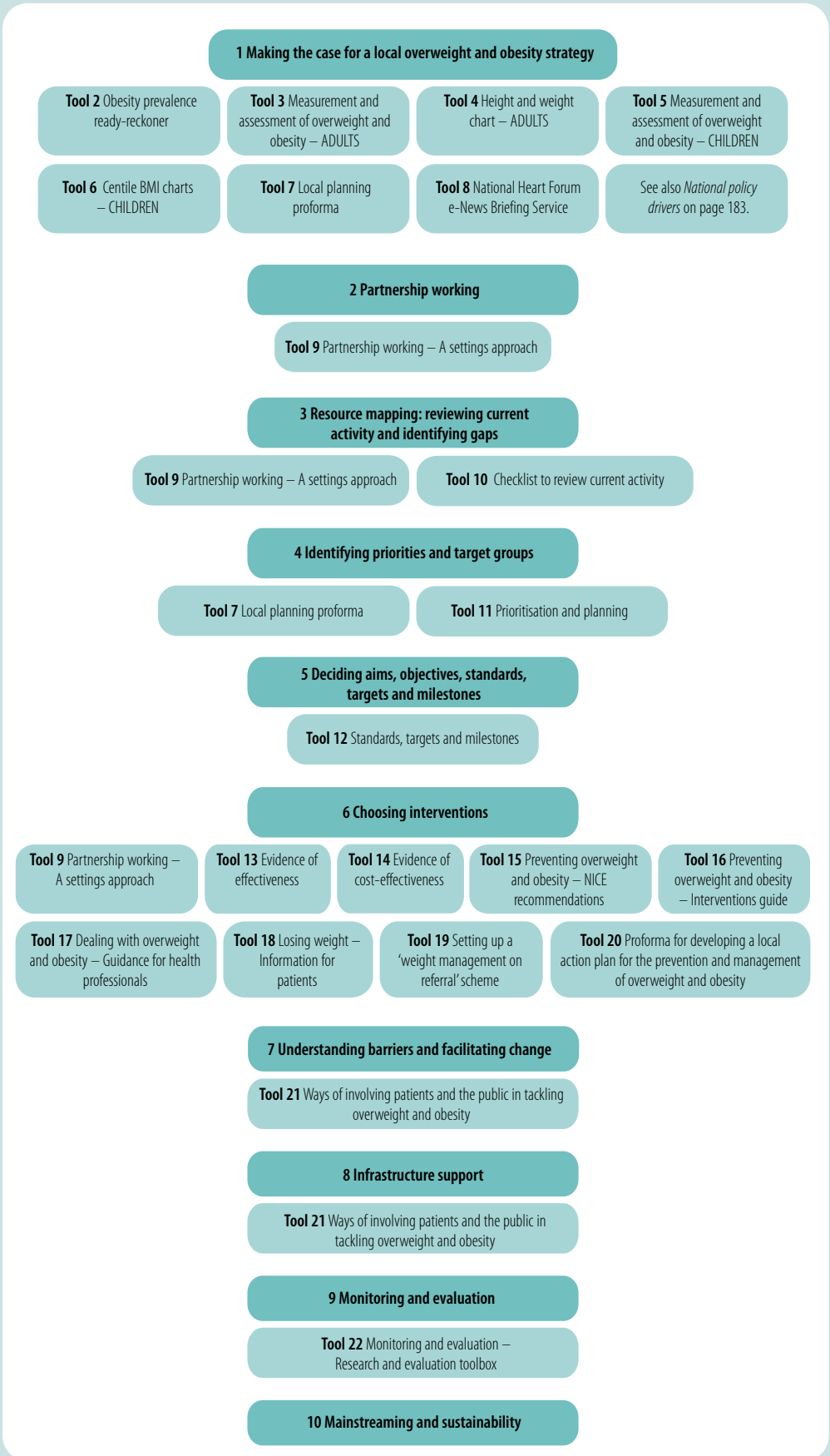
Developing a local overweight and obesity strategy

C

This section of the toolkit provides a practical guide to developing a local strategy to prevent and manage overweight and obesity. The diagram in Figure 10 on the next page shows all the aspects covered in this section and signposts the reader to the relevant tools in section D.

