annual costs to NHS of diseases related to overweight and obesity £ million			Estimated annual costs to NHS of diseases related to obesity £ million		
	2007	2010	2015	2007	2010	2015
Redcar and Cleveland PCT	41	42.5	45.5	21.3	23	26.4
South Tyneside PCT	48.8	50.7	54.2	25.3	27.4	31.5
Sunderland Teaching PCT	88.4	91.7	98.1	45.9	49.7	57
Government Office for the North West						
Ashton, Leigh and Wigan PCT	90.8	94.3	100.8	47.1	51	58.6
Blackburn with Darwen PCT	46.4	48.1	51.4	24.1	26	29.9
Blackpool PCT	45.8	47.5	50.8	23.8	25.7	29.6
Bolton PCT	78.3	81.3	86.9	40.6	44	50.5
Bury PCT	50	51.9	55.5	26	28.1	32.3
Central and Eastern Cheshire PCT	111.4	115.6	123.6	57.8	62.6	71.9
Central Lancashire PCT	119.2	123.7	132.3	61.8	67	76.9
Cumbria PCT	136.8	141.9	151.8	71	76.9	88.2
East Lancashire PCT	110.1	114.2	122.2	57.1	61.9	71
Halton and St Helens PCT	95.3	98.9	105.8	49.5	53.6	61.5
Heywood, Middleton and Rochdale PCT	63.4	65.8	70.4	32.9	35.6	40.9
Knowsley PCT	55	57.1	61	28.5	30.9	35.5
Liverpool PCT	163.6	169.8	181.5	84.9	91.9	105.5
Manchester PCT	166.8	173.1	185.1	86.6	93.7	107.6
North Lancashire PCT	90.5	93.9	100.4	47	50.9	58.4
Oldham PCT	67.5	70.1	74.9	35	37.9	43.6
Salford PCT	73.3	76.1	81.3	38	41.2	47.3
Sefton PCT	82.1	85.2	91.1	42.6	46.1	52.9
Stockport PCT	74.4	77.2	82.6	38.6	41.8	48
Tameside and Glossop PCT	66.8	69.3	74.1	34.6	37.5	43.1
Trafford PCT	57.5	59.7	63.8	29.8	32.3	37.1
Warrington PCT	51.2	53.1	56.8	26.6	28.8	33
Western Cheshire PCT	65.6	68.1	72.8	34	36.8	42.3
Wirral PCT	98.5	102.2	109.3	51.1	55.3	63.6
Government Office for Yorkshire and The Humber						
Barnsley PCT	72.3	75.1	80.3	37.5	40.6	46.7
Bradford and Airedale PCT	142.6	148	158.3	74	80.1	92
Calderdale PCT	53	55	58.8	27.5	29.8	34.2
Doncaster PCT	88.4	91.7	98.1	45.9	49.7	57
East Riding of Yorkshire PCT	76.4	79.3	84.8	39.7	43	49.3
Hull PCT	78.8	81.8	87.4	40.9	44.3	50.8
Kirklees PCT	103.4	107.3	114.8	53.7	58.1	66.7

	Estimated annual costs to NHS of diseases related to overweight and obesity £ million			Estimated annual costs to NHS of diseases related to obesity £ million		
	2007	2010	2015	2007	2010	2015
Leeds PCT	197.4	204.9	219.1	102.4	110.9	127.4
North East Lincolnshire PCT	45.2	46.9	50.1	23.4	25.4	29.1
North Lincolnshire PCT	42	43.6	46.6	21.8	23.6	27.1
North Yorkshire and York PCT	186.6	193.6	207.1	96.8	104.8	120.4
Rotherham PCT	72.2	74.9	80.1	37.4	40.6	46.6
Sheffield PCT	148.7	154.3	165	77.1	83.6	95.9
Wakefield District PCT	98.5	102.3	109.3	51.1	55.4	63.6
Government Office for the East Midlands						
Bassetlaw PCT	29.6	30.8	32.9	15.4	16.7	19.1
Derby City PCT	73.4	76.2	81.5	38.1	41.3	47.4
Derbyshire County PCT	184.3	191.3	204.5	95.6	103.5	118.9
Leicester City PCT	86.6	89.9	96.1	45	48.7	55.9
Leicestershire County and Rutland PCT	147.6	153.2	163.8	76.6	83	95.3
Lincolnshire PCT	187.9	195	208.6	97.5	105.6	121.3
Northamptonshire PCT	167.6	173.9	186	86.9	94.2	108.1
Nottingham City PCT	85.1	88.3	94.4	44.1	47.8	54.9
Nottinghamshire County PCT	166.8	173.1	185.1	86.5	93.7	107.6
Government Office for the West Midlands						
Birmingham East and North PCT	122.5	127.2	136	63.6	68.9	79.1
Coventry Teaching PCT	96.1	99.7	106.6	49.8	54	62
Dudley PCT	80.9	84	89.8	42	45.5	52.2
Heart of Birmingham Teaching PCT	92.9	96.5	103.1	48.2	52.2	60
Herefordshire PCT	46.3	48.1	51.4	24	26	29.9
North Staffordshire PCT	54.7	56.8	60.7	28.4	30.7	35.3
Sandwell PCT	94.1	97.6	104.4	48.8	52.9	60.7
Shropshire County PCT	72.4	75.1	80.3	37.5	40.7	46.7
Solihull Care Trust	51.4	53.4	57.1	26.7	28.9	33.2
South Birmingham PCT	100.9	104.8	112	52.4	56.7	65.1
South Staffordshire PCT	143.7	149.2	159.5	74.6	80.8	92.7
Stoke on Trent PCT	77.9	80.8	86.4	40.4	43.8	50.3
Telford and Wrekin PCT	42.8	44.4	47.5	22.2	24.1	27.6
Walsall Teaching PCT	74.4	77.2	82.5	38.6	41.8	48
Warwickshire PCT	131.6	136.5	146	68.3	73.9	84.9
Wolverhampton City PCT	73.8	76.6	81.9	38.3	41.5	47.6
Worcestershire PCT	136.6	141.8	151.6	70.9	76.8	88.1

	Estimated annual costs to NHS of diseases related to overweight and obesity £ million			Estimated annual costs to NHS of diseases related to obesity £ million		
	2007	2010	2015	2007	2010	2015
Government Office for the East of England						
Bedfordshire PCT	98.8	102.6	109.7	51.3	55.5	63.8
Cambridgeshire PCT	138.3	143.5	153.5	71.7	77.7	89.2
East and North Hertfordshire PCT	134.4	139.4	149.1	69.7	75.5	86.7
Great Yarmouth and Waveney PCT	65.4	67.9	72.6	33.9	36.8	42.2
Luton PCT	50.7	52.6	56.2	26.3	28.5	32.7
Mid Essex PCT	82	85.1	91	42.5	46.1	52.9
Norfolk PCT	188.7	195.8	209.4	97.9	106	121.7
North East Essex PCT	86.3	89.6	95.8	44.8	48.5	55.7
Peterborough PCT	42.7	44.4	47.4	22.2	24	27.6
South East Essex PCT	88	91.3	97.6	45.6	49.4	56.8
South West Essex PCT	106.3	110.3	117.9	55.1	59.7	68.6
Suffolk PCT	146.4	152	162.5	76	82.3	94.5
West Essex PCT	66.7	69.2	74	34.6	37.5	43
West Hertfordshire PCT	130.8	135.8	145.2	67.9	73.5	84.4
Government Office for London						
Barking and Dagenham PCT	54.6	56.7	60.6	28.3	30.7	35.2
Barnet PCT	85.1	88.3	94.4	44.1	47.8	54.9
Bexley Care Trust	55.5	57.6	61.6	28.8	31.2	35.8
Brent Teaching PCT	83	86.2	92.2	43.1	46.7	53.6
Bromley PCT	77.2	80.1	85.7	40.1	43.4	49.8
Camden PCT	74.6	77.4	82.8	38.7	41.9	48.1
City and Hackney Teaching PCT	85.3	88.5	94.6	44.2	47.9	55
Croydon PCT	88.9	92.2	98.6	46.1	49.9	57.3
Ealing PCT	89	92.4	98.8	46.2	50	57.4
Enfield PCT	75.7	78.6	84.1	39.3	42.6	48.9
Greenwich Teaching PCT	73	75.8	81	37.9	41	47.1
Hammersmith and Fulham PCT	53.4	55.4	59.2	27.7	30	34.4
Haringey Teaching PCT	73.7	76.5	81.8	38.2	41.4	47.6
Harrow PCT	50.9	52.8	56.4	26.4	28.6	32.8
Havering PCT	65.2	67.7	72.4	33.9	36.7	42.1
Hillingdon PCT	63.6	66	70.6	33	35.8	41.1
Hounslow PCT	60.8	63.1	67.5	31.6	34.2	39.3
Islington PCT	66.3	68.8	73.6	34.4	37.3	42.8
Kensington and Chelsea PCT	56	58.1	62.1	29.1	31.5	36.1
Kingston PCT	39.7	41.1	44	20.6	22.3	25.6
Lambeth PCT	88.6	91.9	98.3	46	49.8	57.1

	Estimated annual costs to NHS of diseases related to overweight and obesity £ million			Estimated annual costs to NHS of diseases related to obesity £ million		
	2007	2010	2015	2007	2010	2015
Lewisham PCT	76.2	79.1	84.5	39.5	42.8	49.1
Newham PCT	92.6	96.1	102.8	48.1	52.1	59.8
Redbridge PCT	62.3	64.7	69.1	32.3	35	40.2
Richmond and Twickenham PCT	42.4	44	47.1	22	23.8	27.4
Southwark PCT	83	86.1	92.1	43.1	46.6	53.5
Sutton and Merton PCT	93.8	97.4	104.1	48.7	52.7	60.5
Tower Hamlets PCT	80.9	84	89.8	42	45.5	52.2
Waltham Forest PCT	68	70.6	75.5	35.3	38.2	43.9
Wandsworth PCT	74.1	76.9	82.2	38.4	41.6	47.8
Westminster PCT	70.2	72.9	77.9	36.4	39.4	45.3
Government Office for the South East						
Brighton and Hove City PCT	75.3	78.1	83.5	39.1	42.3	48.6
East Sussex Downs and Weald PCT	88.2	91.5	97.9	45.8	49.6	56.9
Eastern and Coastal Kent PCT	201.8	209.5	224	104.7	113.4	130.2
Hastings and Rother PCT	52.2	54.2	58	27.1	29.4	33.7
Medway PCT	69.7	72.3	77.4	36.2	39.2	45
Surrey PCT	251.3	260.8	278.8	130.4	141.2	162.1
West Kent PCT	160	166.1	177.6	83	89.9	103.3
West Sussex PCT	199.5	207	221.4	103.5	112.1	128.7
Berkshire East PCT	91	94.5	101	47.2	51.2	58.7
Berkshire West PCT	103.5	107.4	114.8	53.7	58.1	66.7
Buckinghamshire PCT	113.6	117.9	126.1	59	63.8	73.3
Hampshire PCT	300.8	312.2	333.8	156.1	169	194.1
Isle of Wight NHS PCT	41.9	43.5	46.5	21.8	23.6	27.1
Milton Keynes PCT	56.9	59	63.1	29.5	31.9	36.7
Oxfordshire PCT	143.4	148.8	159.1	74.4	80.6	92.5
Portsmouth City Teaching PCT	50.1	52	55.6	26	28.2	32.3
Southampton City PCT	65.2	67.6	72.3	33.8	36.6	42.1
Government Office for the South West						
Bath and North East Somerset PCT	44.1	45.8	49	22.9	24.8	28.5
Bournemouth and Poole PCT	89.5	92.8	99.3	46.4	50.3	57.7
Bristol PCT	111.6	115.8	123.9	57.9	62.7	72
Cornwall and Isles of Scilly PCT	145.1	150.6	161	75.3	81.5	93.6
Devon PCT	190.5	197.7	211.4	98.8	107	122.9
Dorset PCT	102.4	106.2	113.6	53.1	57.5	66
Gloucestershire PCT	143.7	149.1	159.5	74.6	80.7	92.7
North Somerset PCT	51.4	53.4	57.1	26.7	28.9	33.2

	Estimated annual costs to NHS of diseases related to overweight and obesity £ million			Estimated annual costs to NHS of diseases related to obesity £ million		
	2007	**2010**	**2015**	**2007**	**2010**	**2015**
Plymouth Teaching PCT	68.5	71	76	35.5	38.5	44.2
Somerset PCT	133.8	138.8	148.4	69.4	75.2	86.3
South Gloucestershire PCT	54.8	56.9	60.8	28.4	30.8	35.3
Swindon PCT	48	49.8	53.3	24.9	27	31
Torbay Care Trust	42.4	44	47.1	22	23.8	27.4
Wiltshire PCT	106.6	110.6	118.3	55.3	59.9	68.8
FORESIGHT estimate of national annual costs to NHS	**Elevated BMI (£ million)**			**Obesity (£ million)**		
	2007	**2010**	**2015**	**2007**	**2010**	**2015**
	13,891	14,416	15,415	7207	7,805	8,962

Notes:
Costs are calculated at 2004 prices.
It is assumed the BMI distribution for England changes in line with current trends.

Note:
NICE has produced a report which attempts to estimate the cost of implementing the NICE guidelines on obesity.[142] This report estimates the cost of: treatment of obese/overweight children with co-morbidities (referral to a specialist, drug treatment for some children); bariatric surgery for very obese adults; and staff training in prevention and management of obesity. To view the report, visit www.nice.org.uk

TOOL D4 Identifying priority groups

For:	Commissioners in primary care trusts (PCTs) and local authorities
About:	This tool describes how local areas can access and use the national segmentation analysis produced by the Department of Health through a step-by-step guide.
Purpose:	• To provide local areas with an understanding of why the three priority groups were selected for national intervention. • To explain how the segmentation analysis can be used at a local level.
Use:	• Can be used to identify priority groups in local areas. • The segmentation analysis can be used to further define particular clusters in local areas.
Resource:	*Insights into child obesity: A summary.* A draft of this report is available to PCTs and LAs through their Regional Public Health Group. A final report will be published in late 2008.

National segmentation of families with children aged 2-11

A quantitative segmentation of the population aged 2-11 years was carried out by the Department of Health to help better understand the behaviours that lead to individuals becoming overweight and obese, and to understand which behaviours are common within different clusters in society. Segmenting individuals and families into clusters allows interventions to help support behaviour change – for instance the National Marketing Plan – to be prioritised to the groups with the greatest need, and to tailor the interventions to those needs, increasing their effectiveness.

Analysis showed that children aged 2-11 years and their families could be divided into six broad groups or clusters according to their attitudes and behaviours relating to diet and physical activity, in addition to their demographic make-up, levels of food consumption, socioeconomic grouping, education and employment. The clusters were further developed using qualitative research with the aim of gaining insight from which to design behaviour-change interventions among parents and children. Of the six clusters, three demonstrated common behaviours that put them most 'at risk' of developing obesity – and indeed these clusters had the highest rates of adult and child obesity. These three clusters are the priority clusters within the National Marketing Plan.

The three priority clusters can also be used by local areas to better target interventions to promote healthy weight, leading to more effective interventions and use of public resources. **Local authorities and PCTs can access a draft report that describes the six clusters in detail via the obesity lead in their Regional Public Health Group, or by emailing healthyweight@dh.gsi.gov.uk**. A final version of the report will be published in late 2008, informed by continuing research. In the meantime, the Cross-Government Obesity Unit welcomes feedback on the draft report.

Using the segmentation analysis at a local level – a step-by-step guide

Step 1 – Prioritise clusters 1, 2 and 3 as key intervention groups, in line with national policy.

For details of how to access information on the priority clusters, see page 101.

Step 2 – Use socioeconomic data to identify the most likely areas with the target clusters.

A number of organisations can assist with mapping high-risk groups and identifying deprivation levels:

- Public Health Observatories – *www.apho.org.uk/apho*
- The North East Public Health Observatory has an on-line mapping facility which can identify obesity rates at PCT and ward level (North East region data only) *www.nepho.org.uk*
- University of Sheffield Public Health GIS Unit – *gis.sheffield.ac.uk*
- Communities and Local Government – Indices of Deprivation – *www.communities.gov.uk*
- Local academic departments – *www.hero.ac.uk*

Commercial organisations can also help with mapping.

Key point

To further support the identification of the clusters at a local level, the Department of Health is undertaking a mapping exercise to provide PCTs with information on where they might find clusters within their local population and in what proportion (current percentage sizes given are based on the national sample). This work will be undertaken with CACI using their Health Acorn product and the outputs will be comparable with MOSAIC codes. Maps and data tables will be available at www.dh.gov.uk in late 2008.

Step 3 – Bring together local focus groups of target clusters 1, 2 and 3.

To further inform the selection of target intervention groups, local areas may want to conduct independent qualitative research. Focus groups can be used to identify those families who most need help and support to change behaviours, but also to help align local research programmes with national research.

Step 4 – Tailor your interventions to fit the attitudes, behaviours and barriers elicited by each cluster focus group.

See **Tools D8**, **D9** and **D10** for more information on choosing interventions, targeting behaviours and communicating to key target groups.

CASE STUDY – The People's Movement, Sheffield

Sheffield City Council and Sheffield First for Health and Well-being have set up a physical activity campaign, 'The People's Movement', which encourages people to make positive choices around increasing the amount of physical activity they do. Further details are provided in the table below.

Aim – Behavioural goal	To encourage and support people to be more physically active and to promote 30 minutes' exercise on as many days as possible, broken down into bite-size chunks of 10 minutes.
Market research	Health professionals were consulted when designing the campaign. No focus groups or research were conducted with the target audience.
Segmentation	The target audience was segmented by current behaviour: 1 *Those already active* – the campaign aimed to keep them active (behavioural reinforcement). 2 *The nearly active* – those doing some activity but not reaching minimum recommended levels. The campaign encouraged them to do more (positive behavioural promotion). 3 *The inactive* – the campaign aimed to encourage them to try activities and begin to build activity into their lives (behavioural change).
Intervention	Different interventions for different segments of the target audience were designed: *Behavioural reinforcement* • Celebrating a community champion • A young people's physical activity campaign promoted through competitions. *Positive behavioural promotion* • A website with information and a personalised activity diary • Events such as walking festivals, belly dancing and salsa nights. *Behavioural change* • DVDs to enable beginners to train to participate in a 3k run • Leaflets and large street-based posters carrying powerful messages about the benefits of exercising • Promoting local parks and leisure facilities. Participants could also register to be sent personalised details of events happening in their community that may appeal to them.
Evaluation	No evaluation has yet been conducted. However, there are plans to do an evaluation which will look at awareness.
Further information	www.thepeoplesmovement.co.uk

TOOL D5 Setting local goals

For:	Commissioners in primary care trusts (PCTs) and local authorities
About:	This tool provides advice from the Department of Health on setting local goals using National Child Measurement Programme (NCMP) prevalence estimates.[148] It also provides advice on establishing intervention objectives – a list of National Indicators of success relevant to obesity is provided. Refer to **Tool D14** *Monitoring and evaluation: a framework*.
Purpose:	To give local areas an understanding of how to establish local plans that are based on achieving a change in obesity prevalence.
Use:	• Should be used to set local goals. • Can be used to establish objectives. • Can be used for evaluation and monitoring purposes. Data can be used as performance indicators.
Resource:	*How to set and monitor goals for prevalence of child obesity: Guidance for primary care trusts (PCTs) and local authorities.*[141] www.dh.gov.uk

Setting local goals

All local areas have already set their goals for tackling obesity over the period 2008/09 to 2010/11, either through PCT plans, or additionally in local area agreements. However, this tool summarises the Department of Health's guidance on setting local goals[149] as it is useful to remember what underpins those targets.

Currently, based on Health Survey for England data, the estimated prevalence of obesity in children in both Reception and Year 6 is rising at a yearly rate of around 0.5% points. The Department of Health suggests that local authorities and PCTs should establish **local plans that are based on achieving a change in prevalence in each of the three years that betters the current national trend** – that is, an increase of less than 0.5% points, or no increase at all, or a reduction in obesity. In order that local authorities and PCTs can achieve this change in prevalence, the Department of Health has calculated what percentage changes in obesity prevalence in Reception and Year 6 would be needed by 2010/11 to achieve a statistically significant improvement on the current trend. These data are available at www.dh.gov.uk and are based on NCMP 2006/07 prevalence estimates.[148] Because numbers measured and prevalence will be different for future years of the NCMP, the figures are indicative, but they give a reasonable approximation of the change that needs to be recorded to be statistically significantly less than the national trend.

Note:
These figures provide both 95% and 75% confidence levels. Use of a higher confidence level reduces the risk of incorrectly concluding that a significant improvement in prevalence of child obesity has been achieved. (At 95%, the risk is 1 in 20; at 75%, the risk is 1 in 4.) However, use of a higher confidence level means that a greater change in prevalence is needed for it to be deemed a significant change. In some areas, it may be necessary to sacrifice confidence to some extent in order to set a goal that is achievable. The required changes associated with the 95% and 75% confidence levels could be used as upper and lower limits to inform local negotiations on goal setting.

Step-by-step guide

Barking and Dagenham local authority has been used here as a worked example to show what steps local authorities and PCTs need to take to set a goal to achieve a statistically significant improvement on the current national trend (of annual rises in levels of child obesity of 0.5% points) by 2010/11.

Step 1 – Local authorities choose whether to set a goal for Reception Year, or Year 6, or both. PCTs have to use both for their plans, as required by the Operating Framework.

