Standards, targets and milestones

Tool 12

The following are suggested as achievable milestones for a local action plan to tackle overweight and obesity.

Source: Adapted from *Tackling obesity: a toolkit for local partnership action*, by A Maryon-Davis, A Giles and R Rona[1]

Note: See also the information on the *NICE guideline on obesity – Audit criteria*, on page 84.

MILESTONE	DEADLINE
PARTNERSHIP	
1 The action team should have:	***End of year 1***
• The explicit commitment of each partner organisation to develop a shared approach • Identified a named link person for each partner organisation • Conducted a needs assessment (including equity profiles of access to services) • Developed a systematic approach to involving the community • Agreed aims, objectives, targets, and an outline action plan • Agreed each partner's lead responsibilities for each main component of the action plan • Built in a mechanism for reporting progress to the boards of each partner organisation.	
2 Each partner organisation should have:	***End of year 2***
• A systematic approach to achieving the agreed objectives/changes • An agreed mechanism for assessing the impact of its policies on opportunities for both healthy eating and physical activity.	
3 Each partner organisation should have:	***End of year 3***
• Recent quantitative data integrated into its information strategy • A systematic process for assessing performance and evaluating progress.	
PRIMARY CARE	
1 General practices should have:	***End of year 1***
• All medical records and hospital correspondence filed in date order • Easily discernible lists of prescribed medication on all records of patients on long-term therapy • Clinical audit meetings involving the whole team at least once a quarter.	

MILESTONE	DEADLINE
2 Practices should have:	***End of year 2***
• A systematically developed and maintained register of people in the practice with diagnosed coronary heart disease, transient ischaemic attack (TIA), stroke and peripheral vascular disease, and of people whose risk of a cardiovascular event is greater than 3% per year, who are also known to be overweight or obese • An agreed weight management protocol (describing the systematic assessment, goal-setting, lifestyle advice, medication, referral criteria, follow-up arrangements, and auditing) for people in the priority groups who are known to be, or found to be, overweight or obese. Many practices will choose to deliver their structured care through nurse- or dietitian-led clinics.	
3 Practices should have:	***End of year 3***
• Clinical audit data no more than 12 months old.	
SPECIALIST SERVICE	
1 The specialist service should have:	***End of year 1***
• An effective means of setting clinical standards for obesity management • A systematic approach to determining whether agreed clinical standards are being met.	
2 The specialist service should have:	***End of year 2***
• An agreed protocol for the assessment and management of people who have been referred for specialist management of their obesity.	
3 The specialist service should have:	***End of year 3***
• Clinical audit data, no more than 12 months old, that describe key items and that demonstrate that there is equitable access to the service • Clinical audit data, no more than 12 months old, that demonstrate that at least 85% of people referred for specialist management of their obesity have maintained some weight loss six months after their initial consultation, and that 30% have maintained a weight loss of at least 10% of their presenting weight.	

Reference

1 Maryon-Davis A, Giles A, Rona R (2000) *Tackling obesity: a toolkit for local partnership action.* London: Faculty of Public Health