Tool 1 shows a suggested structure for a local overweight and obesity strategy containing all the elements displayed in the diagram on the next page.

Figure 10 **Suggested structure for developing a local overweight and obesity strategy**



Making the case for a local overweight and obesity strategy

The case for a local overweight and obesity strategy should be built on:

- the key policy drivers – both national and local
- an estimate of the local burden of overweight and obesity
- an estimate of the potential benefits of local action, and
- an estimate of the cost of taking action.

Key policy drivers

National policy drivers

The prevention and management of overweight and obesity is a national government priority concern.

The major policy driver published in 2004 as a public health white paper – *Choosing health: Making healthy choices easier*[1] – set out government commitments for action on obesity, including stemming the rise in obesity among children aged under 11. This reflects the Public Service Agreement shared by the Department of Health, the Department for Education and Skills and the Department for Culture, Media and Sport to **halt the year-on-year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.**[2] The government's delivery plan, published in 2005 in the reports *Delivering Choosing health: Making healthier choices easier,*[3] *Choosing a better diet: A food and health action plan*[4] and *Choosing activity: A physical activity action plan,*[5] provides further details on the action that needs to be taken at national, regional and local level to improve people's health through improved diet and nutrition and increasing physical activity.

More detailed information on relevant national policy drivers is given on page 183.

Local policy drivers

Local policy drivers to tackle obesity are likely to include local agreements, targets, standards, policies and strategies which relate to the promotion of healthy lifestyles and the provision of high-quality management of chronic diseases such as coronary heart disease, diabetes or cancer. Key policy drivers for local action on adult obesity are already in place through the National Service Frameworks for coronary heart disease[6] and diabetes.[7] In addition, the Priorities and Planning Framework[8] for primary care trusts (PCTs) includes advice on diet and activity.

However, the publication of *Choosing health* has pushed forward the obesity agenda and is the key policy driver for tackling obesity, particularly childhood obesity, at the local level. Delivery planning for *Choosing health* is an integral part of PCTs' Local Delivery Plans (LDPs). LDPs are the strategic plans for PCTs in which they set out in detail their plans for delivery of health and social care over a three-year period as detailed in *National standards, local action: Health and social care standards and planning framework 2005/06-2007/08.*[9] They should be developed in close consultation with local authority partners and other key stakeholders in Local Strategic Partnerships (LSPs) to ensure the LDP is aligned with the local community strategy. Under these plans, PCTs take all the best experience of whole-systems planning and cross-sector partnerships based on sound analysis of local need. LDP developments include the introduction of a new monitoring line on adult obesity status from 2005/06 and a new monitoring line on prevalence of obesity among children.

The Department of Health has stated in its instructions to strategic health authorities (SHAs)[10] that local obesity plans will need to have a strong focus on designing and developing services for:

- dietary improvement (eg Food in Schools, 5 A DAY)
- increasing physical activity (eg the National Healthy Schools Programme, pedometers, exercise on referral, more opportunities for children's play)
- provision of services around obesity care pathways for adults and children
- increasing the health improvement workforce (eg school nurses, health trainers), and
- Local Area Agreements (LAAs) and Local PSA targets (LPSAs).

Estimating the local burden of overweight and obesity

Prevalence

Although some areas have local prevalence data derived from various *ad hoc* local surveys, in most areas estimates must be either extrapolated from national surveys or obtained from general practice registers.

The Health Survey for England provides data on the proportion of adults who are overweight and obese. Robust estimates of adult obesity at strategic health authority level are available based on three-year rolling averages. These data can be applied to the local demographic profile of a PCT to calculate an estimate of prevalence.

Tool 2 is a ready-reckoner to help you estimate the prevalence of obesity among both adults and children in your local area.

The Department of Health has produced guidance for PCTs which provides advice on how to measure the height and weight of children aged between 2 and 11 years.[11] PCTs are required to measure all primary school children in the Reception Year (ages 4 to 5 years) and in Year 6 (ages 10 to 11 years). These data will provide an indication of prevalence of overweight and obesity among the population group. (For analysis of the prevalence of overweight and obesity among children measured in 2005/06 data, go to www.dh.gov.uk/assetRoot/04/14/21/56/04142156.pdf). These data will also help inform local planning and targeting of local resources and interventions. The importance of weighing and measuring is detailed further on page 61. (For the Department of Health's guidance on weighing and measuring, go to www.dh.gov.uk/obesity.)