Local authority decisions should be based on current levels of prevalence for each year, the coherence of any goal with others being set (eg on school food), and whether they are jointly setting goals with the local PCT. Government offices and strategic health authorities will of course discuss these decisions with local authorities and PCTs. For the basis of this worked example, it is assumed that Barking and Dagenham local authority choose both years.

Step 2 – Determine what confidence level to use, and look up the required change by 2010/11 at that confidence level. (Go to www.dh.gov.uk for data.)

The confidence level chosen is in part a reflection of how ambitious local areas feel that they can be. The Department of Health would urge as many areas as possible to choose the 95% level of confidence.

Whatever level is chosen, for some areas this will mean that they need to record a reduction in their prevalence of child obesity if they are to be confident of achieving a statistically significant reduction in growth versus the national average growth of 0.5% points. For other areas, this requirement can be met by recording a reduced, but still increasing, level of growth in prevalence.

For Barking and Dagenham, using NCMP (2006/07) data,[148] the figures would be as follows:

Reception year:

- Current prevalence is 14.4%.
- Required change by 2010/11 to be 95% confident of reducing growth in prevalence below the national trend is -1.1% points, ie 13.3%.

Year 6:

- Current prevalence is 20.8%.
- Required change by 2010/11 to be 95% confident of reducing growth in prevalence below the national trend is -1.9% points, ie 18.9%.

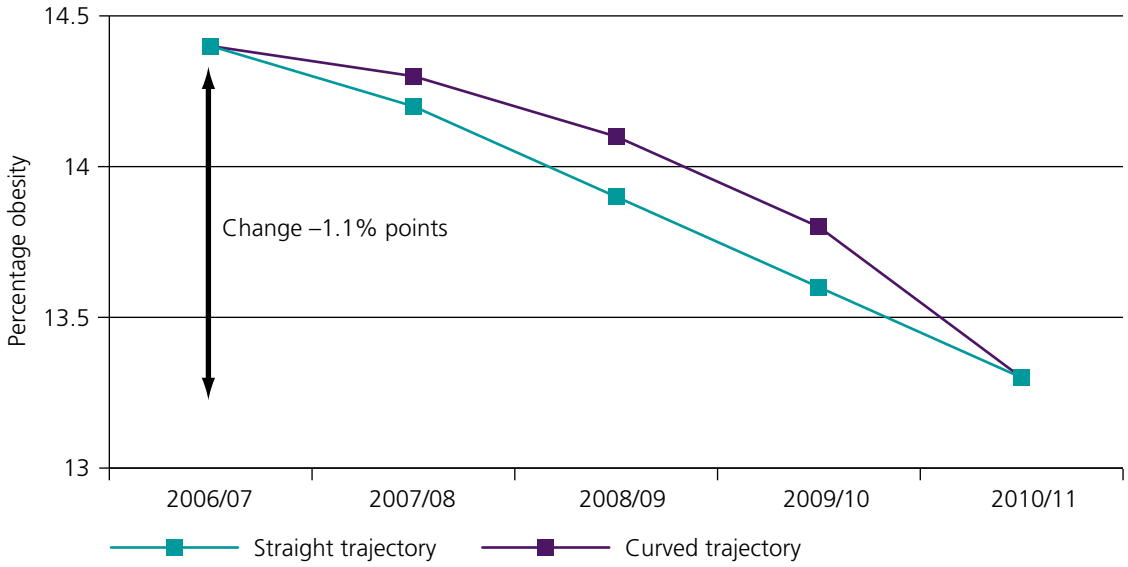
Step 3 – Set trajectory

Once the final goal for 2010/11 has been set, a trajectory for the change in prevalence to 2010/11 must be chosen. If areas are using the latest NCMP data, for 2006/07, as a baseline for their goal, the trajectory will also need to include 2007/08, as well as 2008/09 to 2010/11. Areas that already have established initiatives to tackle child obesity may feel that a straight line trajectory would be more appropriate for them. However, areas where initiatives are in their infancy may want to set a curved trajectory, where a greater proportion of the change is achieved in the later years of the period to 2010/11.

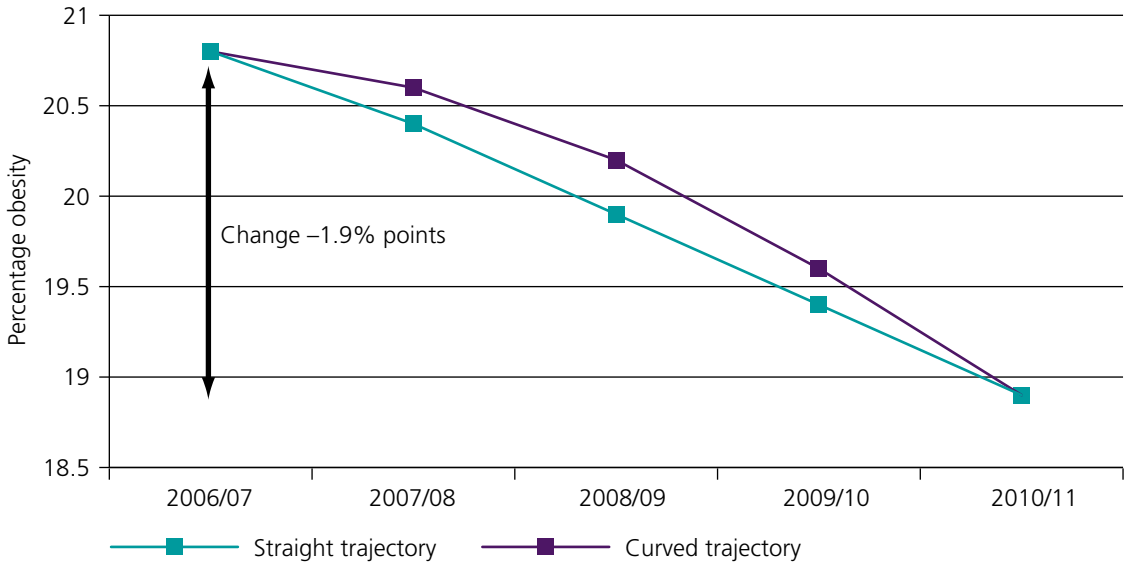
For Barking and Dagenham, the trajectory, whether straight or curved, would look as follows:

Target obesity levels for Reception and Year 6 children, Barking and Dagenham, 2006-07 to 2010-11

Reception children



Year 6 children



Setting objectives

Once the local goal has been set (eg to reduce prevalence by 1.9%), local areas can establish intervention objectives in order to reach that goal. **Tool D7** sets out what success looks like against a range of behaviours and these can be used to set local objectives. A wide range of data can be used to measure success against local objectives and the following table provides a list of the National Indicators of success relevant to obesity.[137]

National Indicators of success relevant to the Department of Health's key themes

Children: healthy growth and healthy weight	
NI 50	Emotional health of children
NI 52	Take-up of school lunches
NI 53	Prevalence of breastfeeding at 6-8 weeks from birth
NI 55	Obesity among primary school age children in Reception
NI 56	Obesity among primary school age children in Year 6
NI 57	Children and young people's participation in high-quality PE and sport
NI 69	Children who have experienced bullying
NI 198	Children travelling to school – mode of travel usually used
Promoting healthier food choices	
NI 119	Self-reported measures of people's overall health and wellbeing
NI 120	All-age, all-cause mortality rate
NI 121	Mortality rate from all circulatory diseases at ages under 75
NI 122	Mortality rate from all cancers at ages under 75
NI 137	Healthy life expectancy at age 65
Building physical activity into our lives	
NI 8	Adult participation in sport
NI 17	Individuals' perceptions of crime and anti-social behaviour
NI 47 and 48	Reduction in road traffic accidents
NI 175	Access to services by public transport, walking and cycling
NI 186	Per capita CO_2 emissions in the local authority area
NI 188	Adapting to climate change
NI 198	Children travelling to school – mode of travel usually used
Creating incentives for better health	
NI 8	Adult participation in sport
NI 119	Self-reported measure of people's overall health and wellbeing
NI 120	All-age, all-cause mortality rate
NI 121	Mortality rate from all circulatory diseases at ages under 75
NI 122	Mortality rate from all cancers at ages under 75
NI 137	Healthy life expectancy at age 65
NI 152 and 153	Working-age people claiming out-of-work benefits
NI 173	People falling out of work and onto incapacity benefits
Personalised support for overweight and obese individuals	
NI 120	All-age, all-cause mortality rate
NI 121	Mortality rate from all circulatory diseases at ages under 75
NI 122	Mortality rate from all cancers at ages under 75
NI 137	Healthy life expectancy at age 65

Refer to **Tool D14** *Monitoring and evaluation: a framework* for advice on using the indicators for evaluation purposes.

TOOL D6 Local leadership

For:	Commissioners in primary care trusts and local authorities
About:	This tool provides a list of key local leaders (actors) in delivering the obesity strategy. It details the rationale for their involvement, their role in promoting a healthy weight, and how to engage them.
Purpose:	To show which actors could be engaged in local obesity strategies. **Please note that the roles set out in this tool will not be appropriate for every area, but they may provide a helpful starting point.**
Use:	Should be used as a guide for recruiting actors.
Resource:	*Healthy Weight, Healthy Lives: Guidance for local areas.*[2] www.dh.gov.uk

Outline of roles and responsibilities of key actors within the obesity delivery chain

Actor	Rationale for involvement	Outline role in promoting healthy weight	How to engage them
Whole strategy			
Strategic leadership in the primary care trust (PCT) acting with partners in the Local Strategic Partnership (LSP) and Children's Trust	• NHS Operating Framework[149] • *How to set and monitor goals for prevalence of child obesity: guidance for primary care trusts (PCTs) and local authorities*[141] • The Every Child Matters (ECM) agenda specifically includes promoting children's health • Statutory duties and guidance for PCTs, local authorities, strategic health authorities (SHAs) and key partners to promote Every Child Matters (ECM) outcomes and reduce inequalities in the outcomes of 0-5 year olds • Guidance on Joint Strategic Needs Assessment	Local Strategic Partnership (LSP): • setting the vision for the local area • carrying out strategic needs assessment • discussing and agreeing local priorities and targets for the Local Area Agreements (LAAs) • developing the Sustainable Community Strategy. Within the LSP 'umbrella', Children's Trust partnership arrangements: • work in partnership to promote the five Every Child Matters outcomes for children and young people • reduce inequalities in ECM outcomes for 0-5s • agree the Children's and Young People's Plan Complementary with *Healthy Weight, Healthy Lives* The five ECM outcomes include *Healthy Weight, Healthy Lives*,[1] and are: • *being healthy* – physical, mental, emotional wellbeing – living a healthy lifestyle • *staying safe* – protection from harm and neglect – growing up able to look after themselves • *enjoying and achieving* – education, training and recreation – getting the most out of life and developing broad skills for adulthood • *making a positive contribution* – to community and society – not engaging in anti-social behaviour • *social and economic wellbeing* – overcoming socioeconomic disadvantages to achieve full potential in life	• Ensure obesity is high on local agenda, with key strategic leaders within PCT, local authority (LA) and partner organisations informed about (using National Child Measurement Programme (NCMP) and other data) and prepared to promote obesity issues, making the links across projects and programmes eg transport and sustainability planning • PCTs, LAs and other partners develop and agree evidence-driven obesity plans using NCMP data and other data Outcomes: • *Healthy Weight, Healthy Lives*[1] is a clearly defined element within strategic plans • Robust and realistic Vital Signs obesity delivery plans are mirrored in LAA delivery plans where obesity and/or related indicators are chosen as LAA priority (from the National Indicator Set)
Children: Healthy growth and healthy weight			
PCT/LA service commissioners	• Joint Planning and Commissioning Framework for Children, Young People and Maternity Services[150]	• Local partnerships use the Joint Commissioning Framework to create a unified system for pooling budgets and providing children's services to meet the needs identified in the strategic needs assessment – within which *Healthy Weight, Healthy Lives*[1] should be clearly defined	• Ensure local commissioners are informed and prepared to commission and fund services so that *Healthy Weight, Healthy Lives*[1] and the revised Child Health Promotion Programme[151] are firmly embedded in sustainable service commissioning • Local Trusts have local protocols to support the management of obese pregnant women that take account of the needs of these women, and the facilities and services available to them. Arrangements through maternity and neonatal networks support these mothers and their babies

Actor	Rationale for involvement	Outline role in promoting healthy weight	How to engage them
Family Information Services (FIS) (formerly Children's Information Services)	• Statutory duties on LAs and guidance	LAs strategically leading and providing an integrated service offering the information parents need to support their children up to their 20th birthday: • comprehensive, accurate, easily accessible information to support all parents, including fathers as well as mothers and all with care of a child or young person eg grandparents • local services and references to national services/information available through websites and helplines • must reach out to disadvantaged families who may benefit most from services, and provide information in ways that will overcome barriers to access	• LA Early Years Lead
Midwives	• Professional expertise and codes of conduct • The National Institute for Health and Clinical Excellence (NICE) guidance[6] • Delivering the revised Child Health Promotion Programme (CHPP)[151]	• Supporting obese women to lose weight before and after pregnancy through a structured and tailored programme that combines advice on healthy eating and physical exercise with ongoing support to allow for sustained lifestyle changes • During pregnancy promoting health and lifestyle advice to include diet and weight control. Encouraging regular physical activity, at an appropriate level, as part of the antenatal care programme • Promotion of benefits of breastfeeding • Following the CHPP schedule to identify families with children at risk of becoming obese • Referral of at-risk families to other services (eg GP) where appropriate • Encouraging regular physical activity, at an appropriate level, during pregnancy and as part of the antenatal care programme	• PCT Early Years Lead (and LA Early Years Lead)
Health visitors	• CHPP[151] • Other guidance (eg NICE obesity guidance[6])	• Leading teams implementing CHPP – focusing on the early identification and prevention of obesity through promoting breastfeeding, healthy weaning and eating, and healthy activity to all families with babies and young children – in health settings including Children's Centres, general practice and in homes • Following the CHPP schedule to identify families with children at risk of becoming obese, providing them with more intensive support and referring to other services where appropriate	• PCT Early Years Lead • LA Early Years Lead, particularly to link with local Sure Start
Sure Start Children's Centre managers and staff	• Sure Start Children's Centre guidance[152] • CHPP[151]	• Integrated multi-agency services for families with young children aged 0–5 years, focused on most disadvantaged areas • Key delivery vehicle for health priorities and targets, including encouraging take-up of breastfeeding and reducing obesity rates for parents and young children • Delivering the revised CHPP (led by health visitors)	• LA Early Years Lead and other LA colleagues responsible for supply and quality of Early Years provision and school standards • PCT Early Years Lead – promoting health activities in Children's Centres such as midwives providing antenatal and postnatal care
Early Years workforce providing integrated care and learning for 0-5 year olds, including childminders and staff in schools and private nurseries	• Early Years providers governed by statutory duties, regulation and inspection by Ofsted, and requirement to deliver the Early Years Foundation Stage (EYFS)[101]	• The EYFS requires young children's physical wellbeing and health to be promoted as part of learning through play, with opportunities for physical activity (including outdoor play wherever possible) • All meals, snacks and drinks provided are healthy, balanced and nutritious • Parents and carers are involved as partners in the learning and development of their children	• PCT Early Years Lead • LA Early Years Lead and other LA colleagues responsible for supply and quality of Early Years provision and school standards
Nominated Health Professionals in multi-agency Family Intervention Projects (FIPs)	• Resource Manual for Nominated Health Professionals working with FIPs	• Multi-agency teams, including health, working to support challenging, vulnerable and marginalised families. Evidence from FIP studies suggests that poor nutrition is a common feature in many of the families involved, with over 50% of FIP children already being obese	• PCT and LA Early Years Leads • Where FIPS are being delivered, support Nominated Health Professionals to tackle *Healthy Weight, Healthy Lives*[1] nutrition and activity issues

Actor	Rationale for involvement	Outline role in promoting healthy weight	How to engage them
Family Nurse Partnerships (FNPs)	• CHPP and other plans and guidance • Integral part of detailed programme manuals	• Evidence-based intensive home visiting preventive programme for the most at-risk young, first time mothers • Delivered by skilled nurses (health visitors, midwives, school nurses) to improve the outcomes of the most at-risk children and families • The strength-based, licensed programme begins in early pregnancy and continues until the child is two years old • Focus on healthy lifestyle and nutrition in pregnancy • Supporting parents in breastfeeding, healthy weaning and eating and healthy activity for all the family • Delivery of CHPP	• PCT and LA Early Years Leads • Where FNPs are being delivered, support Family Nurses to tackle *Healthy Weight, Healthy Lives,*[1] nutrition and activity issues
School nurses	• CHPP[151]	• Advice on healthy nutrition and regular physical activity • Signposting to programmes in extended school services and community-based programmes • Collection of height and weight data for the NCMP	• PCT Early Years Lead • LA lead contact for schools through Children's Trust arrangements
Schools: Governors	• New duty on governors of maintained schools to promote five ECM outcomes of their pupils (s.38 Education and Inspections Act 2006)[153]	• Guidance for governors on the new duty was published for consultation in July 2008	• LA lead contact for schools through Children's Trust arrangements and direct contact with schools through school nurses
Schools: Head teachers and school staff	• Linked to the new duty on governors of maintained schools to promote five ECM outcomes of their pupils (s.38 Education and Inspections Act 2006)[153]	• Implementing plans fulfilling the duty on school governors to promote the five ECM outcomes • Ensuring Healthy School status is acquired and maintained where appropriate • Encouraging extended services to promote *Healthy Weight, Healthy Lives*[1] • Ensuring whole-school approach to school food: – school lunches that meet nutritional standards – no vending machines – water freely available – agreed policies with parents on packed lunches – on-site lunchtimes • Providing cooking lessons in line with the new key stage 3 design and technology curriculum • Ensuring 2 hours of PE/sport a week available for all during the school day and encouraging 100% participation • Promoting provision and participation in a further 3 hours of sporting activities through extended services • Implementing the school active travel plan	• LA lead contact for schools through Children's Trust arrangements and direct contact with schools through school nurses • Work with Local Healthy Schools team to access support, possible partners and practical advice on achieving National Healthy School Status
Promoting healthier food choices			
Health trainers	• *Health Inequalities: Progress and Next Steps*[156] • NICE behaviour change guidance[154]	If a client identifies healthy eating/physical activity as one of their goals: • helping them reflect on their current behaviour and how they might change it for the better • helping them to understand the link between obesity and health-related problems • helping them to set realistic goals for change, helping to monitor these and keep client motivated • increasing client confidence in being able to sustain lifestyle change • signposting the client to appropriate services	• PCT health trainer coordinator • Health trainers are accessible within their communities/groups and people can self-refer or be referred by others

Actor	Rationale for involvement	Outline role in promoting healthy weight	How to engage them
Dietitians	• NICE obesity guidance[6] • Dietitians are responsible for assessing, diagnosing and treating diet and nutrition problems at an individual and wider public health level	• Provision of community-based weight management services • Ensuring consistent advice on healthy eating and physical activity is available • Involvement in research into which interventions are most effective in encouraging individuals and families to change their behaviour • Provision of training for other health workers on motivational interviewing and behaviour change • Provision of personalised health advice and lifestyle management programmes	• Dietetics department manager
Building physical activity into our lives			
Midwives	• CHPP[151]	• Encouraging regular physical activity, at an appropriate level, during pregnancy and as part of the antenatal care programme	• Primary care trust (PCT) Early Years Lead
Health visitors	• CHPP[151]	• Encouraging new mums to be active and suggest ways they could do this • Encouraging regular activity for all the family • Signposting to approved service providers, eg leisure services, commercial weight management organisations, primary care weight management clinics, health walk leaders	• PCT Early Years Lead
School nurses	• CHPP[151]	• Opportunistic advice on regular physical activity • Signposting to programmes in place within school, extended school services and community-based programmes • Collection of height and weight data for the NCMP	• PCT Early Years Lead
Early years workers (eg nursery nurses, play workers, family support workers)	• Early years providers governed by statutory duties, regulation and inspection by Ofsted, and requirement to deliver the EYFS[101] • CHPP[151]	• Encouraging active play for all children as part of daily routine • Discussing activity with young children	• PCT Early Years Lead • Children and Young People's Strategic Partnership
Children's Centres (including Sure Start)	• CHPP[151] • Sure Start Children's Centre guidance[152]	• Provision of physical activity programmes for young families • Educational sessions for young families – for example, how to make healthy food choices, healthy cooking on a budget, ways to be active with young children • Active play facilities on site • Provision of safe and secure cycle storage facilities to encourage active transport to facilities • Signposting to other service providers	• PCT Early Years Lead • Children's Centre coordinators
Dietitians	• NICE obesity guidance[6]	• Provision of community-based weight management services • Ensuring consistent advice on healthy eating and physical activity is available • Encouraging regular physical activity as part of consultations	• Dietetics Department Manager
National Healthy Schools Programme	• CHPP[151] • National Healthy Schools Status (NHSS)	• Working with schools to achieve physical activity and healthy eating core criteria • Encouraging schools to look at other ways to maximise physical activity opportunities for pupils and their families, especially for those schools who draw from communities with higher levels of overweight and obesity, identified from NCMP data	• A Local Healthy Schools team will be based in either the LA or PCT and will provide this function. Details of each Local Healthy Schools team is on www.healthyschools.gov.uk • School Sports Partnerships can be contacted through your Local Healthy Schools team or by contacting Youth Sport Trust
School travel advisers	• NICE physical activity and environment guidance[117]	• Supporting the development of school travel plans • Encouraging schools to look at new ways to increase the number of pupils walking and cycling to school	• Local authority

Actor	Rationale for involvement	Outline role in promoting healthy weight	How to engage them
Leisure providers	• NICE physical activity guidance[128] • National Quality Assurance Framework (NQAF) Exercise Referral Systems[131]	• Provision of facilities and appropriately trained staff to work with patients referred through the local exercise referral system • Provision of approved weight management information within facilities • Provision of weight management support for clients	• Joint LA/PCT strategic partnerships
Youth workers	• NICE physical activity guidance[128]	• Signposting young people to community-based physical activity programmes	• Children and Young People's Strategic Partnerships
Occupational health	• NICE physical activity and workplace guidance[155] • NICE obesity guidance[6]	• Opportunistic physical activity advice for staff accessing occupational health services • Provision of drop-in weight management services for all staff	• PCT Workforce Development Lead
Primary care teams (GPs, practice nurses, district nurses)	• NICE obesity guidance[6] • NICE physical activity guidance[128]	• Provision of opportunistic advice on physical activity and healthy weight • Assessment of height and weight of practice population • Signposting to physical activity opportunities and weight management services • Provision of weight management and physical activity clinics in practices	• Practice-based commissioning groups • PCT Lead Nurse
Pharmacists	• NICE obesity guidance[6] • *Choosing health through pharmacy* (2005)[136]	• Provision of physical activity leaflets and information issued with prescriptions • Opportunistic advice on physical activity • Signposting to local physical activity opportunities	• PCT Medicines Management / Pharmacy Lead
Planners	• NICE physical activity and the built environment guidance[117]	• Promoting a healthy weight through their role in shaping how cities, towns and villages are developed and built • Considering the impact of all planning requests on levels of physical activity and access to healthy food choices	• LA
Transport planners	• NICE physical activity and the built environment guidance[117]	• Promoting a healthy weight • Developing and managing the impact of road, rail and air transport in the local area	• LA
Local authority cycling and walking officers	• Local Area Agreements (LAAs)	• Ensuring local opportunities for walking and cycling • Liaison with planners to ensure walking and cycling opportunities are considered	• LA
Parks management	• NICE physical activity and the built environment guidance[117] • Fair Play (DCSF): Encouraging children and families to engage in physical activity	• Role in the management, maintenance and development of open/green space facilitating and encouraging physical activity by the local and wider community • Working with other LA areas to facilitate walking and cycling routes in, and to, open/green spaces	• LA
Health trainers	• *Health Inequalities: Progress and Next Steps*[156] • NICE behaviour change guidance[154]	• Attending training to be able to discuss physical activity and healthy weight appropriately with clients • Provision of physical activity advice to clients • Signposting clients to physical activity opportunities	• By working with the health trainer coordinators at PCT level • Health trainers are accessible within their communities/groups and people can self-refer or be referred by others
Healthwalk leaders	• Legacy Action Plan[116] • CMO Report *At least five a week*[113]	• Leading health walks for people of all ages across communities and ensuring links to local GP practices and Children's Centres	• Regional Walking the Way to Health (WHI) coordinators and volunteers • PCT
Commercial weight management organisations	• NICE obesity guidance[6]	• Provision of weight management services in easily accessible community venues • Provision of appropriate physical activity advice as part of weight management support	• Health Improvement Programme (HImP) and public health • Nutrition and dietetics services

Actor	Rationale for involvement	Outline role in promoting healthy weight	How to engage them
Creating incentives for better health			
LA and PCT commissioners	• Responsible for commissioning services	• Commissioning prevention, intervention and treatment services, and meeting workforce requirements • Commissioning training for staff who deliver services and staff who come in to contact with those at risk • Management of/influence on resources allocated locally for obesity and making prioritisation decisions • Supporting local flexibilities and rewards in funding flows	• LA • PCT
Occupational health	• NICE physical activity and workplace guidance[155] • NICE obesity guidance[6]	• Opportunistic physical activity advice for staff accessing occupational health services • Provision of drop-in weight management services for all staff	• PCT Workforce Development Lead
Personalised advice and support			
GP	• Quality and Outcomes Framework (QOF) (adults)[134, 135]	• Considering how to make use of existing BMI register for adults • Raising issue of weight with adults/parents proactively • Revisiting issue in future if patient not ready to change • Delivery of brief interventions • Identification of and referral to local or in-house provision of weight management services and wider healthy living services or programmes • Providing pre-conception advice for women	• Engage in development and implementation of local care pathways • PCT/GP forums
Practice nurses	• NICE obesity guidance[6]	• Raising issue of weight proactively • Referral to local or in-house provision of weight management services • Delivery of brief interventions	• Engage in development and implementation of local care pathways • PCT/GP forums
Dietitians	• NICE obesity guidance[6] • Dietitians are responsible for assessing, diagnosing and treating diet and nutrition problems at an individual and wider public health level	• Referral to local or in-house provision of weight management services • Ensuring consistent advice on healthy eating and physical activity is available • Involvement in research into which interventions are most effective in encouraging individuals and families to change their behaviour • Provision of training for other health workers on motivational interviewing and behaviour change • Provision of personalised health advice and lifestyle management programmes	• Dietetics Department Manager • Engage in development and implementation of local care pathways • Direct commissioning/service level agreement (SLA)
Pharmacists	• *Choosing health through pharmacy* (2005)[136]	• Provision of healthy living advice • Referral to local weight management services • Delivery of weight management services or brief interventions where appropriate	• PCT Medicines Management / Pharmacy Lead • Engage in development and implementation of local care pathways
Partners delivering community-based weight management services, eg leisure services, voluntary and community sector groups, commercial sector, training/ programme providers	• SLA with PCT or LA	• Reinforcing consistent national messages in terms of healthy eating and physical activity • Use of social marketing information to promote services and engage potential clients • Feeding back information/progress to referring clinicians (in line with data protection requirements) • Referral to/awareness-raising of wider suite of healthy living and preventative services available locally – for children and adults	• SLA with PCT or LA

TOOL D7 What success looks like – changing behaviour

For:	Commissioners in primary care trusts (PCTs) and local authorities
About:	This tool shows the behaviour change outcomes that the Department of Health highlighted in local obesity guidance.
Purpose:	To show what behaviour changes are required to achieve local goals.
Use:	Can be used for evaluation and monitoring purposes – as performance indicators.
Resource:	*Healthy Weight, Healthy Lives: Guidance for local areas.*[2] www.dh.gov.uk

Children: Healthy growth and healthy weight	Promoting healthier food choices	Building physical activity into our lives	Creating incentives for better health	Personalised advice and support
As many mothers breastfeeding up to 6 months as possible, with families knowledgeable about healthy weaning and feeding of their young children All children growing up with a healthy weight by eating well, for example by eating at least 5 portions of fruit and vegetables a day All children growing up with a healthy weight by enjoying being active, for example by doing at least one hour of moderately intensive physical activity each day Parents have the knowledge and confidence to ensure that their children eat healthily and are active and fit All schools are Healthy Schools, and parents who need extra help are supported through Children's Centres, health services and their local community	More eligible families signing up to the Healthy Start scheme Less consumption of high fat, sugar, salt (HFSS) foods, especially by children More consumption of fruit and vegetables and more people eating 5 A DAY, especially children More healthy options in convenience stores, school canteens, vending machines, at supermarket tills and at non-food retailers	More people, more active, more often, particularly those individuals and families who are currently the most inactive Reduced car use, especially for trips under a mile in distance More outdoor play by children	More workplaces that promote healthy eating and activity, with the public sector acting as an exemplar, both through the location and design of the buildings on the government estate and through staff engagement programmes	Everyone able to access appropriate advice and information on healthy weight Increasing numbers of overweight and obese individuals able to access appropriate support and services Local staff/practitioners understanding their role and empowered to fulfil it

TOOL D8 Choosing interventions

For:	All commissioners in local areas developing an obesity strategy
About:	This tool provides information on interventions, divided into the Department of Health's five core themes, as set out in *Healthy Weight, Healthy Lives*.[1] It is based on evidence of effectiveness and cost-effectiveness adapted from the NICE guideline on obesity.[6] Interventions have been ranked according to the level of evidence of effectiveness as assigned by NICE.
Purpose:	To give local areas an understanding of what interventions are effective and cost-effective. However, **local areas should not feel constrained to implement only interventions with evidence of effectiveness. It is important that areas try new interventions, provided they are evaluated and so add to the evidence base.** See **Tool D14** *Monitoring and evaluation: a framework*.
Use:	• Should be used as a guide to selecting interventions. • Can be used as a checklist of interventions.
Resource:	*Obesity: The prevention, identification, assessment and management of overweight and obesity in adults and children.*[6] www.nice.org.uk

Key to grading evidence

Levels of evidence for intervention studies	
Level of evidence	**Type of evidence**
1++	High-quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1+	Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias*
2++	High quality systematic reviews of non-RCT, case-control, cohort, CBA or ITS studies High quality non-RCT, case-control, cohort, CBA or ITS studies with a very low risk of confounding, bias or chance and a high probability that the relation is causal
2+	Well conducted, non-RCT, case-control, cohort, CBA or ITS studies with a very low risk of confounding, bias or chance and a moderate probability that the relation is causal
2-	Non-RCT, case-control, cohort, CBA or ITS studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal
3	Non-analytic studies (eg case reports, case series)
4	Expert opinion, formal consensus

Notes:
* Studies with a level of evidence (-) should not be used as a basis for making recommendations.
RCT: Randomised controlled trial. CBA: Controlled before and after. ITS: Interrupted time series.

Source: National Institute for Health and Clinical Excellence (2006)[6]

Evidence tables

Children: healthy growth and healthy weight

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost-effectiveness		
EARLY YEARS						
More healthy options and healthy eating	Improvement in food service to pre-school children	Reductions in dietary intakes of fat and improved weight outcomes **(1+)**	A US-based study reported that a parent education programme focusing on nutrition-related behaviour resulted in the intervention group consuming significantly more fruits, vitamin-C-rich fruits, green vegetables, breads, rice/pasta and orange vegetables than the control group.[157] Another study reported that attending educational sessions significantly improved the frequency of parents offering their child water.[158] Furthermore, a systematic review reported beneficial effects on the nutritional content of day-care menus.[66]	–		
	Education through videos and interactive demonstrations Changing food provision at nursery	Small but important beneficial effect as long as interventions not solely focused on nutrition education **(2+)**		–		
	Provision of regular meals in supportive environment free from distractions	Opinion of Guideline Development Group (GDG) **(4)**		–		
More physical activity	Encourage parents to engage in a significant way in active play, and reduce sedentary behaviour	Particularly effective **(2+)**	One study reported that attending educational sessions significantly improved the frequency of parents engaging in active play with their child.[158] A UK-based study was successful in significantly reducing television-viewing (the primary aim of the study) but did not show significant improvements in snacking or watching television during dinner.[159] The UK-based MAGIC (Movement and Activity Glasgow Intervention in Children) pilot study reported that a nursery-based structured physical activity programme resulted in a significant improvement in children's physical activity levels.[6]	–		
	Structured physical activity programmes within nurseries	Limited evidence of effectiveness **(grade pending)**		–		

Key points

- Interventions should be tailored as appropriate for lower-income groups. **(1+)**
- 2-5 years is a key age at which to establish good nutritional habits, especially when parents are involved. **(1+)**
- Interventions require some involvement of parents or carers. **(1+)**

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost-effectiveness		
SCHOOLS						
More healthy eating	Reduce consumption of carbonated drinks	Limited evidence that interventions were effective in reducing overweight and obesity **(1++)**	Three large-scale interventions aimed to modify school lunch provision: one significantly reduced children's total energy and fat intake;[160] one reduced children's fat intake but not total energy intake in school lunch observations;[161] and the last showed no difference in fat intake.[162] One additional study within the fruit and vegetable intervention review showed that reducing relative prices of low-fat snacks was effective in promoting lower-fat snack purchases from vending machines in adolescents over one year.[163] Analysis of the UK National School Fruit Scheme (now known as the School Fruit and Vegetable Scheme or SFVS) showed that 4-6 year old children receiving school fruit had a significantly higher daily intake than controls (117g/day compared to 67g/day, respectively) but this difference was not maintained two years after the intervention when free fruit was no longer available.[164]	There is some evidence that school-based interventions can result in cost-effective health gains. Both interventions identified resulted in weight loss at acceptable costs. (Wang et al, 2003[165] **(1+)**; Wang et al, 2004[166] **(2+)**)		
	Increase fruit and (to a lesser extent) vegetable intake Improve school meals Promote water consumption	Effective in improving dietary intake **(1+)** **Key point** Schoolchildren with the lowest fruit and vegetable intakes at baseline may benefit more from the school-based interventions than their peers **(2+)**				
More physical activity	Promotion of less sedentary behaviour (television watching)	May help children lose weight **(no grade)**	*Active play:* A 12-week, US-based intervention promoting active play supplementary to usual PE among 9 year olds showed significant improvements in the intervention children compared with the controls, particularly among girls.[167] Another study reported that a small intervention over 14 months resulted in 5-7 year old children in the intervention group being more active in the playground than the control group children.[168] *PE classes:* One study reported significant increases in moderate physical activity among female adolescents, particularly 'lifestyle' activity, at four-month follow-up, following the promotion of 60-minute PE classes five days a week and associated education classes.[169] There is good corroborative evidence from the UK that 'safer routes to school' schemes can be effective.[170] A series of studies found that, when both school travel plans and safer routes to school programmes were in place, there was a 3% increase in walking, a 4% reduction in single-occupancy car use and a 1.5% increase in car sharing. Bus and cycle use remained largely static.[171] Conversely, a series of selected case studies found an overall increase in cycle use and a decrease in car travel whereas the effects on walking and bus travel were variable.[172] Another scheme also found a considerable increase in walking and cycling to and from school three years after the intervention.[173]			
	Multi-component interventions	Effective while intervention in play **(1+)**				

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost-effectiveness		
More healthy schools	Multi-component addressing various aspects including school environment	Equivocal to prevent obesity **(2+)** Effective in improving physical activity and dietary behaviour during intervention. UK-based evidence is limited **(1+)**	One study reported that 7-11 year old children in schools adopting a whole-school approach were consuming significantly more vegetables at one-year follow-up.[174] Another multicomponent intervention study reported that 5-7 year old children in the intervention group consumed significantly more vegetables and fruit (girls only).[168] The two-year Planet Health programme among US 12 year olds – promoting physical activity, improved diet and reduction of sedentary behaviours (with a strong emphasis on reducing television-viewing) – resulted in a reduction in the prevalence of obesity in intervention girls (but not boys) compared with controls.[175, 176] A review of five UK school-based interventions concluded that all five interventions considered (fruit tuck shops, CD-ROM, art/play therapy, whole-school approach and a family-centred school-based activity) have the potential to be incorporated into a health-promoting school approach and could be more effective than stand-alone interventions. The authors highlighted the importance of actively engaging schools for the success of the intervention.[177]	There is some evidence that school-based interventions can result in cost-effective health gains. Both interventions identified resulted in weight loss at acceptable costs. (Wang et al, 2003[165] **(1+)**; Wang et al, 2004[166] **(2+)**)		

Key points

- There is a body of evidence to suggest that young people's views of barriers and facilitators to healthy eating indicated that effective interventions would (i) make healthy food choices accessible, convenient and cheap in schools, (ii) involve family and peers, and (iii) address personal barriers to healthy eating, such as preferences for fast food in terms of taste, and perceived lack of will-power. **(1++)**
- There is a body of evidence to suggest that young people's views on barriers and facilitators to physical activity suggest that interventions should (i) modify physical education lessons to suit their preferences, (ii) involve family and peers, and make physical activity a social activity, (iii) increase young people's confidence, knowledge and motivation relating to physical activity, and (iv) make physical activities more accessible, affordable and appealing to young people. **(1++)**
- There is limited UK evidence to indicate that in terms of engaging schools it is important to enlist the support of key school staff. **(2+)**

Promoting healthier food choices

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost–effectiveness		
RAISING AWARENESS						
More healthy eating	Educational promotional campaign	Unclear for weight management **(1+)** Evidence that campaign can increase awareness of healthy diet and subsequently improve dietary intake **(2+)**	Interventions can result in improvements in various dietary outcomes, including a decrease in fat consumption, an increase in fruit and vegetable intake, and a decrease in fried foods and snacking. For example: • The BBC's Fighting Fat, Fighting Fit campaign demonstrated statistically significant improvements in diet five months after the campaign in a random survey of people who registered for more information. Significant improvements were reported in fruit and vegetable intake, with a 13% increase in respondents eating the recommended 5 portions a day. There was also a 16% increase in participants eating fried food less than once a week. Significant improvements were also observed in consumption of fat spreads, consumption of lower-fat milk, removal of fat from meat, snacking and consumption of starch-based meals.[178, 179] • One-year follow-up of the Department of Health's community-based 5 A DAY pilot projects demonstrated that the intervention had stemmed a fall in fruit and vegetable intake against the national trend. Overall the intervention had a positive effect on people with the lowest intakes. Those who ate fewer than 5 portions a day at baseline increased their intake by 1 portion over the course of the study. In contrast, those who ate 5 or more portions a day at baseline decreased intakes by about 1 portion per day.[180] • A review by the Food Safety Promotion Board in Ireland reported that social marketing interventions were strongly and equally effective at influencing behaviour, knowledge and psychosocial variables such as self-efficacy, attitudes and perceptions of the benefits of eating more healthily. Social marketing interventions appeared to be moderately effective at influencing stage of change in relation to diet, and to have a more limited effect on diet-related physiological outcomes such as blood pressure, Body Mass Index and cholesterol.[181]	–		
	Food promotion	Some evidence that it can have an effect on children's food preferences, purchase behaviour and consumption. The majority of food promotion focuses on foods high in fat, sugar and salt and therefore tends to have a negative effect. However, food promotion has the potential to influence children in a positive way **(2+)**		–		
	Public health media campaign	Limited evidence that it can have beneficial effect on weight management, particularly among individuals of higher social status **(2+)**		–		

Key points

- Parents are important role models for children and young people in terms of behaviours associated with the maintenance of a healthy weight. **(3)**
- Books, magazines and television programmes are an important source of information, and actively involving media providers may improve the effectiveness of interventions. **(3)**
- A significant proportion of parents may not recognise that their child is overweight and may have a poor understanding of how to translate general advice into specific food choices. **(3)**

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost–effectiveness		
COMMUNITY INTERVENTIONS LED BY HEALTHCARE PROFESSIONALS						
More healthy eating	Support and advice on physical activity and diet (not alone)	Effective for weight management **(1+)**	–	–		
	Moderate or high intensity dietary interventions – reduce fat intake and increase fruit and vegetable consumption	Clinically significant reductions in fat intake and increases fruit and vegetable consumption **(1++)**	–	–		
	Brief counselling, or dietary advice by GPs or other health professionals	Effective in improving dietary intake but tend to result in smaller changes than intensive interventions **(1++)**	–	–		

Key points

- Interventions with a greater number of components are more likely to be effective. **(1++)**
- Although the majority of studies included predominantly white, higher social status and reasonably motivated individuals, there is some evidence that interventions can also be effective among lower social groups and effectiveness does not vary by age or gender. **(1+)**
- Tailoring dietary advice to address potential barriers (taste, cost, availability, views of family members, time) is key to the effectiveness of interventions and may be more important than the setting. **(3)**
- The type of health professional who provides the advice is not critical as long as they have the appropriate training and experience, are enthusiastic and able to motivate, and are able to provide long-term support. **(3)**
- There is some evidence that primary care staff may hold negative views on the ability of patients to change behaviours, and on their own ability to encourage change. **(3)**
- There is a body of evidence from UK-based qualitative research that time, space, training, costs and concerns about damaging relationships with patients may be barriers to action by health professionals (GPs and pharmacists). **(3)**
- There is some evidence from the UK that patients are likely to welcome the provision of advice, despite concerns by health professionals about interference or damaging the relationship with patients. **(3)**
- It remains unclear whether interventions are more effective when delivered by multidisciplinary teams. **(N/A)**

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost–effectiveness		
BROADER COMMUNITY						
More healthy eating	Point-of-purchase schemes in shops, supermarkets, restaurants and cafés – supported by education, information and promotion	Effective in short term. Longer-term, multi-component interventions may show greater effects **(2++)**	Strategies to minimise barriers to healthy eating by improving availability and access: Studies that looked at the effect of the opening of a supermarket in a deprived, poor-retail-access community in Leeds found that participants who switched to the new store increased their consumption of fruit and vegetables by 0.23 portions per day. The findings suggest that fundamental issues around cost, availability and taste are key considerations for future interventions. Twenty-eight per cent of those who did not switch to the new store were concerned about the expense. This was backed up by qualitative work which found that, although the stores improved physical access, this did not fundamentally alter economic access.[182, 183]	There is some evidence that a diet and physical activity intervention incorporating interactive educational sessions is cost-effective when compared with a similar intervention using only mailshot advice for couples living together for the first time. (Dzator et al, 2004[184] **(1+)**, Roux et al, 2004[185] **(1+)**)		
	Novel educational and promotional methods such as videos and computer games	May be effective in improving dietary intake **(1++)**				

Key points

- Interventions may be ineffective unless fundamental issues are addressed, such as: individual confidence to change behaviour; cost and availability; pre-existing concerns such as poorer taste of healthier foods and confusion over mixed messages; and the perceived 'irrelevance' of healthier eating to young people. **(3)**
- Auditing the needs of all local users can help engage all potential local partners and establish local ownership. **(3)**