The quality of general practice data has up until now been patchy, but the introduction of standardised clinical systems software and the Quality and Outcomes Framework (QOF) under the General Medical Services (GMS)[12] contract mean that more reliable and more comprehensive data are now becoming available. The data include numbers of patients on practice registers for a range of chronic diseases and risk factors. These are collated centrally through the Quality Management and Analysis System (QMAS) and provided to primary care trusts as annual estimates of prevalence. The revision of the QOF (2006)[13] has included the addition of obesity as a new area offering 8 points to GP surgeries for producing a register of patients who are obese: "OBESITY 1: The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30kg/m^2 in the last 15 months." This will provide an indication of prevalence.

Cost

Estimating the costs of overweight and obesity at local level is difficult, and depends on:

- the degree of complexity used in modelling
- the validity of the various assumptions used in calculations
- the clinical guidelines and prescribing regimes followed, and
- the current costs of drugs.

Approximate values can be derived by applying national figures to the local estimates of prevalence, either as calculated using the process described in **Tool 2,** or from the prevalence data derived from general practices through the Quality and Outcomes Framework of the GMS contract (eg via QMAS).

Estimating the potential benefits of local action

Ideally, estimations should include cost-benefit analyses, although these are extremely difficult to quantify. Theoretically, there are two components to analyse:

- the number of cases of overweight and obesity prevented by lifestyle changes in the population (and hence the cost-benefits of prevention), and
- the number of cases of coronary heart disease, diabetes, strokes, and obesity-related cancers prevented by effective identification and management of overweight and obesity (and hence the cost-benefits of screening for obesity).

In practice, however, it has proved difficult to model such analyses with any degree of accuracy.

Estimating the cost of taking action

NICE has produced a costing report and costing template to estimate the financial impact to the NHS of implementing the clinical guideline on obesity. The costing template provides health communities with the ability to assess the likely local impact of the principal recommendations in the clinical guideline based on local population, and other variables can be amended to reflect local circumstances. The costing report focuses on the financial impact of the recommendations that require most change in resources to implement in England. Go to www.nice.org.uk/guidance/CG43 to download the costing report and template.

Other tools which can help with making the case for a local overweight and obesity strategy include:

Tool 3 *Measurement and assessment of overweight and obesity – ADULTS*
Tool 4 *Height and weight chart – ADULTS*
Tool 5 *Measurement and assessment of overweight and obesity – CHILDREN*
Tool 6 *Centile BMI charts – CHILDREN*
Tool 7 *Local planning proforma.*

See also **Tool 8** *National Heart Forum e-News Briefing Service* for how to get up-to-date information on issues related to overweight and obesity.

Key Point

Tackling overweight and obesity should be a given priority – but estimating the size of the problem locally, and the burden it represents, is often useful in securing commitment.

Partnership working

The public health white paper, *Choosing health,*[1] emphasises the importance of partnership working. In a *Planning and performance toolkit*[14] sent to PCTs from the Department of Health, great emphasis was placed on partnership working to ensure the delivery of the plan. Particular importance was placed on the partnership between PCTs, local authorities and other stakeholders in Local Strategic Partnerships.

Identifying key partners

Tackling overweight and obesity at local level requires a 'whole-systems' approach to increase physical activity levels and to promote a balanced diet. This involves a range of partners in planning the strategy, steering its implementation, ensuring that it meshes appropriately with a wide range of related parallel strategies and policies, and implementing the strategy. Many of these partnerships are likely to exist already, either formally or informally – for example, as part of a healthy lifestyles programme, a National Service Framework implementation programme or a chronic disease management programme.

Key partners may include representatives from the NHS, local authorities, the private sector, patient groups, and the voluntary and community sectors.

Benefits of partnership working

The Health Development Agency (HDA)[15] outlined the following advantages created by partnership working:

Good partnership working can:

- generate solutions to problems that single agencies cannot solve
- improve the services local communities receive
- enhance the coordination of services across organisational boundaries, and
- avoid wasteful duplication and gaps in services, thus making better use of existing resources.