Building physical activity into our lives

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost–effectiveness		
RAISING AWARENESS						
More physical activity	Promotional campaigns	Unclear on weight maintenance **(1+)** Can improve knowledge, attitudes and awareness of physical activity. Levels of awareness are likely to vary according to type of medium used and the scale of the campaign **(2++)**	Physical activity and fitness campaigns: • The BBC's Fighting Fat, Fighting Fit campaign showed significant improvements in physical activity: overall 39% of the full sample and 74% of completers increased their activity levels and the proportion undertaking regular moderate exercise increased from 29% to 45% (and from 29% to 60% for completers only).[179] • The US-based VERB campaign which aims to increase awareness of physical activity among 9-13 year olds, found that levels of activity increased in line with awareness of the campaign. Those 9-10 year olds who were aware of the campaign engaged in 34% more free-time physical activity sessions per week than those who were unaware. However, no overall effect on free-time physical activity sessions was detected at the population level. Furthermore, 90% of children who were aware of VERB also demonstrated understanding of the messages. A significant positive relation was detected between the level of awareness of VERB and weekly average sessions of free-time physical activity.[186] • The Australian Walk Safely to School Day attributed a relative, short-term increase of 31% of children walking to school to the campaign. On a population level this equates to a 6.8% increase in walking to school.[187, 188]	–		
	Public health media campaign	Limited evidence of beneficial effect on weight management, particularly among individuals of higher social status **(2+)** Unclear on influencing participation in physical activity. Evidence that campaigns should target motivated sub-groups **(2++)**		–		
Key points • Books, magazines and television programmes are an important source of information, and actively involving media providers may improve the effectiveness of interventions. **(3)**						

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost–effectiveness		
COMMUNITY INTERVENTIONS LED BY HEALTHCARE PROFESSIONALS						
More physical activity	Support and advice on physical activity and diet (not alone)	Effective for weight management **(1+)**	–	–		
	Behavioural/ educational interventions	Moderately effective for walking and non-facility-based activities **(1++)**	–	–		
	Free access to leisure facilities	Limited evidence – increase in activity levels **(1+)**	–	–		

Key points

- Interventions with a greater number of components are more likely to be effective. **(1++)**
- Although the majority of studies included predominantly white, higher social status and reasonably motivated individuals, there is some evidence that interventions can also be effective among lower social groups and effectiveness does not vary by age or gender. **(1+)**
- Tailoring physical activity advice to address potential barriers (such as lack of time, access to leisure facilities, need for social support and lack of self-belief) is key to the effectiveness of interventions. **(1++)**
- The type of health professional who provides the advice is not critical as long as they have the appropriate training and experience, are enthusiastic and able to motivate, and are able to provide long-term support. **(3)**
- There is some evidence that primary care staff may hold negative views on the ability of patients to change behaviours, and on their own ability to encourage change. **(3)**
- There is a body of evidence from UK-based qualitative research that time, space, training, costs and concerns about damaging relationships with patients may be barriers to action by health professionals (GPs and pharmacists). **(3)**
- There is some evidence from the UK that patients are likely to welcome the provision of advice despite concerns by health professionals about interference or damaging the relationship with patients. **(3)**
- It remains unclear whether interventions are more effective when delivered by multidisciplinary teams. **(N/A)**

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost–effectiveness		
BROADER COMMUNITY						
More physical activity	Promotion of active travel (eg publicity campaigns)	Not effective **(1++)**	A systematic review of active travel versus car travel concluded that targeted behavioural change programmes with tailored advice can improve the travel behaviour of motivated subgroups (the largest study showing a 5% shift to active travel).[189]	There is some evidence that a diet and physical activity intervention incorporating interactive educational sessions is cost-effective when compared with a similar intervention using only mail-shot advice for couples living together for the first time. (Dzator et al, 2004[184] **(1+)**, Roux et al, 2004[185] **(1+)**)		
	Targeted behavioural change programmes with tailored advice. Subsidies for commuters	Effective in changing travel behaviour of motivated groups May be effective **(1++)**	–			
	Creation of, or enhanced access to space for physical activity (such as walking or cycling routes), combined with supportive information/ promotion	Effective **(2++)**	A systematic review (of all US-based studies of varying designs) found strong evidence that the creation of space or enhanced access to places for physical activity combined with informational outreach activities is effective in increasing physical activity levels. Interventions increased the frequency of activity by between 21% and 84%. Interventions included access to fitness equipment, access to community centres and creation of walking trails.[190]			
	Point-of-decision prompts or educational materials such as posters and banners	Weak positive effect on stair walking **(2+)**	–			
	Changes to city-wide transport, which make it easier and safer to walk, cycle and use public transport – such as the congestion charging scheme in the City of London and Safe Route to School schemes	May be effective in making active transport appealing to local users **(3)**	–			

Key points

- Addressing safety concerns in relation to walking and cycling may be particularly important for females, and for children and young people and their parents. **(3)**
- Interventions may be ineffective unless fundamental issues are addressed, such as individual confidence to change behaviour; cost and availability; and the potential risks (including perception of risk) associated with walking and cycling. **(3)**
- Auditing the needs of all local users can help engage all potential local partners and establish local ownership. **(3)**

Creating incentives for better health

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost-effectiveness		
More healthy eating	Information strategies such as labelling Increased provision of healthier food Reduction in cost of low-fat snacks	Effectiveness on weight outcomes is unclear **(2++)** Encourages consumption of a healthy diet **(2++)**	*Healthier food provision* – One systematic review concluded that worksite intervention studies targeting healthier food provision by information strategies such as labelling and/or changes in food availability or cost can encourage healthier eating.[191] *Incentives* – One study concluded that, when prices of low-fat snacks in 55 vending machines were reduced by 10%, 25% and 50%, the total number of items sold increased by 9%, 39% and 93%, respectively.[192]	–		
	Provision of water	No studies identified **(N/A)**	–	–		
	Behaviour modification programmes such as health screening with counselling/ education	Short-term weight loss. Weight loss may be regained post intervention **(1+)**	Evidence from 10 randomised controlled trials and one controlled non-randomised trial suggests that worksite behaviour modification programmes, such as a 'health check' followed by counselling, can result in short-term weight or body fat loss, although there was a tendency for weight regain after the intervention.[6]	–		
	Behaviour modification programmes such as health screening followed by counselling and sometimes environmental changes	Improvements in nutrition while intervention in place **(1+)**	A systematic review found that worksite behaviour modification programmes can show a positive effect on dietary fat intake (up to 3% decrease in percentage of energy from fat).[193] Programmes can also increase consumption of fruit and vegetables from 0.09 to 0.5 portions per day. Successful programmes included a wide range of educational interventions (such as a health check followed by counselling) sometimes accompanied by environmental changes. Information about long-term effects was limited.[6]	–		
More physical activity	Use of educational sessions and informative materials	Inconclusive evidence on weight outcomes **(N/A)**	*Encouraging increased physical activity* – A systematic review concluded that the use of workplace-based educational sessions and informative materials had significant effects on levels of physical activity.[193] Results from a systematic review support the implementation of worksite physical activity programmes.[194] The overall conclusion of the review was that there was strong evidence for a positive effect of physical activity programmes on levels of physical activity.	Evidence suggests that physical activity counselling does not result in any cost-effective gains in health outcomes, and studies on the benefits in terms of lost productivity are equivocal. (Proper et al, 2004[195] **(1+)**, Aldana et al, 2005[196] **(2-)**)		
	Active travel schemes	No studies identified **(N/A)**	*Active travel plans* (eg *Cycle to Work scheme*) There is evidence from a UK-based study[197] and a Finnish-based study[198] that workplace promotional strategies can increase the number of people travelling actively to work.	–		

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost-effectiveness		
More physical activity *(continued)*	Payroll incentive schemes (eg free gym membership)	Either only effective in the short term (during the period of the intervention) or ineffective for weight control **(1+)**	–	–		
	Using the stairs	No studies identified **(N/A)**	–	–		
	Behaviour modification programmes such as health screening with counselling/ education	Short-term weight loss. Weight loss may be regained post intervention **(1+)**	Evidence from 10 randomised controlled trials and one controlled non-randomised trial suggests that worksite behaviour modification programmes, such as a 'health check' followed by counselling can result in short-term weight or body fat loss although there was a tendency for weight regain after the intervention.[6]	–		
	Behaviour modification programmes such as health screening followed by counselling and sometimes environmental changes	Improvements in physical activity while intervention in place **(1+)**	–	–		

Personalised support for overweight and obese individuals

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost-effectiveness		
NON-CLINICAL SETTINGS TARGETED AT ADULTS						
More healthy eating and physical activity	Multi-component commercial group programmes	Multi-component programme more effective than standard self-help programme. It remains unclear whether the branded commercial group programme for which there is evidence of effectiveness (WeightWatchers) is more or less effective than other branded commercial programmes **(1++)**	–	–		
	Computer/email/ internet-based programmes accompanied by greater ongoing support – in person, by post or email	Programmes more effective with than without ongoing support **(1+)**	–	–		
	Peer-led programme and a group-based and individual-based weight loss programme in a religious-based setting, a home-based exercise programme (accompanied by regular group sessions) and a programme providing information through interactive television	May be effective in the management of obesity **(1+)**	–	–		
	Meal replacement products	No strong evidence **(N/A)**	–	–		
	Commercial and computer-based weight loss programmes in men	Unclear **(N/A)**	–	–		

Key points

- There is limited evidence that interventions to manage obesity based in workplace settings can be effective, although weight loss may be small in the long term. **(1-)**
- There is limited evidence on the effectiveness of interventions based in non-clinical settings to manage obesity in adults (particularly men). **(N/A)**

Desired behaviour	Interventions	Evidence base			Intervention already in place	Select intervention
		Effectiveness	Evidence	Cost-effectiveness		
NON-CLINICAL SETTINGS TARGETED AT CHILDREN						
More healthy eating and physical activity	Home-based interventions accompanied by behaviour modification material and ongoing support	Effective but replicability on wider scale remains unclear **(1+)**	–	–		

Key points

- There is limited evidence that interventions provided by school staff can aid the management of obesity in children and young people, at least in the short term, but this may be less effective than a more intensive intervention delivered in a clinical setting. **(2-)**
- There is a paucity of evidence on the effectiveness of interventions to manage obesity in children based in non-clinical settings. The evidence that was identified was generally for children aged 8-12 years and at the extreme end of obesity. **(N/A)**
- There is no UK-based evidence available on the effectiveness of interventions to manage obesity in children and young people in non-clinical settings. **(N/A)**
- There is insufficient evidence to compare the effectiveness of interventions with or without family involvement in non-clinical settings. **(N/A)**
- No evidence was identified which considered the effectiveness of exercise referral programmes to manage overweight or obesity in children and young people. **(N/A)**
- Among both children and adults, interventions in non-clinical settings that are shown to be effective in terms of weight management, are likely to demonstrate significant improvements in participants' dietary intakes (most commonly fat and calorie intake) or physical activity levels. **(1+)**
- The impact of participant joining fees and participant costs on the long-term effectiveness in 'real life' commercial programmes remains unclear. **(N/A)**
- There is insufficient evidence to identify strategies in non-clinical settings that are associated with the long-term maintenance of weight and continuation of improved behaviours among overweight and obese adults and children. **(N/A)**
- It remains unclear whether the source of delivery (both the main intervention and ongoing support) has an influence on effectiveness. **(N/A)**
- There is insufficient evidence to assess the importance of the source of delivery (for example, health professional versus volunteer worker) on the effectiveness of programmes for children or adults. **(N/A)**
- None of the identified studies considered inter-agency or inter-professional partnerships. **(N/A)**

TOOL D9 Targeting behaviours

For:	Commissioners in primary care trusts (PCTs) and local authorities
About:	This tool details the key behavioural insights from the national social marketing research conducted by the Department of Health.
Purpose:	• To give local areas an understanding of how families with children aged 2-11 years and minority ethnic communities perceive health and weight and diet and physical activity (see below). • To give local areas a sense of the difficulties of achieving the desired behaviours.
Use:	Can be used to help inform the initial design of interventions which can then be tailored to take account of the local environment by testing the design with the target groups.
Resource:	*Insights into child obesity: A summary.* A draft of this report is available to PCTs and LAs through their Regional Public Health Group. A final report will be published in late 2008.

When structuring local obesity strategies, it is important to understand the behaviours of the target group so that interventions can be designed accordingly. At a national level, the Department of Health conducted qualitative research among families with children aged 2-11 years, including both general population families and families in black and minority ethnic (BME) communities (Pakistani, Bangladeshi and Black African [Ghanaian and Nigerian]), to gain an understanding of their diet and physical activity behaviours. Researchers observed families over a number of days to obtain knowledge of what families were 'actually' doing rather than what the families 'perceived' themselves or 'claimed' to be doing. Below are details of the key behavioural insights from this research.

Insights on health and weight

General population

Parents have an inaccurate picture of their own and their children's weight

While childhood obesity is acknowledged as a problem, parents often do not recognise that it is relevant to their own family. Only 11.5% of parents with obese and overweight children identified their children as being obese or overweight.

Parents disassociate their families from the issue of obesity

Parents often refuse to acknowledge that their children are overweight, even when told so by a health professional. This is a sensitive issue for parents as childhood obesity is often connected in parents' minds with cases of severe neglect and abuse. This is repeatedly reinforced by media stories of extreme obesity. Also, parents are alienated by academic and medical language: phrases like 'clinical' or 'morbid' obesity encourage many families in the priority clusters to disassociate themselves from the issue.

Parents are unaware of the risks associated with behaviours such as sedentary activity or constant snacking

Many parents seriously misperceive the risks associated with their diet and levels of physical activity. High-risk behaviours like eating a lot of convenience foods, high levels of snacking and sedentary behaviour are prevalent, yet perception of risk is low. 'At-risk' families are also largely unaware of their own risk behaviours, underestimating how much unhealthy food and convenience food they buy and overestimating the amount of activity their children do.

Awareness of health risks associated with being overweight or obese is limited

The relatively low importance attached to concerns about diet and activity could be partly explained by lack of awareness of the health risks associated with poor diet and inactivity. Data from Cancer Research UK show that only 38% of adults recognise that obesity is a risk factor for heart disease and just 6% are aware of the link to cancer. Awareness of the health risks for children is particularly low.

Parents believe their children are healthy if the children are happy

Many parents assume their children are 'healthy' as long as they seem happy and provided they have no obvious health problems. Many families in the priority clusters therefore see health as related to emotional and psychological wellbeing rather than physical wellbeing. Prioritising children's happiness in this way can lead parents to encourage 'unhealthy' activities such as snacking and excessive sedentary behaviour because it makes their children happy.

It can be hard to engage with the concept of 'healthy living'

Adopting a 'healthy lifestyle' is seen as hard work, stressful and unrealistic. It is also strongly linked to 'middle class' values and activities such as yoga classes, gym membership and buying organic food. Many families in the priority clusters see healthy living as the province of stay-at-home mums who can afford not to work and instead spend their time exercising and shopping for and cooking healthy meals. At the same time, they identify strongly with those commercial brands that seem to align themselves with their priorities and promise rewarding, positive experiences.

Black and minority ethnic (BME) families

Parents' attitude towards health is reactive and tends to be more rational and physical than emotional

Parents took a reactive approach to their child's health, seeing it as an absence of illness. They defined health as the child's ability to function in terms of their overall priorities, especially around education and faith, such as doing homework, going to school and observing religious obligations.

Childhood obesity is not an overt issue

The media gave younger parents some low-level awareness of childhood obesity being a government concern. However, older parents tended to be less engaged with the media and thus were less aware. Parents were unlikely to personalise the issue, even if they were aware of it. This was because they were unaware of the long-term health risks or the risks attached to poor diet and low activity levels, and they misjudged the weight of their children, either assuming that it was puppy fat or that their child was an appropriate weight. Importantly, it was possible to talk to parents directly about obesity. Direct and rational messages that deal with obesity and health were very motivating to minority ethnic parents, and obesity did not carry the same emotive connotations that it did for mainstream parents.

'Big is beautiful' is a powerful cultural influence

Many parents were more concerned about their children being underweight rather than overweight and often cited family pressures to have 'chubby' children. There was a sense that being 'big' was considered to be more appealing and desirable and a sign of health and wealth.

Insights on family diet

General population

Parents have surrendered food choices to their children

In many of the families in the priority clusters, parents placed great value on giving choice to children, particularly over food. Given the choice, children will more often than not opt for unhealthy foods which can lead to problem behaviour such as hyperactivity, lethargy or tantrums.

Snacking is a way of life for many families in the priority clusters

Families in the priority clusters use snacks in a number of complex ways: for example, as rewards for good behaviour, as 'fillers' during periods of boredom, or to appease conflict. Parents are often unaware of how much snacking they are doing themselves and how much their children are doing. They have a false picture of what kinds of snacks their children are consuming, and they have a misplaced sense of 'control' – they say they only allow snacks when their children ask but in reality they never say 'no'.

Parents focus on 'filling up' their children

Parents are more likely to be concerned about not giving their children enough food than about giving them too much. In young children there are concerns over a failure to grow and develop rapidly. By school age, parents are often concerned that their children have enough energy for the multitude of activities that they have to do. In older children there is a perceived risk of eating disorders such as anorexia nervosa or bulimia nervosa, despite the absence of evidence that parental behaviour can affect the risk of developing these conditions. Parents' shopping choices are therefore focused on buying the foods they know their children will eat.

Parents lack knowledge, skills and confidence in the kitchen

While parents will often cite 'time and convenience' or their own 'laziness' as the reasons why they don't cook from scratch, in reality the main barriers to cooking meals are lack of knowledge, skills and confidence. Anecdotally, mothers talked about experiencing feelings of rejection in the past when children had refused meals that they had prepared. Many therefore stick to a limited repertoire of 'tried and tested' meals which has the effect of making their children more fussy about food.

Black and minority ethnic (BME) families

Food is a critical part of community life

Food plays an important role and there is considerable emotion invested in cooking, sharing and consumption of 'good' food. For women it fulfilled a number of functions – demonstrating love for their family (by taking time and effort to cook 'proper' family meals); a sign of status – being able to provide food in abundance to families and friends; and a sign of good upbringing – for women in traditional families, being able to cook ethnic meals from scratch demonstrated they had been well brought up by their mothers.

Cooking from scratch is widespread and knowledge and skills are high

Cooking traditional foods from scratch with fresh ingredients was widespread and occurred on a daily basis, so parents believed that their diets were healthy. Traditional cooking methods were observed and cooking practices had been passed on from mother to daughter. However, unhealthy elements, particularly in the use of cooking oils and ghee (clarified butter), were found to be commonplace. While some mothers believed they had cut down on the use of cooking oils, others felt they could not because of family members' preferences.

Family diets are well planned and organised but there is an emphasis on abundance

The cultural significance of food and the prevalence of more authoritarian parenting styles meant that family meals were well planned and organised. However, it was clear that even within this there were unhealthy practices, such as large portion sizes at mealtimes because of the value placed on the provision of abundant food, frequent meals (sometimes twice in an evening) and children being encouraged to clear their plates.

Consumption of unhealthy 'Western foods' is unregulated by parents

Children were being allowed to consume large quantities of Western convenience foods in addition to their traditional family meals. Parents acknowledged that Western foods could be unhealthy but because children were also eating traditional foods which maintained their cultural values, parents believed that overall their children's diet was acceptable.

Insights on physical activity

General population

Parents believe their children are already sufficiently active

Many parents believe their children are getting enough exercise during the school day to justify sedentary behaviour at home. In most cases, researchers believed that parents were confusing high energy levels with high levels of activity.

Children are allowed and encouraged to be sedentary

High levels of sedentary behaviour were observed among children in families in the priority clusters. It was apparent that currently parents tend to encourage this, both as a way of controlling children and stopping them from behaving boisterously, and as a way of bonding with them by getting them to join in the sedentary activities they themselves prefer.

Sedentary behaviour is a status symbol

Sedentary behaviour is often linked to expensive and aspirational entertainment products such as games consoles and televisions. This is partly why a sedentary lifestyle is seen as a status symbol – as something the family has earned, and as compensation for working hard the rest of the time. Having paid for expensive toys such as PlayStations, parents will also put pressure on children to get 'value for money' by using them regularly.

Playing outside is perceived to be too dangerous

Parents were often reluctant to let their children play outside, whether or not they were accompanied by an adult, because of concerns about safety and the nature of the local environment. They also wanted to keep their own children away from older children, who might be a negative influence.

Car use is habitual and regarded as a status symbol

Families in the priority clusters see cars as status symbols and a means of exercising power and control over their own lives. Thus many are using them for short, walkable journeys, for example to school or the local shops. Many parents reported that their children strongly resisted the idea of walking to school and cited the simplicity, speed and convenience of the car. However, it seems likely that their own reluctance to walk is a major reason for their car-dependency, and a powerful influence on their children's attitudes and behaviour.

Black and minority ethnic (BME) families

Children want to be more physically active

Parents believe that enough physical activity is being done in school and that the children are therefore already sufficiently active. However, children themselves want to be more active to relieve boredom.

Physical activity is not a key part of any of the three cultures (Pakistani, Bangladeshi, and Black African [Nigerian and Ghanaian])

Physical activity was not a cultural norm in any of the three cultures, particularly taking part in organised activity. The parents' priority for their children was the children's education, and in Muslim families this included religious instruction after school. The focus outside school hours was therefore homework, extra tuition and attendance at Mosque schools. In addition, mothers were expected to care for their family and extended families, and so it was hard to justify time away from home being physically active.

Key barriers cited are 'tiredness', 'time', 'weather' and 'safety'

Low activity levels were observed across mothers. Health reasons were not a reason for being physically active and there is a belief, especially among older Black African women, that 'big is beautiful'. For other mothers, tiredness and time associated with work and family pressures were often cited. The UK weather made walking less attractive and not a practical option. Safety was a key issue for children being physically active.