Working together should help individual partners to meet their own objectives, as well as contributing to shared targets and objectives through:

- access to additional data and information
- improved understanding of community needs and aspirations
- economies of scale through pooling resources
- access to a broader range of skills through joint appointments, secondments and shared training
- potential for innovation, and
- opportunities for shared learning.

Effective partnerships

There are no unique models for partnership working. Partnerships should be developed to meet local needs and circumstances. Evidence collected by the HDA[16] suggests that the following factors help to build successful partnerships:

- a shared vision and common priorities
- a strategic planning framework – themes, population groups, areas and settings
- a strategic partnership structure and accountability agreements
- champions and leaders at strategic and operational levels
- coordinated needs assessment and community involvement
- cross-cutting commissioning arrangements
- flexible use of resources – staff, money, time and facilities
- a coordinated approach to mainstreaming initiatives
- common local targets and indicators, and
- partnership learning and staff development.

Tool 9 provides examples of partnership working in different settings.

Establishing a local overweight and obesity action team

A key partnership that may need to be created specifically is an overweight and obesity action team to coordinate and steer the elements most relevant to tackling overweight and obesity. This team does not need to be large and unwieldy. Core inputs are:

- health promotion
- public health
- nutrition and dietetics
- leisure/physical activity
- school nursing
- education
- transport.

It is essential to include in the overweight and obesity action team someone with expertise in the evaluation of community projects (see page 83).

Others can be included as and when appropriate. For example, if the focus is on detection and management of existing cases, the team might also include:

- patient or carer
- GP and/or practice nurse
- primary care quality facilitator
- commissioner
- hospital specialist.

Key Point

A useful model is to establish a dedicated operational partnership, such as a local overweight and obesity action team, working under a more strategic partnership framework such as the Local Strategic Partnership.

Resource mapping: reviewing current activity and identifying gaps

This involves a service review, a 'gap analysis' or audit of local services, initiatives and infrastructure including protocols, procedures, pathways and practice, to find out:

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

Tool 10 provides a checklist to use when reviewing current activity and assessing how well services and initiatives are delivering in the various settings.

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

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

Key Point

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

Identifying priorities and target groups

With limited resources and capacity, and with such a wide range of possible initiatives and interventions, both in terms of prevention and management, decisions will have to be made about where to focus efforts. A balance must be found between a whole-population approach and an 'individuals-at-risk' approach.

First, the balance between prevention and management needs to be considered. How much of the available resources and capacity should go into changing the environment from an obesogenic environment to a supportive environment to prevent overweight and obesity, and how much into case-finding and treatment?

Second, within each of these broad approaches, decisions have to be made about priority interventions and target groups. Each partner agency should contribute to this process, beginning with those interventions for which it has the lead role. So, for example, the leisure department of the local authority might propose that certain physical activity or sports programmes be focused on men aged over 35 years. Or the primary care trust might propose a case-finding and treatment scheme aimed specifically at ethnic groups who have a high risk of obesity.

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/index.php?c=204*
- University of Sheffield Public Health GIS Unit – *gis.sheffield.ac.uk/newpages/projects.htm*
- Communities and Local Government – Indices of Deprivation – *www.communities.gov.uk/index.asp?id=1128440*
- Local academic departments – *www.hero.ac.uk/uk/home/index.cfm*
- A number of commercial organisations can also help with mapping.

Targeting specific population groups

Some sectors of the population are more at risk of developing obesity or its complications[17] and should be considered as priorities for targeting preventive initiatives. These include the following.

- Children from low-income families. There is a correlation between low income and a greater risk of obesity in childhood as well as adulthood.
- Children from families where at least one parent is obese. The increased risk may be due to genetic and/or environmental reasons.
- Individuals of Asian origin, particularly those of South Asian origin, for whom obesity carries a greater risk of metabolic syndrome and its consequences.
- Ethnic groups with a higher than average prevalence of obesity (BMI 30-39.9kg/m^2 – ie excluding the severely obese). The latest Health Survey for England (2004)[18] shows that the highest prevalences are among Black African women (33.5%), Black Caribbean women (27.9%), Pakistani women (26%), Black Caribbean men (25%), and Irish men (23.6%), compared to 21.7% of men and 20.8% of women in the general population. Other groups have average or below average prevalences. The lowest prevalences are in Chinese women (7.3%), Chinese men (5.7%) and Bangladeshi men (5.5%).
- Adults in semi-routine and routine occupations (using the National Statistics Socio-Economic Classification [NS-SEC]): 18.7% of women in managerial and professional households are obese compared with 29.1% of women in routine and semi-routine households.[19]