Some differences among younger, less traditional fathers

Younger fathers, particularly those born and brought up in the UK, are more likely to be involved in playing sports at the weekend, particularly cricket and football. These were activities that they often involved their male children in, but female children were often not perceived to be their responsibility.

TOOL D10 Communicating with target groups – key messages

For:	Commissioners in primary care trusts (PCTs) and local authorities
About:	This tool provides the key messages for communicating to mainstream and minority ethnic families about diet and physical activity. It also provides details on the National Marketing Plan.
Purpose:	To give local areas an understanding of how they can reach the priority cluster groups (1, 2 and 3) using key messages derived from national qualitative research.
Use:	• The key messages should be used to reach appropriate cluster groups. • Details of the National Marketing Plan can help local areas synchronise their marketing strategy with national policy.
Resource:	*Insights into child obesity: A summary*. A draft of this report is available to PCTs and LAs through their Regional Public Health Group. A final report will be published in late 2008.

Communicating to families

The findings of the national qualitative research commissioned by the Department of Health (see page 59 and **Tool D9**) suggest that parents overall need to be more engaged with the child obesity issue in order to take proactive steps to prevent obesity in their children. To do this, it will be important to raise their awareness of what healthy behaviour is and the risks and benefits associated with it, through targeted interventions. To engage families with messages about diet and physical activity, it is essential that the national research findings are taken into account. For example, the qualitative research found that effective communications should focus on either diet or physical activity, but not both:

- When messages are combined, diet messages dominate and the activity component is ignored, regardless of the order in which messages are presented.
- Parents are likely to acknowledge the need for dietary change but are not likely to recognise the need for a change in activity levels. This is because for diet, parents' awareness of the problem is high so they are already actively engaged in risk behaviours. However, for physical activity, parents tend to believe their children are already active enough and they are less inclined to see their children's activity levels as their responsibility than they are with their children's diet.
- In addition, some parents find it difficult to make the link between diet and activity, and will reject communications that try to make that connection clear.
- Combining diet and physical activity in communications can also perpetuate unhealthy diets as parents believe that as long as children are active, it does not matter what they eat.

The research concluded that, to be sufficiently motivating, diet and activity messages need to occupy very different emotional territories:

- Messages on diet that outweigh the negative, short-term consequences of introducing healthy diets (eg resistance from fussy children) by 'shocking' parents with the long-term negative consequences of failing to change behaviour can be very motivating, but careful testing with representative focus groups is needed on the exact wording before such messages are used.

- Successful messages about activity focus on 'disarming' parents by showing the positive benefits (non-health-related) of being active with children, such as creating treasured family memories.

In addition to communication which motivates families to address their children's diet and activity levels, the research recommended that:

- Parents would require specific, supportive messages that empower them to make changes.
- Messages will need to feel relevant and actionable and should be easily adaptable to normal family life, and presented in a down-to-earth way.
- The language used when communicating to families needs to be clear, simple and non-judgemental, and the tone of voice needs to be empathetic and positive. This will help secure participation from the target audience. Further details about what works (language and imagery) are provided below.

What works for the priority clusters – Language

- Language should be empathetic. Use 'we' and 'us', rather than 'you'.
- Don't tell parents what to do. This alienates and 'de-skills' them.
- Use 'could happen' rather than 'will happen' when talking about negative consequences. Parents need to feel that there is hope.
- Use the kind of colloquial phrases that parents use themselves, like 'bags of energy'.
- Acknowledge their concerns and reflect them back, by using phrases like 'It's hard to say no to your kids' and 'You don't have to turn into a health fanatic to do something about it.'
- Don't be judgmental. Avoid talking about the 'right' foods or 'good' and 'bad' energy.
- Direct references to 'obesity' and 'weight' alienate parents and may mean they fail to recognise themselves as part of the audience for a campaign or intervention.
- If you must talk about weight, use clear, simple language. Explain jargon and define terms like 'overweight' and 'obese'.
- Focusing on future dangers, which most parents are willing to acknowledge, will reduce the risk of parents 'opting out' of a communication because they don't believe their children are currently overweight or inactive.

What works for the priority clusters – Imagery

- Images of happy, healthy children draw parents in and encourage them to identify with a shared goal.
- Images of adults make parents more likely to think "They're not like me, so this doesn't apply." Images of children are likely to appeal to adults, regardless of their background.
- However, images of very overweight or obese children also encourage de-selection since the majority of parents with overweight and obese children may be unaware of or sensitive about their children's weight status.
- Settings should be familiar and everyday, for example local parks, gardens or the kitchen.
- Avoid anything too aspirational or 'middle-class' – for example, toys, environments or clothes.
- Focus on images of children playing as opposed to taking part in specific sports or types of exercise, as sports and exercise may lead parents to turn off.
- For the same reason, avoid images of children eating specific foods.
- Imagery should reflect the fact that families, particularly those in the 'at-risk' clusters, often don't fit the stereotype of two parents and 2.4 children.

Cluster-specific messages

Research has established that motivating propositions (re-framing diet in terms of negative long-term consequences, and activity in terms of positive family experiences) worked to stimulate a desire to change behaviour across all of the at-risk cluster groups. However, when creating targeted messages it may be necessary to create a mix of tailored messages.

Tool D8 and the overview of research given on pages 139–140 provide insight into how families think and feel about issues and are a useful starting point for message development, as will any locally commissioned research. The following table suggests key issues that should be considered when developing messages to target one of the priority clusters.

Cluster	Mindset	Messaging considerations
1	Cluster 1 families are fatalistic about their ability to make changes and believe the barriers to doing anything are too substantial. They are particularly sensitive to judgement of their parenting skills.	Emphasise how the barriers – time, cost and convenience – can be overcome. Demonstrate that change is achievable – possibly by showing that others like them are achieving it. Avoid any implicit judgement of parenting skills.
2	Cluster 2 parents have low levels of understanding of the issues but are keen to be 'good parents'.	Encourage personalisation by talking about the kinds of issues they are struggling with, such as child fussiness. Messages should aim to increase their awareness of diet- and activity-related issues but will need to focus on 'skills' for implementing solutions as well as the solution, eg how to encourage fruit and vegetable consumption, and not just why it is important. As this cluster tends to be in a lower socioeconomic group, solutions should be low-cost.
3	Cluster 3 parents believe they know a lot about diet and physical activity and believe their family are already healthy.	As parents in this cluster are least likely to recognise the issue as belonging to them, messaging will need to personalise the issue by demonstrating likely gaps between perceived and actual behaviour. There will be less need to overtly tackle barriers such as 'time' and 'cost'.

Communicating to black and minority ethnic (BME) families

Research with BME communities shows that **direct messages regarding health, childhood obesity and associated health risks were most successful**. As with mainstream communities, messages about diet tended to have more impact than messages about physical activity, and communications will have to work hard to encourage take-up of messages about physical activity.

Hard-hitting messages relating to diet resonate

As with the general population, effective diet messages were often those that raised parents' awareness of the long-term, negative consequences of indulgent food practices.

Rational messaging relating physical activity to education is more successful than emotional messages

The positive emotional messages that connected physical activity with happy family memories were seen as too 'soft' and emotional. This reflects the insight that parents in these communities do not connect health with happiness in the same way that mainstream communities do, and also reflects the absence of physical activity traditions in their cultural life. Messages that motivated parents most were those that linked educational attainment and physical activity under the heading of 'energy for learning'. This fitted parents' own priorities and was easy to understand.

Other considerations based on research findings

- It is possible to talk directly to these communities about the dangers of childhood obesity. The issue is not as emotive in these communities and deselection is less likely.
- Extended family will be an important additional target audience, to ensure that grandparents do not undermine mothers' attempts to improve children's diets.
- For mothers with low English language levels, children are important conduits for information.
- These communities are more comfortable with face-to-face communication through community workers than with communication using telephone, internet services or leaflets.
- Engaging community leaders and workers is likely to be important, particularly to create 'cultural licence' for increased activity levels.

The National Marketing Plan – social marketing at a national level

The Government has committed £75 million to a three-year marketing programme to combat obesity. This programme will be amplified by partnership work with commercial organisations and non-governmental organisations. This programme is driven by a substantial body of research. **Local authorities and PCTs can access a draft report that describes this research via the obesity lead in their Regional Public Health Group, or by emailing healthyweight@dh.gsi.gov.uk**. A final version of the report will be published in late 2008, informed by continuing research. In the meantime, the Cross-Government Obesity Unit welcomes feedback on the draft report.

The aim of this programme is to use marketing as a catalyst for a societal shift in lifestyles in England, resulting in fundamental changes to those behaviours that lead to people becoming overweight and obese. The programme will not tell people what to do; rather it will seek to recruit people to a lifestyle movement, which they can join and in which everyone can play their part.

The programme will:

- create a new 'movement' called Change4Life, which will speak to and for the public on this issue; the new movement will be the author of all public-facing marketing and communications
- direct people to a suite of targeted products and services (including those developed/delivered locally)
- build a coalition of partners (across Government, local service providers, commercial and third sector), all working together under a common banner
- create targeted campaigns which use a mix of very simple universal messages and tailored messages which take account of people's individual needs and circumstances.

The programme will explain the long-term health consequences of poor diet and activity levels and will raise this as an issue that is relevant to the whole of society.

Specific targeted campaigns will be developed for the following groups:

- pregnant women
- parents of children aged 0-2
- at-risk families
- those minority ethnic groups that the Health Survey for England and Department of Health research shows to be most at risk.

The campaign will initally focus on clusters 1, 2 and 3 (see **Tool D4** and page 59) as the highest priority since research indicated that these families had the highest risk of their children developing obesity.

The campaign will seek to 're-frame' the issue of obesity so that families begin to personalise the issues of poor diet and low physical activity levels. The Department of Health will then schedule messages promoting diet and physical activity to fit into the natural calendar of family life. For example, messages about physical activity will be timed to coincide with school holidays.

In later years, specific activity will be developed for:

- young people
- at-risk adults
- stakeholders (such as the NHS workforce).

There will be a Change4Life website and helpline giving people access to tools, support, advice and information. In particular, there will be a tool that lets people search for local services and activities.

The Department of Health team will make detailed marketing plans available in advance of all activity and will provide a campaign toolkit to give local and regional teams everything they need to develop activity locally. It is recommended that, wherever possible, local organisations join up any marketing or communications activity that are run so that:

- local activity can benefit from the umbrella support provided by the national campaign, and
- people who are motivated by the national activity can easily find locally-delivered products and services.

In addition, the Department of Health recommends that local areas do the following.

- Design interventions or services that support the national movement: eg opportunities for children to get their hour a day of physical activity, or opportunities for families to trial different ways of achieving 5 A DAY.
- Ensure details of all services (such as breastfeeding cafés, walking buses, or cookery classes) are included within the searchable tool.
- Synchronise any behavioural guidance with that provided by the Department of Health campaign (so that people are not given conflicting advice).
- Explore ways in which they can recruit local partners, whether from the commercial or voluntary sector, to the movement.
- When appropriate, use the brand name for new communications.
- When appropriate, use the central helpline and website as the call-to-action in communications.

TOOL D11 Guide to the procurement process

TOOL D11

For:	Commissioners in primary care trusts (PCTs)
About:	This tool provides details regarding the correct procedure to follow when procuring services. **It is not a complete and comprehensive procurement guide. However, it has been developed to assist PCT commissioners to better understand the tender process for procuring services that will help to tackle obesity. This tool assumes the decision has already been made by the PCT to procure services. PCTs are strongly advised to seek their own legal advice when using this procurement guidance; this guidance should not be taken in any way as constituting, or as a substitute for, legal advice.**
Purpose:	To provide local areas with a high-level summary of key factors for PCTs to consider when commissioning services.
Use:	To be used when procuring services in conjunction with the *PCT procurement guide for health services*.[199]
Resource:	*PCT procurement guide for health services.*[199] www.dh.gov.uk

1. Commissioning obesity services

This tool is designed to support the overall commissioning of interventions to tackle obesity and promote healthy weight, using the five simple steps set out in *Healthy Weight, Healthy Lives: Guidance for local areas*[2] as a framework. Once local authorities, PCTs and their partners are clear on the intervention they need to commission to meet their locally set goals, the next step is to procure those interventions.

This tool provides a high-level summary of key factors for PCTs to consider when procuring services.

2. Is a formal procurement required?

This paper must be read in conjunction with the *PCT procurement guide for health services*[199] document which sets out guidance to assist PCTs in:

i) deciding whether to procure; and

ii) how to procure health care services through formal tendering and market testing.

There is no general policy requirement for the NHS to be subject to formal procurement process. It remains with the PCT as a Commissioner to decide whether they want to formally tender or not after carefully considering their internal governance, legal advice and advice in the *PCT procurement guide for health services*.[199]

However, the use of independent and third sector Providers to provide NHS-funded services is becoming more and more widespread and PCT Commissioners would be expected to select and use Providers who are best placed to deliver cost-effective and high-quality services.

If PCTs do decide to procure the required services, the general procurement thresholds can assist PCTs in making a decision as to which procurement route to follow.

3. EU Procurement Requirements and Regulations

Contract Value Thresholds and Tender Process

Public Sector procurement is governed by UK regulations that implement EU procurement directives; these apply specifically to any procurement with a total value over a specified threshold.

Where contract value is above the EU public procurement threshold, it is important to review whether the service falls within 'Part A' or 'Part B' of the procurement regulations. Contracts for health and social care services and some training services, including weight management training programme services (CAT24), are defined by procurement regulations as 'Part B' service contracts. Under the regulations, only certain procurement obligations apply to the award of Part B contracts. In particular, if a contract is for purely 'Part B' public services then an OJEU (Official Journal of the European Union) notice publication is not automatically required. For example, it is possible to advertise in local or national newspapers or trade journals rather than OJEU in some circumstances. In contrast, those contracts which are designated 'Part A' service contracts are subject to the full extent of the requirements of the procurement regulations.

The following table sets out basic rules for Part B services and is for information only.

Threshold for value of contract	Guidance Tender Process
Contract values up to £139,893	All tender processes must be fair, open and transparent. Bids should normally be obtained in writing depending on the value and type of service. PCT Commissioners are advised to liaise with their legal advisers to ensure they meet the necessary requirements. However, a PCT would normally issue tenders (with detailed service specifications) to a minimum of three interested Bidders, and following evaluation against predefined criteria the Bidder offering the best service and the right price would be awarded a contract.
Contract values at or above £139,893	EU public procurement threshold, which requires services to be advertised and tendered. A PCT would normally advertise the procurement for services more widely. PCTs should consider publishing an OJEU (Official Journal of the European Union) notice and in addition place advertisements in national newspapers or trade journals as appropriate.

Note: If the contract is one of a series of contracts for similar services then the aggregate value of all the contracts must be used in relation to the financial thresholds. Thresholds should be checked on the EU website as they may be revised. Go to www.tendersdirect.com

The Department of Health's Procurement Centre of Expertise has set out the following different procedures for the procurement of Part A management services (only) which sets out the tender processes required. PCTs may choose to use this as a general guide when procuring weight management training services.

Up to £4,000	One quote
£4,000 to £10,000	Three written quotes
£10,000 to £90,319 (up to EU threshold)	Three or more formal tenders
£90,319+ (over EU Part A threshold)	EU public procurement limit applies

4. Procurement Route – Four Options

Once the PCT Commissioner has established what thresholds the services to be tendered fall into, they can decide which procurement option is most suitable to meet its needs. A number of considerations including the size and scope of the services, the service specification, the target market, and key stakeholders will drive this decision.

There are four main options available to PCTs for procurements that exceed the EU threshold:

i) **Open Tender** (all interested Bidders invited to tender)

All interested Providers (Bidders) who respond to an OJEU notice/advertisement must be invited to tender. This procedure does not allow for prequalification or selection prior to final contract award stage.

ii) **Restrictive Tender** (entails limited dialogue with Bidders)

Interested Bidders are invited to respond to an OJEU notice/advertisement by submitting a prequalification questionnaire (PQQ) in which they reply against defined criteria relating to their organisation's capability and financial standing. Following receipt and evaluation, a shortlist of Bidders are invited to tender. The PCT Commissioner can carry out some limited discussion and dialogue with Bidders prior to selecting the successful Bidder. The discussion can, for example, enable the Commissioner to clarify minor details about the bid, but does not allow for substantial negotiations around the service requirements and pricing.

The initial PQQ selection process allows PCT Commissioners to restrict the number of Bidders invited to tender to a more manageable number, allowing the Commissioner to focus more on the quality of bids and to make the assessment process more cost-effective.

iii) **Competitive Dialogue** (appropriate for more complex procurements and entails dialogue with Bidders)

The competitive dialogue procedure is a more flexible procedure than the Restrictive Tender procedure, and enables the PCT Commissioner and Bidders to discuss aspects of the contract and services prior to concluding and agreeing these. The Commissioner can utilise this process, for example, to help refine the service requirements further in discussions/ negotiations with Bidders. On conclusion of this stage the Commissioner will issue a final Invitation to Tender (ITT), to which Bidders must respond with a final tender. There is opportunity for the Commissioner to ask Bidders to tweak or fine tune their bids further. The preferred Bidder(s) can then be selected.

iv) **Competitive Negotiated Procedure with a Single Provider** (should only be used in very exceptional circumstances)

This procedure is limited to specific circumstances and should only be used when other procedures will not work, competition is not viable or appropriate, work is needed for research or development purposes, or where prior overall pricing is not possible.

In all of the options outlined above, the PCT Commissioner must ensure that an evaluation plan is in place and that the evaluation against which Bidders will be assessed are clearly set out.

5. Three Key Stages of Procurement

For any procurement route, and in line with the Office of Government Commerce (OGC) guidance, the process can be broken into three key stages:

Stage 1 Pre Procurement

- Health Needs Assessment and Planning
- Development of Service Specifications
- Consultation
- Stimulate Market
- Strategic/Outline Business Case including Affordability Exercise
- Build a Project Team

Stage 2 Procurement

- Procurement Strategy and Plan
- Advertise
- Prequalification Questionnaire (PQQ)
- Memorandum of Information
- Issue ITPD/ITT tenders
- Dialogue/Negotiations
- Select Preferred Providers
- Sign Contract

Stage 3 Contract Management

- Service Transition and Mobilisation
- Full Service Commencement
- Ongoing Contract Management (including Performance Management of Providers)

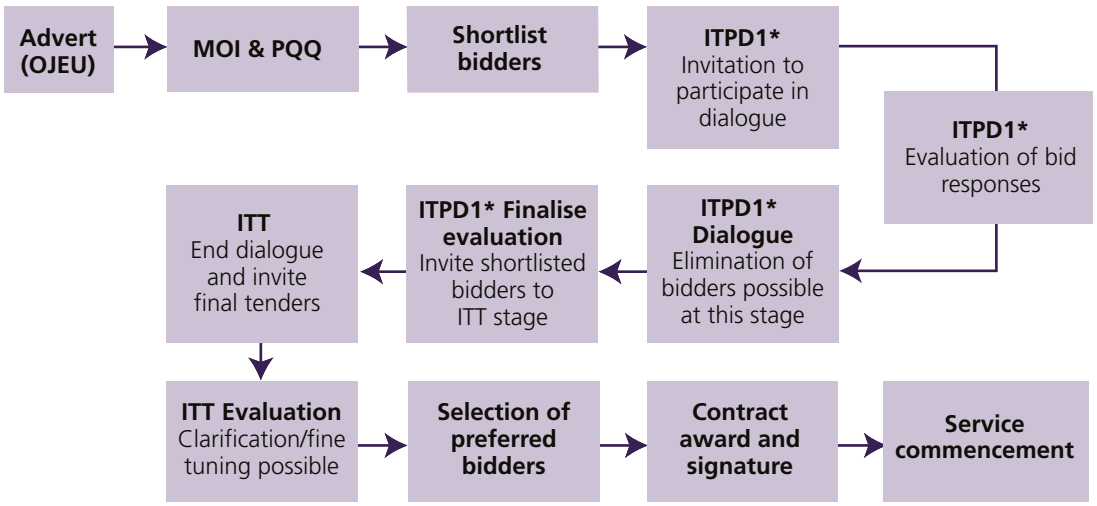
A Typical Procurement Process that PCTs may consider

Detailed guidance and tools that expand on the information in this guide are currently being developed and will be available in late 2008. This will:

- provide a foundation for PCTs to build a comprehensive procurement plan
- provide a step-by-step guide to manage a procurement.

The following illustration sets out a high-level procurement process where dialogue is required with Bidders. The Invitation to Participate in Dialogue stage (ITPD) has been marked as optional. Whether or not the Dialogue route is pursued depends on the PCT's individual requirements.

Typical procurement process



*Further stages of dialogue are possible, eg ITPD1, ITPD2. However, these should be planned for at the outset.

Procurement Timelines

The time required to undertake a procurement can vary greatly depending on the size and complexity of the product(s) or service(s) being procured (from a few days or weeks to 12 months for larger scale procurements). Procurements may vary in size and duration – for example a PCT Commissioner may decide to tender on an individual user-by-user basis or undertake a procurement to cover all service users over the next four to five years. Some PCTs may choose to procure collaboratively and maximise the opportunity to benefit from economies of scale, which may also have an impact on the timescale.

Competition Challenge

The *PCT procurement guide for health services*[199] should be read in conjunction with the 'Principles and Rules for Cooperation and Competition', published as Annex D of the 2008/9 Operating Framework,[138] and the *Framework for Managing Choice, Cooperation and Competition*.[200]

It is important to note that a Department of Health Cooperation and Competition Panel is being established in October 2008, which will need to be satisfied that PCTs have consulted and complied with the *PCT procurement guide for health services*[199] as a basis for the decisions they have made. More information about the Cooperation and Competition Panel is available in the *Framework for Managing Choice, Cooperation and Competition*.[200]

Further Guidance

The Cross-Government Obesity Unit has commissioned the development of a set of tools to support PCTs and local authorities in the specific area of commissioning weight management services. The toolkit will be available in late 2008 and will provide practical support to local areas, including in the procurement of weight management services.

More detailed advice and template documents relating to procurement are currently available via the Equitable Access to Primary Care web-based toolkit which many PCTs are already familiar with. Go to www.dh.gov.uk

TOOL D12 Commissioning weight management services for children, young people and families

TOOL D12

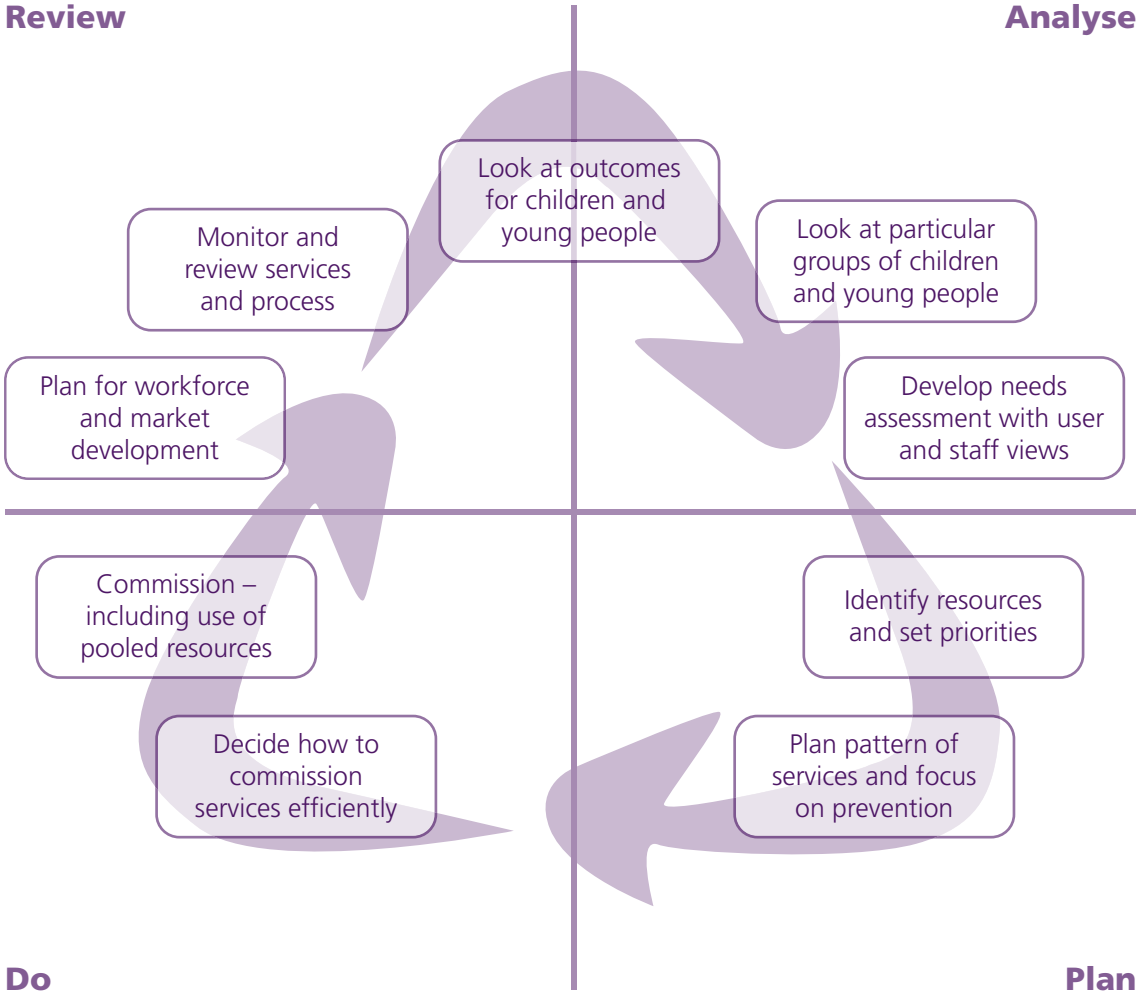
For:	Commissioners in primary care trusts (PCTs) and local authorities
About:	This tool offers a framework for commissioning weight management services for children, young people and families. The framework is a combination of the Joint Planning and Commissioning model, the Commissioning Framework for Health and Well-Being and a model offered by the Institute of Public Care used in the Commissioning eBook and further developed by the Care Services Improvement Partnership North West (CSIP NW). The framework reflects the principles of World Class Commissioning, focusing on how commissioners achieve the greatest health gains and reduction in inequalities, at best value, through 'commissioning for improved outcomes'. It also recognises that a) some children, young people and their families will be motivated to achieve a healthy weight and will require a minimum level of support and b) as indicated in *Healthy Weight, Healthy Lives,*[1] commissioners in local areas will want to commission a range of interventions that prevent and manage excess weight, including weight management services.
Purpose:	To provide local areas with an understanding of the key steps to commissioning weight management services for children, young people and families. This is the first tool and overarching framework of a more comprehensive resource being developed to support commissioners specifically in the area of weight management.
Use:	• As a guide for commissioners in local authorities and PCTs to develop commissioning plans for weight management services • As a checklist of activities to be agreed, and to measure progress against, as part of the commissioning process and joint performance management systems • In working with partners and providers to develop both a shared language and commissioning model • To engage children, young people and families and providers in the process of service planning and design
Resource:	*PCT procurement guide for health services.*[199] www.dh.gov.uk

The Joint Planning and Commissioning model outlines nine steps to commissioning services for children and young people (see diagram on next page). Each of these nine steps will involve a number of 'activities' that can be broadly divided into four sections, which also reflect the processes and competencies of World Class Commissioning:

- analysis
- planning
- doing, and
- reviewing.

The diagram below shows these nine planning and commissioning steps divided into the four sections. The table on the next page offers, through a series of questions, a guided journey through some of the key commissioning activities, including needs assessment, service specification, contract management, relationship with providers and workforce development. Some of these activities will be supported by more specific tools and templates with case studies and examples as best practice emerges and the body of evidence grows.

Steps involved in commissioning services for children and young people

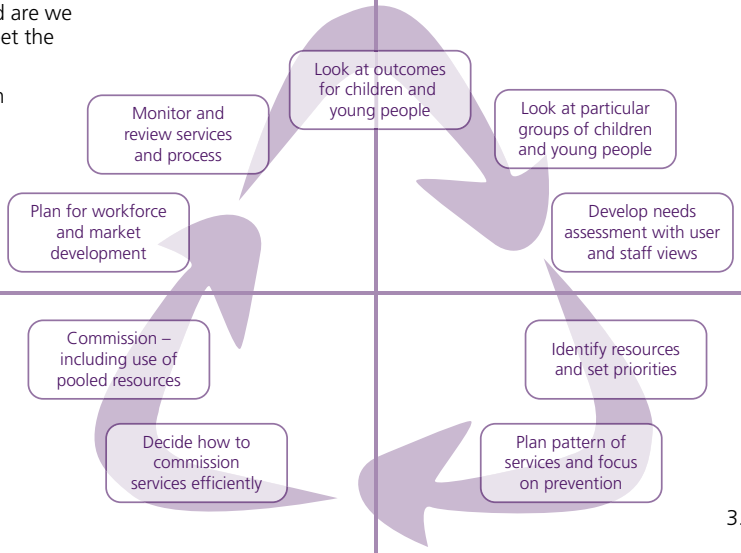


4. Review

1. Are we achieving the intended outcomes for individual children, young people and families?
2. Is the monitoring of services and processes giving us the financial and activity data we require, including GP-based services?
3. Can we demonstrate value for money?
4. Are the commissioned services supported by relevant policies and guidance?
5. How does provider performance match up to our commissioning strategy?
6. Is a workforce training plan for weight management services being implemented?
7. Is the capacity of the provider market developing and are we confident that it is sustainable, dynamic and able to meet the diversity of demands?
8. Are we sharing and using all the relevant information collectively?
9. What changes, if any, do we therefore need to make to our process for joint planning and commissioning to ensure the best outcomes for children, young people and their families?

1. Analyse

1. What are successful healthy weight outcomes for children, young people and their families?
2. How well do we know and understand the weight management needs and lifestyle interests of children, young people and their families?
3. What are our local, regional and national priorities in terms of reaching and caring for particular children, young people and their families?
4. What does the review of existing weight management services tell us, including GP-based services?
5. What is the current level of capacity and financial investment across our partners in these services?
6. What is our analysis of the current market place and providers of weight management services?
7. What is the legislative base and guidance to meeting the healthy weight management needs of our local and national population?
8. What is our analysis of the research and current evidence base for this work, including the views and experience of people delivering services?



3. Do

1. What is in our joint purchasing plan – including advertising, tendering process, selection process and contracting?
2. What needs to be in place for joint commissioning of weight management services to be carried out efficiently, for example, capability, leadership and accountability?
3. How do we manage joint commissioning of weight management services with pooled resources?
4. Having secured our range of weight management services, who will manage the contracts?
5. What is in place to quality assure services?
6. Who will manage relationships with providers and how will this be done?
7. Is our approach to contracting helping to build a dynamic and diverse market place and supply of effective services?

2. Plan

1. How do we ensure we have children, young people and their families at the centre of joint planning and commissioning of weight management services?
2. What are the gaps in service provision across PCTs and local authorities, including GP-based services, that we need to plan for?
3. What levels of resources are available to address gaps in services and identified inequalities?
4. Who will be involved in our joint commissioning strategy planning exercise?
5. When will we complete our strategy, which could include working with GPs through practice-based commissioning?
6. What is the design of the services and the range of care pathways we are planning to put in place?
7. What do we need to include in our range of service specifications?
8. What needs to go into service level agreements and contracts to ensure high quality services delivered by high quality providers?

TOOL D13 Commissioning social marketing

For:	Commissioners in primary care trusts (PCTs) and local authorities
About:	This tool provides details on how to commission a social marketing agency. It provides a checklist for assessing an agency and sample interview questions with answers which can be used when interviewing social marketers.
Purpose:	To provide local areas with information about the key issues relating to procuring a social marketing agency.
Use:	• Should be used in planning social marketing interventions. • Should be used in commissioning social marketing agencies. • Can be used as an assessment tool when interviewing agencies.
Resource:	National Social Marketing Centre (NSMC): www.nsms.org.uk

If commissioners decide to procure a social marketing agency to support their programme, then they should ensure that the correct procurement procedure is put in place when approaching social marketing agencies. (See **Tool D11** – *Guide to the procurement process*.)

This tool provides an evaluation checklist for assessing social marketing agencies and some sample interview questions (with robust responses). These have been developed by the National Social Marketing Centre (NSMC) in order to assist local areas in the process of commissioning a social marketing agency.

Assessing social marketing agencies – a checklist

Essentially, a social marketing agency tendering for programme work should be able to demonstrate:

- a clear understanding of social marketing
- experience of social marketing, especially in the health sector
- a clear approach to a social marketing commission, based upon the National Benchmark Criteria[201]
- sound company history
- adequate capacity – such as personnel and infrastructure
- capability of delivery
- financial competence.

To assess the suitability of an agency tendering for social marketing work more comprehensively, the following checklist can be used by commissioners.

Checklist for agency	Yes	No	Unsure	Action
Can the agency demonstrate a clear understanding of the project's objectives and broader strategic goals?				
Can the agency provide examples of clear strategic planning, monitoring and evaluation of past projects?				
Is the agency suggesting clear indicators to demonstrate return on your investment? These may include relevant measures to demonstrate influence on behaviour, awareness, attitudes, or other relevant process or interim measures such as evidence of stakeholder engagement.				
Can the agency demonstrate an ability to understand your research needs? Have they insisted that all secondary data be utilised before undertaking new market research at local level?				
Can the agency provide evidence of genuine stakeholder engagement, partnerships, and collaborative delivery?				
Is the agency proposing that local delivery staff be involved in the development and support of the programme?				
Has an adequate budget been allocated for each stage of the proposed social marketing intervention?				
Is there evidence that the agency can customise a solution to meet a specific challenge rather than simply repeating a similar approach they have used elsewhere?				
Can the agency demonstrate an ability to use research techniques to segment, target and design interventions that meet the needs of distinct target audiences?				
Has the agency offered promotional freebies, materials, or discounts before demonstrating a clear understanding of the strategic objectives and the specific needs of the target audience the project hopes to reach?				
Is the agency considering a multi-pronged approach that considers a mixture of interventions to enhance customer benefits or achieve policy and environmental objectives?				
Is the agency clear about the consequences of failing to deliver (for example, built-in penalty clauses)?				

Sample interview questions for interviewing social marketers

The National Social Marketing Centre has developed eight questions to assist commissioners when interviewing agencies bidding for social marketing projects. Examples of robust responses have also been given. The National Benchmark Criteria[201] can also be used to help guide the interview process. Go to the National Social Marketing Centre website at www.nsms.org.uk

Question	Answer
Explain to us what social marketing is and how it can help us at a local level.	In formal terms, social marketing has been defined as '*the systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, for a social good*'.[202] This definition highlights the systematic nature of social marketing, while also emphasising its behavioural focus and its primary concern with a 'social good'. Social marketing has been used successfully in a variety of local interventions. [At this point a competent company should be able to talk about a social marketing case study, and discuss lessons learnt from the example. The case study may be international, as the British evidence base is still in its infancy.]
Social marketing is a staged and systematic process. Please take me through the different stages of the social marketing process.	Successful social marketing programmes reflect a logical planning process, which can be used at both individual and strategic policy development levels. The total process planning model (see www.nsms.org.uk) is a simple conceptualisation of the process, which in practice can be challenging to action. The key stages are: • scope: examine and define the issue • develop: test out the proposition and pre-test, refine and adjust it • implement: commence interventions/campaign, and • evaluate: impact, process and cost assessment. The emphasis is placed on the 'scoping stage' of the model and its role in establishing clear, actionable and measurable behaviour goals to ensure focused development across the rest of the process. Although the model appears linear, people's needs, wants and motivations change over time so it is important that follow-up is conducted to make sure the needs of the consumers are still being met by the intervention.
How long does the scoping to development phase usually take?	It can depend on a variety of factors, such as ease of recruitment from the target audience for the qualitative research, etc. However, scoping done thoroughly usually takes between two and four months. The development phase usually takes around the same amount of time. However, again, this can depend on various factors – for example, on how many times the intervention needs to be pre-tested and refined before it is ready to roll out.
How involved will the primary care trust/strategic health authority be in the social marketing process?	We hope that the PCT/SHA will be heavily involved in the scoping and the development phases of the social marketing process. From our experience local employees sit on vast amounts of invaluable local knowledge. We attempt to harness this knowledge by interviewing key stakeholders during the scoping phase. We also hope that the PCT/SHA will wish to be involved in all four stages of the social marketing process.
Talk me through what you plan to do in the scoping phase and why.	During the scoping phase we will map the issue we are addressing (using epidemiological/prevalence data) and try to build up a detailed psychographic picture of the target audience – what their current behaviour is, their attitudes, values, etc. This mapping exercise will be completed using secondary data (both national and local). Where there are gaps in the existing data, these will be filled by collecting qualitative data at the local level. During the scoping phase the following actions will also be completed: a review of past interventions – what has worked/ what did not work nationally and locally; a competition analysis; a policy review – how the topic area/target audience fits into the current political climate; audience segmentation; and interviews with key stakeholders.

Question	Answer
What research methods do you think would be applicable for understanding the target audience?	It really depends on who the target audience is. Often qualitative methods, such as focus groups and individual interviews, if performed in a robust manner, can provide useful insight. However, sometimes these commonly employed methods are not suitable for certain audiences. In some cases, using ethnographic techniques to collect the data may prove more insightful. (Ethnography is a method of observing human interactions in their social, physical and cognitive environments.)
How would you evaluate the intervention and at what stages in the process?	It is important to think about evaluation during the scoping phase of the process and that a clear behavioural baseline is identified early on. Qualitative research can be used when undertaking a process evaluation which might involve speaking to members of the project team, stakeholders and users to see how the intervention is currently doing – with the option of adaptation if needed. Other forms of evaluation can include quantitative analysis looking at the uptake of a particular service, or how satisfied customers were with it. Media evaluation is another form of assessing the effectiveness of campaigns. This can involve an analysis of press coverage. Budget and time permitting, it may be advantageous to run a control group to compare against, to assess the effectiveness of a particular intervention.
What do you think the intervention will be?	Until we have conducted the scoping phase, it is not possible to know what the intervention will be and how much it will cost exactly. However, it is most likely that the intervention will be multi-faceted and build on existing good services and work that is currently being done in the local area.

TOOL D14 Monitoring and evaluation: a framework

For:	• Commissioners in primary care trusts (PCTs) and local authorities • Programme managers
About:	This tool provides a framework for evaluating and monitoring local interventions. It presents a 12-step guide on the key elements of evaluation, an evaluation and monitoring checklist, and a glossary of terms.
Purpose:	To provide local areas with an understanding of the basics of evaluating and monitoring interventions.
Use:	Should be used as a guide to plan and implement an evaluation and monitoring framework for interventions to tackle obesity.
Resource:	*Passport to evaluation*.[203] See: www.homeoffice.gov.uk

When an evaluation of an intervention is undertaken, it is important that it is:

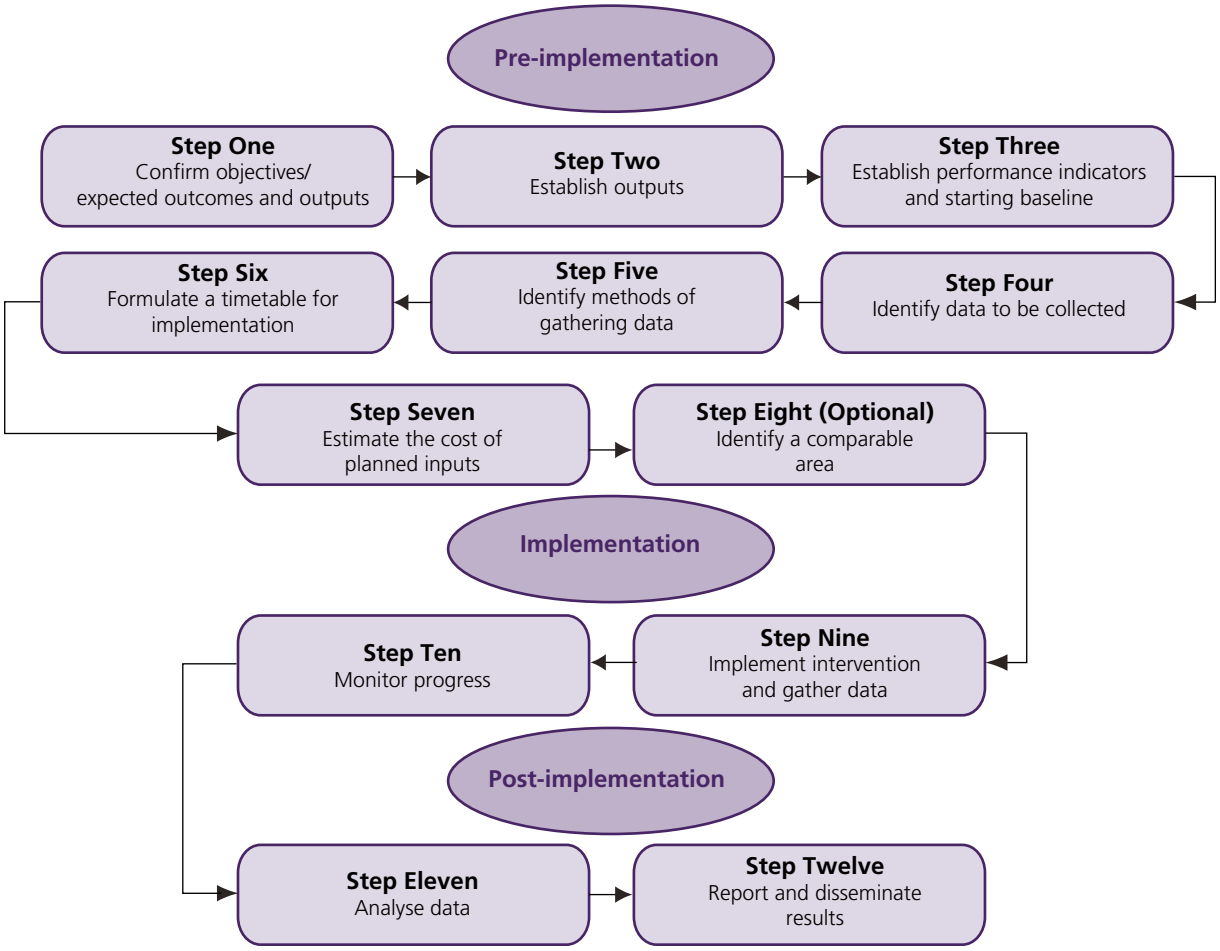
- planned
- organised, and
- has clear objectives and methods for achieving them.

There are three stages to the monitoring and evaluation framework:

1 Pre-implementation (planning)
2 Implementation
3 Post-implementation.

The diagram on the next page outlines the framework, with detailed information provided on pages 160-170.

A framework for evaluating and monitoring local interventions



Pre-implementation (planning)

Step One: Confirm objectives/expected outcomes and outputs

Objectives are the key to every successful programme and evaluation. Every evaluation is about measuring whether the objectives have been achieved. Before starting the evaluation, local areas must be clear about what the objectives are.

Unless you have a clear idea about what the project is trying to achieve, you cannot measure whether or not it has been achieved.