- People who have a physical disability, particularly in terms of mobility, which makes exercise difficult.
- People with learning difficulties.
- Older people. Increasing age is associated with increasing prevalence of obesity up to the age of 64 years, and then a decline in the prevalence begins.

The national annual weighing and measuring exercise to record the heights and weights of children in Reception (ages 4-5 years) and Year 6 (ages 10-11 years) will enable primary care trusts, local authorities and other partners to gain a better understanding of children's needs in this area. This will enable local organisations to target resources and interventions where they are most needed, and ensure efforts are directed more effectively. Go to www.dh.gov.uk/obesity for the Department of Health's guidance on how to measure the height and weight of children.

CASE STUDY

Using local weighing and measuring data to target resources – Westminster PCT

Westminster PCT is using local weighing and measuring data to tackle childhood obesity in their area. School nurses weighed and measured more than 90% of primary school pupils in Reception Year and in Year 6. Data showed that a third of these children are overweight or obese, putting child obesity levels at the second highest in London. Westminster PCT is therefore targeting two to five year olds by working with families through Children's Centres and the Health Visitor Health Promotion Programme; and targeting nine and ten year olds by working on a one-to-one basis in schools with the highest percentage of obese children. This includes using intensive robust physical exercise and healthy eating programmes.

For more information contact: Alison Wright, Professional Lead for Children's Services, Westminster PCT.

Phone: 020 7150 8030

Targeting individuals

In terms of the individual, there are times when people are more likely to put on weight: for example, men in their late 30s, women entering long-term partnerships, women during and after pregnancy, women at the menopause, people suffering from psychosocial problems such as stress or depression, people who retire, and people giving up smoking.[17]

Key Point

Because of the national target to tackle obesity in children under 11, any preventive programme should give priority to this broad group.

The following tools can help with identifying priorities and target groups:

Tool 7 *Local planning proforma*

Tool 11 *Prioritisation and planning*

Deciding aims, objectives, standards, targets and milestones

Aims and objectives set the 'direction of travel' of the strategy. Standards, targets and milestones are more specific operational goals against which the whole strategy and its component strands can be evaluated.

Aims and objectives

An **aim** is a general statement of strategic intent. For example, the overall aim of your local overweight and obesity strategy could be along the following lines:

- To reduce the burden of death, disability and distress due to overweight and obesity in the population served by [the named PCT].

The strategy should have two basic subsidiary aims reflecting its two main approaches, such as:

- **Prevention:** To prevent overweight and obesity developing in the community, and
- **Management:** To manage existing cases of obesity.

Objectives are more specific than aims. They refer to particular outcomes or outputs of either the preventive or management elements of the strategy. For example, 'prevention' objectives might be:

- To encourage children to adopt and sustain healthy eating patterns in school, at home and in the community.
- To increase the habitual level of physical activity in young women.

A 'management' objective might be:

- To establish a 'weight management on referral' scheme for patients who have a BMI above 30kg/m^2.

Standards, targets and milestones

A **standard** is an operational goal which usually prescribes a specific level of quality of a service. Standards are particularly useful as 'process' indicators – a way of assessing how well a service is delivering or developing its intended outputs. In practice, standards to be achieved within given timeframes are often used as targets and milestones.

A **target** is an objective or standard with a specified measurable outcome, output or level of quality within a timeframe. For example, a prevention target might be:

- To increase the proportion of the local population who participate in 30 minutes of moderate physical activity five or more times a week to 70% by 2020.

Local target-setting is being encouraged as a core principle of NHS and local partnership planning. For example, the Department of Health has issued the following checklist of principles for local target-setting in its latest planning guidance.[9] In developing local plans, PCTs should ensure that the plans:

- are in line with population needs
- address local service gaps
- deliver equity
- are evidence-based
- are developed in partnership with other NHS bodies and local authorities, and
- offer value for money.