A simple way to set objectives is to use SMART objectives:

- **S**pecific – Objectives should specify what you want to achieve.
- **M**easureable – You should be able to measure whether you are meeting the objectives or not.
- **A**chievable – Are the objectives you have set achievable and attainable?
- **R**ealistic – Can you realistically achieve the objectives with the resources you have?
- **T**ime – When do you want to achieve the set objectives?

The National Indicators of success can guide local areas in establishing intervention outcomes. See **Tool D5** for a list of indicators relevant to obesity.

Step Two: Establish outputs for the intervention

Outputs are the things that need to be produced or done in order to achieve the desired objectives/outcomes. For example, if the intervention is to set up a local football club to increase the amount of physical activity among children, the outputs might be: organise publicity for the club in local schools and communities, employ and train volunteers, organise the location for the club and so on.

Step Three: Establish performance indicators and starting baseline

Once your local area is clear about the objectives and outcomes of the intervention, the next step is to think about how to measure the extent to which they have been achieved. **Performance indicators** (PIs) are a means by which you can do this. They can be quantitative, which means that they use statistical information to measure the effects of a piece of action. Or they can be qualitative, which means that they measure things such as feelings and perceptions.

Performance indicators can use any information, from any source, that shows whether objectives are being met. Obesity prevalence figures are quantitative PIs – they are a direct measure of the degree of the problem in your area. Other PIs, such as those that measure parents' perceptions of their child's diet, are qualitative. If an intervention's objective is to educate parents in the target clusters about healthy eating, qualitative PIs must be used to measure this.

When you are developing performance indicators, it is important to establish a **starting baseline** for the intervention against which performance will be measured. Performance indicators are a key part of any monitoring and evaluation framework, as they enable the measurement of what actions have been achieved.

Key points

- *Be clear about what you are measuring. Having a clear idea of what you are trying to achieve will help in selecting the right indicators. Always ensure that the data required are available and easily collected.*
- *Think about the context. Performance indicators may need to take account of underlying trends, or the environment in which the intervention is operating.*
- *Performance indicators can never be conclusive proof that a project is successful; they can only ever be indicators. This is because external factors, which have not been measured, can have an impact on an intervention without a local area being aware of them. However, well chosen indicators that come from a wide range of sources and illustrate different aspects of an intervention can provide good evidence of its success.*

Step Four: Identify data to be collected

The next step in the framework is to decide what data need to be collected to measure the intervention's success against the performance indicators. It is important to collect the right information, at the right time and in the right format. Some questions to be asked at the beginning are:

- **What data are needed to calculate the performance indicators?**

  It is important to write a list of the data that might be available already, eg local GP lists, health inequalities data, healthy lifestyle behaviour data, land use statistics, indices of

deprivation, National Statistics Socio-economic Classification (NS-SeC) data, distance travelled to work data, and so on.

- **How much detail is needed?**

  The level of data required depends on what the data are going to be used for. Generally speaking, detailed data help to pinpoint problems and provide an accurate picture of what has happened, and higher level data are useful for showing general trends. Collecting and analysing detailed data can be expensive and time-consuming, so plan ahead and only collect as much as is needed.

- **When and how often are data needed?**

  It is important to have data at the start of the intervention for comparison purposes and at the end so that the long-term effects can be measured.

- **What format are the data required in?**

  It is important to remember that data come in different forms because of different IT packages. If the data are not in an accessible format, this may incur extra work to get it in the right format. Think about the extra work and costs involved.

- **Where do the data come from?**

  Data can come from many different sources, eg partner organisations, GP surgeries, National Statistics, voluntary organisations, census information, and existing perception surveys.

- **Are the data available, accurate and reliable?**
  - **Availability:** If the data are not available, local areas may need to collect it themselves. Some questions to ask are: Are the data vital to the evaluation? Are the time and cost worthwhile? Will resources will available? (See Step Five – *Identify methods of gathering data*.)
  - **Accuracy:** This is vital. Some important questions to ask are: Is the sample of population the data were taken from representative of the target population? Are the data recorded correctly? Did the analytical package used produce an accurate picture of the raw data? Have data been collected objectively or has the collector introduced bias?
  - **Reliability:** Some questions to ask are: Are the data available at the times required? Are the data measuring the same or a similar thing to what you are evaluating? Are the data current?

Step Five: Identify methods of gathering data

If data are not available or are not of sufficient quality or relevance, local areas may need to collect data themselves. A selection of methods and techniques for collecting data is shown in the table on the next page. These are provided to give local areas an idea of what methods are available to them.

Methods of gathering data

Method	Typical techniques	Typical context of use	Pros and cons
Surveys	Interviews Mapping Questionnaires	All-purpose. Operational: mapping interactions between actors. Summative: user satisfaction; user impacts. Learning: surveys of participants' experiences.	Easy to carry out. Can produce large numbers of responses. Limited depth in questionnaire surveys (more depth in interviews and focus groups). Good in outcome-linked evaluations.
Field studies	Observation Task analysis Critical incidents Case studies Diaries	All-purpose. Summative: how users respond to intervention. Operational: how institutional structures operate. Learning: retrospective analysis of what happened. Comparison of different settings.	In-depth data, giving insights on social construction of intervention. Time-consuming and skill-intensive. Difficult to utilise in outcome-linked evaluations.
Modelling	Simulations Soft systems	Usually operational and learning modes. Assessing organisational structure, dynamics and change. Cost-benefit analysis. Optimisation of management functions.	Can predict possible outcomes to adjustments in uncertain and complex contexts. Sometimes highly abstracted. Requires high level of skill.
Interpretative	Content analysis	All purpose. Used in operational (analysis of meetings etc), summative (analysis of materials or reports) and learning (deconstruction of programme reports).	Deconstruction of 'hidden' meanings and agendas. Rich interpretation of phenomena. Inherent risk of ideological bias.
Critical	Discourse analysis	More theoretical (usually critical theory) based than content analysis. Typically used to assess structure, coherence and value of large-scale programmes for learning purposes.	As for interpretative methods, but emphasises establishment of generalisable laws. Perceived to be unscientific, especially by experimentalist practitioners.
Participatory	Action research	Typically in developmental evaluation mode.	Encourages real engagement of subjects of intervention. Good in highly uncertain contexts. Evaluators sometimes get too involved in intervention itself.

The table below summarises the broad types of interventions used in tackling obesity, and gives some examples of evaluation questions and evaluation methods that would be associated with a particular type of intervention.

Type of initiative	Evaluation questions	Evaluation methods
Awareness-raising campaigns	Which cluster group(s) changed their attitudes towards healthy eating and in what ways? How many articles were published in the local media and what was the content?	Cross-sectional surveys Focus groups Content analysis of media
Public participation	How can more people become physically active? Should GPs be providing more advice?	Focus groups Questionnaire surveys
Interactive events (outreach, theatre, demonstrations)	How many and what type of people attended the event? How engaged was the audience? In what ways did participants' views of obesity change?	Exit polls Quota sample Analysis of attendance records Observation Interviews
Education and training	How many healthcare professionals attended obesity training courses? How many overweight and obese patients were provided with advice by healthcare professionals?	Statistical analysis Questionnaire surveys Interviews
Ongoing profile-raising	To what degree and in what way is obesity covered in popular media? What contribution does profile-raising investment make to obesity policy and improving the knowledge base?	Content analysis of sample of newspapers Citation analysis of academic journals
Targeted access and inclusion actions	Are minority ethnic groups more receptive to advice on healthy eating or physical activity than the general population? Has this had an effect on the number of obese people in the target cluster group?	Statistical analysis Questionnaire surveys
Policy actions	Has the implementation of the consultation exercise created new partnerships?	Focus groups Documentation Analysis
Horizontal and supporting actions	How many schools are taking part in the National Child Measurement Programme?	Statistical surveys Documentation Analysis
Operational reviews	Which public engagement approach is most cost-effective?	Process evaluation Cost-effectiveness Analysis

Key point

Analysis requirements: *Bear in mind that the selection of particular methods and techniques also implies using the appropriate type of data analysis (which has its own resource and skills implications). In general, large data sets (such as those derived from surveys) normally need statistical software systems such as SPSS. Interpretative data (derived, for example, from content analysis) can be analysed with proprietary qualitative software packages such as NVivo. In any case, a clear coding frame to analyse such data is necessary.*

Step Six: Formulate a timetable for implementation

In order that the programme runs as smoothly as possible and meets deadlines, local areas should put together a timetable of implementation. As a minimum, the timetable should:

- list all the key stages of work including milestones for key activities, eg football club to be set up by (date)
- show the dates by which each stage needs to be completed
- show what resources are needed for each stage
- show who needs to be involved at each stage
- include milestones for regular review of the inputs and outputs, and
- be regularly updated to reflect any changes.

An example of a timetable grid for implementation is presented below:

No.	Intervention	Lead officer	Inputs	Outputs	Outcome	Baseline	Performance measures	Timetable
1								
2								
3								

Step Seven: Estimate the costs of planned inputs

Estimating the costs of planned inputs at the beginning of and during the intervention will enable analysis of the cost-effectiveness of the intervention. Some examples of input costs are staff time, publicity costs, equipment and transport costs, and use of leisure centre. It is important to review input costs during the intervention to ensure that an accurate analysis of cost-effectiveness is undertaken.

Step Eight (Optional): Identify a comparable area

Comparing changes in the intervention area with what is happening in another area is useful in helping to establish whether any changes are a result of the intervention or could have happened anyway. If local areas undertake this step, they should identify a comparison area (similar in size and characteristics) not covered by the intervention so that a comparison at the post-implementation stage can be undertaken. It is important to look at the wider area around the intervention for comparison.

Implementation

Step Nine: Implement intervention and gather data

The following are some important aspects to consider for the implementation step of the evaluation framework.

- **Contingency planning:** As with planning an evaluation in general, anticipating adjustments and changes to data collection is to be encouraged. It is useful to have a 'plan B' with alternative arrangements for data collection should it become apparent that, for example, time, skills or operational constraints are likely to conspire against planned activities.

- **Triangulation:** The evaluation should already have been designed with regard to the resource requirements of the choices specified and with the 'insurance' of contingency planning in mind. It is also worth noting that 'insurance' also has a methodological component: triangulation. Triangulation means utilising different methods to cover the evaluation from different angles (for example, assessing the effectiveness of organisational structures of an intervention from the points of view of different actors).
- **Operational rules:** The evaluation should be able to track (and have a record of): what data are being collected, who collects the data, and in what form and location the data are stored. Clear rules about operational procedures should be set out and distributed to all those involved in data collection and analysis. Similarly, it is useful to draw up 'evaluation contracts' with other stakeholders, especially those supplying information. These contracts should specify the objectives of the evaluation and any guarantees that apply (for example, on confidentiality).

Step Ten: Monitor progress

Make any necessary adjustments to implementation, structures and processes using the pre-implementation steps.

- Monitor inputs.
- Monitor output and outcome data using the performance indicators identified.
- Monitor key milestones.
- Consider whether there are any core tracking data that do not relate directly to the inputs, milestones, outputs or outcomes that it may also be useful to collect and monitor.
- Allow the results of the monitoring to dictate any changes to the ongoing implementation of the intervention.

An example of monitoring the intervention would be: Keep a record of the resources used in running the intervention, eg number of staff, who the staff are, how many hours staff work, and costs incurred by the intervention.

Once a framework is established, those running the intervention monitor the data and feed back the relevant information to the partnership.

Post-implementation

Step Eleven: Analyse data

Before analysing data, local areas need to ask the following questions:

- Are the data in the right format to apply to the performance indicators?
- Are there in-house facilities for analysing the data or do they need to be bought in?
- What methods of analysis are there?

Key point

It is important that data analysis is undertaken by an expert in statistical analysis.

Once the intervention has been implemented and data collected for evaluation, local areas should:

- compare outcome data with the baseline
- calculate the cost-effectiveness of the intervention

- calculate the costs of the intervention, including any inputs monitored during the intervention
- examine comparable areas
- examine trends in the wider area and any similar comparison area to assess the impact of the intervention.

Step Twelve: Report and disseminate results

This step should be a continuation of the evaluation process. In this sense, it is important to give those involved in the intervention being evaluated, as well as in the evaluation itself, and project participants a sense of closure of the project and the evaluation, where appropriate, by running concluding feedback events.

More generally, it is important to the reputation, value and impact of the evaluation to give final formal feedback to everybody who has contributed in some way to the evaluation (for example, by sending them a copy of the report or inviting them to a final feedback event).

Dissemination should not be restricted to the circulation of a final report – especially in the case of developmental process evaluation. Different stakeholders may require different communication approaches. These might include:

- short summaries of the evaluation, tailored to different audiences
- journal articles for other researchers
- topical articles in the 'trade' press
- workshops for specific audiences
- feedback seminars for key decision makers.

The results from the evaluation should always be fed back into the future planning of interventions.

Monitoring and evaluation framework checklist

	Yes	No	Action
Pre-implementation			
Step One: Confirm objectives/expected outcomes and outputs			
Have SMART objectives been developed to show what the intervention is trying to achieve?			
Are outcomes in place to show what the final achievement of the intervention will be? (This should relate to the overall aim.)			
Step Two: Establish outputs for the intervention			
Have outputs been established to show what tasks are being carried out to achieve the outcomes (eg establishing a baseline, producing quarterly reports)?			
Step Three: Establish performance indicators and starting baseline			
Have performance indicators been established, taking into account data availability, surrounding environment and underlying trends of local area?			
Has a starting baseline been established?			
Step Four: Identify data to be collected			
Has the source of data been identified to calculate the performance indicators?			
Do the data need to be collected?			
Have the data been checked for accuracy and reliability?			
Is extra work required to format the data for analysis?			
Step Five: Identify methods of gathering data			
Have the methods of data collection been agreed?			
Have appropriate analytical methods been agreed?			
Have statistical specialists been employed to complete the analysis?			
Step Six: Formulate a timetable for implementation			
Has an implementation timetable been formulated to ensure the intervention runs and finishes on time?			
Have milestones for key activities of the intervention been established?			
Have milestones for regular review of the inputs and outputs been established?			
Step Seven: Estimate the costs of planned inputs			
Have the input costs been estimated, to enable the analysis of cost-effectiveness of the intervention?			
Step Eight (Optional): Identify a comparable area			
Has a comparable area been identified to ensure any changes are a result of the intervention?			

	Yes	No	Action
Implementation			
Step Nine: Implement intervention and gather data			
Has a contingency plan been organised?			
Have operational rules been written and sent to all partners?			
Step Ten: Monitor progress			
Are the inputs being monitored?			
Are the output and outcome data being monitored?			
Are the key milestones being monitored?			
Post-implementation			
Step Eleven: Analyse data			
Have the outcome data been compared with the baseline?			
Has the cost-effectiveness of the intervention been calculated?			
Have the costs of the intervention, including any inputs monitored during the intervention, been calculated?			
Has the comparable area been examined?			
Have the trends in the wider area and any similar comparison area been examined, to assess the impact of the intervention?			
Step Twelve: Report and disseminate results			
Have the results been disseminated to stakeholders in an appropriate form?			
Have the results been fed back into the future planning of interventions?			

Glossary

Aim	A simple statement that sets out the purpose of the intervention.
Baseline	The situation at the start of an intervention, before any preventive work has been carried out. The information that helps to define the nature and extent of the problem.
Evaluation	Evaluation is the process of assessing, at a particular point in time, whether or not particular interventions are achieving or have achieved their objectives. Evaluation is about measuring the outcomes of a particular intervention. An outcome is the overall result of an intervention. Evaluation can also be used to measure whether the processes used in an intervention are working properly. This is called process evaluation and it measures the inputs and outputs of an intervention.
Input	The inputs to an intervention are the resources used to carry out the work. Resources can be financial, material or human.
Milestones	Key points during the life of an intervention. They are decided at the planning stage and can be time-based or event-based.
Monitoring	The process of continually assessing whether or not particular interventions are achieving or have achieved their objectives. Monitoring is also used to check whether the processes being used are working effectively. Monitoring is carried out throughout the life of an intervention, while evaluation is only carried out at specific points in time.
Objective	A statement that describes something you want to achieve – a desired outcome of an intervention or an evaluation study.
Outcome	The outcome of an intervention is the overall result of applying the inputs and achieving the outputs.
Output	A piece of work produced for an intervention. An output is not necessarily the final purpose of an intervention. Outputs are usually things that need to be done in order to produce the desired result. During the life of an intervention, outputs are monitored to make sure they are being achieved on time and with the resources available.
Performance indicator (PI)	The means by which you know whether or not you have achieved your targets and objectives. A PI is any information that indicates whether a particular objective has been met. You can also use PIs that measure whether the inputs and outputs in an intervention are working. For example, if a project is using public meetings as one of its inputs, a PI could be used to measure the number of meetings held and the number of people who attend each meeting. These kind of PIs are called process PIs.
Process evaluation	Process evaluation measures the inputs and outputs of a project.
Programme	A programme is a group or collection of interventions designed to achieve particular objectives. The interventions in a programme are usually linked to a particular problem or a particular area and fall under a common aim.
Qualitative PI	PIs that measure qualities, which are usually quite intangible things, such as the perceptions and feelings of individuals and groups.
Quantitative PI	PIs that measure tangible things, such as the number of obese children in an area.

TOOL D15 Useful resources

For:	All partners involved in planning and implementing an obesity strategy
About:	This tool provides a list of training programmes, publications, useful organisations and websites and tools for healthcare professionals.
Purpose:	To provide local areas with the resources to build local capability.
Use:	• Can be used for keeping up to date with the latest developments in obesity. • Can be used to gather more detailed information on science and policy.
Resource:	See the *Organisations and websites* section of this tool on page 185.

National Heart Forum e-News Briefing Service

The National Heart Forum e-News Briefing Service provides subscribers with electronic information on the latest reports and developments relevant to the prevention of avoidable chronic diseases including cardiovascular diseases, cancer, diabetes and related conditions such as obesity.

It covers a broad range of topics including nutrition, physical activity, alcohol, cancer, obesity, tobacco control, stroke, diabetes, hypertension, child poverty and health inequalities.

The service contains details of current media reports, training courses, consultations, policy development, campaigns, career opportunities, latest public health guidance, new resources and forthcoming events.

It is an essential information source for all policy makers, strategic health authorities, local authorities, researchers, public health and primary care professionals and others with an interest in disease prevention and health promotion.

To subscribe

The e-News Briefing Service is **FREE** by e-mail either three times a week (Monday, Wednesday and Friday) or once a week (Wednesday only). You can subscribe by emailing **briefings@heartforum.org.uk**. In the subject heading, request either "e-News Briefing Service – weekly" or "e-News Briefing Service – 3 x per week".

Further information on this service and archived versions of the Weekly e-News briefings can be found at **www.heartforum.org.uk/News_Media_eNewsbrief.aspx**

Promotion opportunity

The National Heart Forum also encourages you to take advantage of this free resource to promote your organisation's activities by forwarding any press releases, new resource information or forthcoming events to **briefings@heartforum.org.uk**

Training programmes

Obesity training courses for primary care

Produced by: Dietitians in Obesity Management DOM UK, National Obesity Forum (NOF) and The Association for the Study of Obesity (ASO) (2005)
Available at: domuk.org

This is a training directory for primary care trusts (PCTs) to give an overview of the different types of training courses available for obesity prevention and management. This can provide a starting point for PCTs. This directory is currently being updated. The new version will be available by Spring 2009.

Obesity: A guide to prevention and management – in association with NICE

Developed by: BMJ Learning in collaboration with the National Institute for Health and Clinical Excellence (NICE)
Available at: learning.bmj.com

This module has been designed to train GPs and other healthcare professionals, on the following:

- BMI and other measures of adiposity
- what level of advice or intervention to use with a patient, depending on their BMI, waist circumference and co-morbidities
- how to explore a patient's readiness to change
- advice to patients on diet, physical activity, and community-based interventions
- when to refer to a specialist.

The module is **online** and takes about an hour to complete.

Expert Patients Programme (for patients)

Established by: Department of Health (In 2007, the EPP was established as a Community Interest Company to increase the capacity of course places)
To access course details: www.expertpatients.co.uk

The Expert Patients Programme (EPP) is a national NHS-based self-management training programme which provides opportunities for people who live with long-term conditions to develop new skills to manage their condition better on a day-to-day basis. For example, in terms of tackling overweight and obesity, patients with diabetes or heart disease can learn how to start and maintain an appropriate exercise or physical activity programme. Training programmes are available across the country.

Publications

Prevalence and trends of overweight and obesity

Health Survey for England

Health Survey for England 2006. Volume 1: Cardiovascular disease and risk factors in adults
R Craig and J Mindell (eds.) (2008).
London: The Information Centre for Health and Social Care.
Available from: www.ic.nhs.uk

Health Survey for England 2006. Volume 2: Obesity and other risk factors in children
R Craig and J Mindell (eds.) (2008).
London: The Information Centre for Health and Social Care.
Available from: www.ic.nhs.uk

Health Survey for England 2005: Updating of trend tables to include 2005 data
The Information Centre for Health and Social Care (2006).
London: The Information Centre for Health and Social Care.
Available from: www.ic.nhs.uk

Health Survey for England 2004. Volume 1: The health of minority ethnic groups
The Information Centre for Health and Social Care (2006).
London: The Information Centre for Health and Social Care.
Available from: www.ic.nhs.uk

Health Survey for England 2003. Volume 2: Risk factors for cardiovascular disease
K Sproston and P Primatesta (eds.) (2004).
London: TSO.
Available from: www.dh.gov.uk

Health Survey for England 2002: The health of children and young people
K Sproston and P Primatesta (eds.) (2003).
London: TSO.
Available from: www.archive2.official-documents.co.uk

Foresight publications

Foresight tackling obesities: Future choices – project report, 2nd edition
B Butland, S Jebb, P Kopelman, K McPherson, S Thomas, J Mardell and V Parry (2007).
London: Department for Innovation, Universities and Skills.
Available from: www.foresight.gov.uk

Modelling future trends in obesity and the impact on health. Foresight tackling obesities: Future choices, 2nd edition
K McPherson, T Marsh and M Brown (2007).
London: Department for Innovation, Universities and Skills.
Available from: www.foresight.gov.uk

Other

Forecasting obesity to 2010
P Zaninotto, H Wardle, E Stamatakis, J Mindell and J Head (2006).
London: Joint Health Surveys Unit.
Available from: www.dh.gov.uk

Obesity among children under 11
D Jotangia, A Moody, E Stamatakis and H Wardle (2005).
London: National Centre for Social Research, Department of Epidemiology and Public Health at the Royal Free and University College Medical School.
Available from: www.dh.gov.uk

National Child Measurement Programme: 2006/07 school year, headline results
The Information Centre (2008).
London: The Information Centre.
Available from: www.ic.nhs.uk

PCO level model based estimates of obesity (adults)
The Information Centre (2008).
London: The Information Centre.
Available from: www.ic.nhs.uk

Storing up problems. The medical case for a slimmer nation
Working Party of the Royal College of Physicians of London, Royal College of Paediatrics and Child Health, and Faculty of Public Health (2004).
London: Royal College of Physicians of London.

The health risks of overweight and obesity, and the health benefits of losing excess weight

Foresight tackling obesities: Future choices – project report, 2nd edition
B Butland, S Jebb, P Kopelman, K McPherson, S Thomas, J Mardell and V Parry (2007).
London: Department for Innovation, Universities and Skills.
Available from: www.foresight.gov.uk

Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk

Storing up problems: The medical case for a slimmer nation
Working Party of the Royal College of Physicians of London, Royal College of Paediatrics and Child Health, and Faculty of Public Health (2004).
London: Royal College of Physicians of London.

Tackling obesity in England
National Audit Office (2001).
London: TSO.
Available from: www.nao.org.uk

Obesity: Preventing and managing the global epidemic. Report of a WHO consultation. Technical Report Series 894(3)
World Health Organization (2000).
Geneva: WHO.

Obesity in Scotland. Integrating prevention with weight management. A National Clinical Guideline recommended for use in Scotland (Under review)
Scottish Intercollegiate Guidelines Network (1996).
Edinburgh: SIGN.
Available from: www.sign.ac.uk

National Obesity Forum training resource for health professionals
National Obesity Forum.
London: National Obesity Forum.
Available from: www.nationalobesityforum.org.uk

The economic costs of overweight and obesity

Economic costs of obesity and the case for government intervention
B McCormack and I Stone (2007).
Obesity Reviews; 8 (s1): 161-164.
Available from: www.foresight.gov.uk

Obesity: Costing template and **Obesity: Costing report**
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk

See also ***Foresight publications*** on page 173.

Causes of overweight and obesity

Foresight tackling obesities: Future choices – project report, 2nd edition
B Butland, S Jebb, P Kopelman, K McPherson, S Thomas, J Mardell and V Parry (2007).
London: Department for Innovation, Universities and Skills.
Available from: www.foresight.gov.uk

Foresight tackling obesities: Future choices – obesity system atlas
IP Vandenbroeck, J Goossens, M Clemens (2007).
London: Department for Innovation, Universities and Skills.
Available from: www.foresight.gov.uk

Preventing chronic disease: A vital investment. WHO global report
World Health Organization (2005).
Geneva: World Health Organization.
Available from: www.who.int

Storing up problems: The medical case for a slimmer nation
Working Party of the Royal College of Physicians of London, Royal College of Paediatrics and Child Health, and Faculty of Public Health (2004).
London: Royal College of Physicians of London.

Government action on overweight and obesity

Key publications

Healthy Weight, Healthy Lives: A cross-government strategy for England
Cross-Government Obesity Unit (2008).
London: Department of Health and Department for Children, Schools and Families.
Available from: www.dh.gov.uk

Healthy Weight, Healthy Lives: Guidance for local areas
Cross-Government Obesity Unit (2008).
London: Department of Health and Department for Children, Schools and Families.
Available from: www.dh.gov.uk

See also ***Foresight publications*** on page 173 and ***Children: Healthy growth and healthy weight*** below.

Children: Healthy growth and healthy weight

The Child Health Promotion Programme: Pregnancy and the first five years of life
S Shribman and K Billingham (2008).
London: Department of Health and Department for Children, Schools and Families.
Available from: www.dh.gov.uk

Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. NICE public health guidance 11
National Institute for Health and Clinical Excellence (NICE) (2008).
London: NICE.
Available from: www.nice.org.uk

Statutory Framework for the Early Years Foundation Stage. Setting the standards for learning, development and care for children from birth to five
Department for Children, Schools and Families (2008).
London: Department for Children, Schools and Families.
Available from: www.standards.dfes.gov.uk

Practice guidance for the Early Years Foundation Stage. Setting the standards for learning, development and care for children from birth to five
Department for Children, Schools and Families (2008).
London: Department for Children, Schools and Families.
Available from: www.standards.dfes.gov.uk

Eating well for under-5s in child care. Practical and nutritional guidelines
H Crawley (2006).
St Austell: Caroline Walker Trust.
Available from: www.cwt.org.uk

The National Child Measurement Programme. Guidance for PCTs: 2008-09 school year
Cross-Government Obesity Team (2008).
London: Department of Health and Department for Children, Schools and Families.
Available from: www.dh.gov.uk

National Child Measurement Programme: 2006/07 school year, headline results
The Information Centre (2008).
London: The Information Centre.
Available from: www.ic.nhs.uk

Tackling child obesity – first steps
The Audit Commission, the Healthcare Commission and the National Audit Office (2006).
London: The Stationery Office.
Available from: www.nao.org.uk

Eating well at school. Nutritional and practical guidelines
H Crawley, on behalf of the Caroline Walker Trust and the National Heart Forum (2005).
The Caroline Walker Trust.
For details see: www.cwt.org.uk

Food in Schools toolkit
Department of Health (2005).
London: Department of Health.
Available from: www.foodinschools.org

Obesity guidance for healthy schools coordinators and their partners
Department of Health (2007).
London: Department of Health.
Available from: www.dh.gov.uk

Preventing childhood obesity: Health in the balance
Institute of Medicine of the National Academies (2005).
Washington DC: Institute of Medicine of the National Academies.
Available from: www.nap.edu

Towards a generation free from coronary heart disease: Policy action for children's and young people's health and well-being
National Heart Forum (2002).
London: National Heart Forum.

See also ***Choosing interventions*** on page 182.

Promoting healthier food choices

Choosing a better diet: A food and health action plan
Department of Health (2005).
London: Department of Health.
Available from: www.dh.gov.uk

Family food in 2006. A National Statistics publication by Defra
Department for Environment, Food and Rural Affairs (2008).
London: TSO.
Available from: statistics.defra.gov.uk

Family spending. 2007 edition
E Dunn (2007).
London: Office for National Statistics.
Available from: statistics.defra.gov.uk

Nutrition and food poverty: A toolkit for those involved in developing or implementing a local nutrition and food poverty strategy
V Press, on behalf of the National Heart Forum and Faculty of Public Health (2004).
London: National Heart Forum.
Available from: www.heartforum.org.uk

See also ***Choosing interventions*** on page 182.

Building physical activity into our lives

At least five a week: Evidence on the impact of physical activity and its relationship to health. A report from the Chief Medical Officer
Department of Health (2004).
London: Department of Health.
Available from: www.dh.gov.uk

Building health: Creating and enhancing places for healthy, active lives: What needs to be done?
National Heart Forum, Living Streets, CABE (2007).
London: National Heart Forum.
Available from: www.heartforum.org.uk

Building health: Creating and enhancing places for healthy, active lives. Blueprint for action
National Heart Forum, Living Streets, CABE (2007).
London: National Heart Forum.
Available from: www.heartforum.org.uk

National Travel Survey: 2007
Department for Transport (2007).
London: Department for Transport.
Available from: www.dft.gov.uk

Promoting and creating built or natural environments that encourage and support physical activity. NICE public health guidance 8
National Institute for Health and Clinical Excellence (NICE) (2008).
London: NICE.
Available from: www.nice.org.uk

See also ***Choosing interventions*** on page 182.

Creating incentives for better health

Working for a healthier tomorrow. Dame Carol Black's review of the health of Britain's working age population
Cross-government Health, Work and Wellbeing Programme (2008).
London: TSO.
Available from: www.workingforhealth.gov.uk

See also ***Choosing interventions*** on page 182.

Personalised advice and support for overweight and obese people

Clinical guidance: UK – Children and young people

Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk

Care pathway for the management of overweight and obesity
Department of Health (2006).
London: Department of Health.
Available from: www.dh.gov.uk

Management of obesity in children and young people. A National Clinical Guideline
Scottish Intercollegiate Guidelines Network (2003).
Edinburgh: SIGN.
Available from: www.sign.ac.uk

An approach to weight management in children and adolescents (2-18 years) in primary care
Royal College of Paediatrics and Child Health and National Obesity Forum (2002).
London: Royal College of Paediatrics and Child Health.
Available from: shop.healthforallchildren.co.uk

Clinical guidance: UK – Adults

Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk

Care pathway for the management of overweight and obesity
Department of Health (2006).
London: Department of Health.
Available from: www.dh.gov.uk

JBS 2: Joint British Societies' guidelines on prevention of cardiovascular disease in clinical practice
British Cardiac Society, British Hypertension Society, Diabetes UK, HEART UK, Primary Care Cardiovascular Society, The Stroke Association (2005).
Heart; 91; Suppl V: v1-v52.
Available from: heart.bmj.com

National Obesity Forum obesity care pathway and toolkit
National Obesity Forum (2005).
London: National Obesity Forum.
Available from: www.nationalobesityforum.org.uk

National Obesity Forum guidelines on management of adult obesity and overweight in primary care
National Obesity Forum (2004).
London: National Obesity Forum.
Available from: www.nationalobesityforum.org.uk

Obesity
PRODIGY Knowledge (2001).
Newcastle: Sowerby Centre for Health Informatics at Newcastle Ltd (SCHIN).
Available from: www.prodigy.nhs.uk

Obesity in Scotland. Integrating prevention with weight management. A National Clinical Guideline recommended for use in Scotland (Under review)
Scottish Intercollegiate Guidelines Network (1996).
Edinburgh: SIGN.
Available from: www.sign.ac.uk

Clinical guidance: Australia and United States

Clinical practice guidelines for the management of overweight and obesity in children and adolescents
National Health and Medical Research Council (2003).
Canberra, ACT: NHMRC.
Available from: www.health.gov.au

Clinical practice guidelines for the management of overweight and obesity in adults
National Health and Medical Research Council (2003).
Canberra, ACT: NHMRC.
Available from: www.health.gov.au

The practical guide: Identification, evaluation, and treatment of overweight and obesity in adults
National Heart, Lung and Blood Institute (2000).
Bethesda, MD: National Institutes of Health.
Available from: www.nhlbi.nih.gov

Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults: The evidence report
National Heart, Lung and Blood Institute (1998).
Bethesda, MD: National Institutes of Health.
Available from: www.nhlbi.nih.gov

NICE clinical guidance implementation support tools

Obesity: Costing template, Costing report, Audit criteria, Presenter slides and **Guide to resources to support implementation**
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk

Referral to services

Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling
National Institute for Health and Clinical Excellence (2006).
London: NICE.
Available from: www.nice.org.uk

Overweight health professionals giving weight management advice: The perceptions of health professionals and overweight people
V Lawson and C Shoneye (2008).
London: Weight Concern.

GP contract

Standard General Medical Services contract (2006)
Available from: www.dh.gov.uk

Revisions to the GMS contract, 2006/07. Delivering investment in general practice
British Medical Association and NHS Employers (2006).
London: BMA and NHS Employers.
Available from: www.nhsemployers.org

World Class Commissioning

World Class Commissioning: Competencies
Department of Health (2008).
London: Department of Health.
Available from: www.dh.gov.uk

Setting local goals

How to set and monitor goals for prevalence of child obesity: Guidance for primary care trusts (PCTs) and local authorities
Cross-Government Obesity Unit (2008).
London: Department of Health and Department for Children, Schools and Families.
Available from: www.dh.gov.uk

National Child Measurement Programme: 2006/07 school year, headline results
The Information Centre (2008).
London: The Information Centre.
Available from: www.ic.nhs.uk

The new Performance Framework for local authorities and local authority partnerships: Single set of National Indicators
Department for Communities and Local Government (2007).
London: Department for Communities and Local Government.
Available from: www.communities.gov.uk

Choosing interventions

NICE guidance

Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk

Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling. Public health intervention guidance no. 2
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk

Behaviour change at population, community and individual levels. NICE public health guidance 6
National Institute for Health and Clinical Excellence (NICE) (2007).
London: NICE.
Available from: www.nice.org.uk

Promoting and creating built or natural environments that encourage and support physical activity. NICE public health guidance 8
National Institute for Health and Clinical Excellence (NICE) (2008).
London: NICE.
Available from: www.nice.org.uk

Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. NICE public health guidance 11
National Institute for Health and Clinical Excellence (NICE) (2008).
London: NICE.
Available from: www.nice.org.uk

Workplace health promotion: How to encourage employees to be physically active. NICE public health guidance 13
National Institute for Health and Clinical Excellence (NICE) (2008).
London: NICE.
Available from: www.nice.org.uk

Promoting healthier food choices

Nutrition and food poverty. A toolkit for those involved in developing or implementing a local nutrition and food poverty strategy
V Press, on behalf of the National Heart Forum and the Faculty of Public Health (2004).
London: National Heart Forum.
Available from: www.heartforum.org.uk

Think fit! Eat well! A guide to developing a workplace healthy eating programme
British Heart Foundation (2008).
London: British Heart Foundation.
For details see: www.bhf.org.uk

Physical activity

The effectiveness of public health interventions for increasing physical activity among adults: A review of reviews. 2nd edition
M Hillsdon, C Foster, B Naidoo and H Crombie (2005).
London: Health Development Agency.
Available from: www.publichealth.nice.org.uk

Let's get moving! A physical activity handbook for developing local programmes
A Maryon-Davis, L Sarch, M Morris, B Laventure (2001).
London: Faculty of Public Health and National Heart Forum.

Think fit! A guide to developing a workplace activity programme
British Heart Foundation.
London: British Heart Foundation.
For details see: www.bhf.org.uk

Active for later life – Promoting physical activity with older people. A resource for agencies and organisations
BHF National Centre for Physical Activity and Health (2003).
London: British Heart Foundation.

General

Weight management in primary care: How can it be made more effective?
A Maryon-Davis (2005).
Proceedings of the Nutrition Society; 64: 97-103.
For details see: www.ingentaconnect.com

Creating a healthy workplace
(Leaflet and accompanying booklet.)
London: Faculty of Public Health and Faculty of Occupational Medicine (2006).
Available from: www.fph.org.uk

Diabetes commissioning toolkit
Department of Health (2006).
London: Department of Health.
Available from: www.dh.gov.uk

See also ***Children: Healthy growth and healthy weight***, on page 176.

Commissioning services

PCT procurement guide for health services
Department of Health (2008).
London: Department of Health.
Available from: www.dh.gov.uk

See also ***National Social Marketing Centre*** at www.nsms.org.uk

Monitoring and evaluation

Obesity: Audit criteria
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk

Passport to evaluation
Home Office (2002).
York: Home Office.
Available from: www.crimereduction.gov.uk

Evaluation resources for community food projects
P McGlone, J Dallison and M Caraher (2005).
London: Health Development Agency.
Available from: www.nice.org.uk

HEBS Research and evaluation toolbox
Health Education Board for Scotland (HEBS).
Available from: www.hebs.com

Self-evaluation: A handy guide to sources
New Opportunities Fund (2003).
London: New Opportunities Fund.
Available from: www.biglotteryfund.org.uk

Building local capabilities

Obesity training courses for primary care
Dietitians in Obesity Management DOM UK (2005)
London: DOM UK
Available from: domuk.org
(Please note this directory is being updated. The new version will be available by Spring 2009.)

Expert Patients Programme
For details see: www.expertpatients.nhs.uk

Obesity: A guide to prevention and management
See learning.bmj.com for information about this training module. (See also page 172.)

Organisations and websites

Alcohol Concern
www.alcoholconcern.org.uk

American Heart Association (AHA)
www.americanheart.org

Arthritis Research Campaign (ARC)
www.arc.org.uk

Association for the Study of Obesity (ASO)
www.aso.org.uk

Association of Breastfeeding Mothers
www.abm.me.uk

Asthma UK
www.asthma.co.uk

Australasian Society for the Study of Obesity (ASSO)
www.asso.org.au

Beat (Beating eating disorders)
www.b-eat.co.uk

British Association of Sport and Exercise Sciences (BASES)
www.bases.org.uk

British Cardiac Society
www.bcs.com

British Dietetic Association (BDA)
www.bda.uk.com

British Heart Foundation (BHF)
www.bhf.org.uk

British Heart Foundation National Centre for Physical Activity and Health (BHFNC)
www.bhfactive.org.uk

British Nutrition Foundation (BNF)
www.nutrition.org.uk

British Obesity Surgery Patient Association (BOSPA)
www.bospa.org

British Trust for Conservation Volunteers (BTCV)
www.btcv.org

Cancer Research UK
www.cancerresearch.org.uk

Central Council for Physical Recreation
www.ccpr.org.uk

Child Growth Foundation
www.childgrowthfoundation.org

Children's Play Council
www.ncb.org.uk/cpc

Cleaner Safer Greener Communities
www.cleanersafergreener.gov.uk

Communities and Local Government
www.communities.gov.uk

Community Practitioners' and Health Visitors' Association (CPHVA)
www.msfcphva.org

The Counterweight Programme
www.counterweight.org

Cycling England (previously the National Cycling Strategy Board)
www.cyclingengland.co.uk

Department for Children, Schools and Families
www.dcsf.gov.uk

Department for Culture, Media and Sport
www.culture.gov.uk

Department for Transport
www.dft.gov.uk

Department of Health
www.dh.gov.uk

Diabetes UK
www.diabetes.org.uk

Dietitians in Obesity Management (UK) – DOM (UK)
www.domuk.org

European Association for the Study of Obesity (EASO)
www.easoobesity.org

European Childhood Obesity Group
www.childhoodobesity.net

European Commission (Health and Consumer Protection Directorate-General)
europa.eu.int

The European Men's Health Forum (EMHF)
www.emhf.org

Faculty of Public Health
www.fph.org.uk

Fitness Industry Association (FIA)
www.fia.org.uk

The Food Commission
www.foodcomm.org.uk

Food Standards Agency
www.food.gov.uk
www.eatwell.gov.uk

Foresight
www.foresight.gov.uk

Free Swimming
www.freeswimming.org

Heart UK
www.heartuk.org.uk

International Association for the Study of Obesity (IASO)
www.iaso.org

International Diabetes Federation
www.idf.org

International Obesity Taskforce (IOTF)
www.iotf.org

Local Government Association (LGA)
www.lga.gov.uk

Maternity Alliance
www.maternityalliance.org.uk

MEND Programme
www.mendprogramme.org

Men's Health Forum
www.menshealthforum.org.uk

National Heart Forum
www.heartforum.org.uk

National Institute for Health and Clinical Excellence (NICE)
www.nice.org.uk

National Institutes of Health (NIH)
www.nih.gov

National Obesity Forum (NOF)
www.nationalobesityforum.org.uk

National Social Marketing Centre
www.nsms.org.uk

North American Association for the Study of Obesity (NAASO), The Obesity Society
www.naaso.org

Nutrition Society
www.nutritionsociety.org

Obesity Management Association (OMA)
www.omaorg.com

Office for National Statistics (ONS)
www.statistics.gov.uk

The Overweight and Obesity Organization
www.oo-uk.org

PE, School Sport and Club Links (PESSCL)
www.teachernet.gov.uk/pe

Register for Exercise Professionals (REPS)
www.exerciseregister.org

Royal College of General Practitioners
www.rcgp.org.uk

Royal College of Midwives
www.rcm.org.uk

Royal College of Nursing
www.rcn.org.uk

Royal College of Paediatrics and Child Health
www.rcpch.ac.uk

Royal College of Physicians of London
www.rcplondon.ac.uk

Royal Institute of Public Health
www.riph.org.uk

Royal Pharmaceutical Society of Great Britain
www.rpsgb.org.uk

Royal Society for the Promotion of Health
www.rsph.org

Royal Society of Medicine
www.rsm.ac.uk

Safe Routes to Schools
www.saferoutestoschools.org.uk

Scottish Intercollegiate Guidelines Network (SIGN)
www.sign.ac.uk

Sport England
www.sportengland.org

The Stroke Association
www.stroke.org.uk

Sustain: The alliance for better food and farming
www.sustainweb.org

Sustrans
www.sustrans.org.uk

TOAST (The Obesity Awareness and Solutions Trust)
www.toast-uk.org.uk

TravelWise
www.travelwise.org.uk

United Kingdom Public Health Association (UKPHA)
www.ukpha.org.uk

Walking the Way to Health Initiative (WHI)
www.whi.org.uk

Weight Concern
www.weightconcern.org.uk

Weight Loss Surgery Information and Support (WLSINFO)
www.wlsinfo.org.uk

World Health Organization
www.who.int/en

Tools for healthcare professionals

The following tools are in section E of this toolkit.