A **milestone** is an interim position on the way towards a target. It provides a useful means of demonstrating shorter-term progress and is used in monitoring and evaluation.

Tool 12 provides further information about standards, targets and milestones.

The challenge for local overweight and obesity action teams is to choose the appropriate combination of a whole-population approach and an individuals-at-risk approach.

Choosing interventions

A fundamental aspect of planning is to consider which of the many possible interventions or actions should be incorporated into local strategies and plans. Decisions will be based on various factors, including:

- evidence of effectiveness
- outcomes of public health interventions
- appropriateness for the local community or local groups (eg black and minority ethnic communities) and cultural issues
- cost-effectiveness
- national guidance such as the NICE guideline on obesity[20]
- available resources
- timeframes, and
- organisational and political pressures.

Tool 13 provides evidence of effectiveness of interventions for tackling overweight and obesity, improving diet and nutrition and increasing physical activity levels.

Tool 14 provides evidence of cost-effectiveness of interventions.

Tool 15 gives a summary of the NICE recommendations for preventing overweight obesity. It includes recommendations both for NHS health professionals and for local authorities and partners in the local community.

NICE has also produced *Quick reference guide 1 – For local authorities, schools and early years providers, workplaces and the public*, which contains guidance on how to put the NICE guideline's recommendations into practice. The guide can be downloaded from www.nice.org.uk/guidance/CG43

PREVENTING OVERWEIGHT AND OBESITY

It is important to recognise that the concept of obesity prevention does not simply mean preventing normal-weight individuals from becoming obese. Rather, it encompasses a range of strategies that aim:

- to prevent the development of overweight in normal-weight individuals
- to prevent the progression of overweight to obesity in those who are already overweight, and
- to prevent weight regain in those who have been overweight or obese in the past but who have since lost weight.

The prevention strand of the overweight and obesity strategy should be based on providing supportive and accessible physical environments and on the 'lifecourse' approach. It should include interventions, starting from childhood:

- to improve diet and nutrition (eg providing advice about infant feeding and healthy eating for young families, reducing salt consumption and increasing fruit and vegetable consumption), and
- to increase community-wide levels of physical activity (eg promoting walking and cycling, promoting use of leisure facilities, and local transport policies).

The selection of interventions might involve:

- assessing the feasibility and probability of success
- where possible, considering the cost-effectiveness of particular interventions
- achieving a balance between the preventive and management strands of the overall strategy
- taking into account national guidance such as the NICE guideline on obesity[20]
- assessing what can be done within budget and infrastructure constraints
- developing action plans for the key settings, and identifying specific 'deliverables', the lead agency or individual for each deliverable, and the date by which these must be achieved, and
- choosing appropriate settings for interventions as detailed below.

A practical framework for local programmes could be that offered by the so-called 'healthy settings' approach, which focuses on interventions in a number of key settings to develop a coordinated programme for obesity prevention. There are many possible settings to develop: from home to hospital, from park to prison, and from community group to club or pub. Each provides a particular opportunity to influence people's eating, drinking and physical activity habits. A range of settings for action to prevent overweight and obesity is shown in Table 8. Some examples of interventions to prevent obesity by improving nutrition and increasing physical activity are given on pages 65-69.[21]

Tool 9 describes how partnerships can work in different settings.

Table 8 Main settings for preventing overweight and obesity

Setting	Main target group(s)
Home (including pre-school)	Infants, pre-school children and their parents or carers
School	School-age children, parents, teachers, school governors
Workplace	Employees and employers, and their families; catering providers
Community (community groups and faith groups)	Minority groups, eg people with cultural or ethnic identities, refugees and asylum-seekers, travellers, homeless people
Leisure outlets	General public and specific sub-groups (eg older people)
Retail and commerce outlets	General public and specific sub-groups (eg younger people), food retailers, catering providers
Media	General public and specific sub-groups (eg younger people, older people)

Source: Adapted from Maryon-Davis, 2005 [22]

Home (including pre-school)

- Promotion of breastfeeding.
- Promotion of healthy infant feeding.
- Promotion of healthy eating and active lifestyles for young families, eg encouraging parents to actively play with their children and to reduce sedentary behaviour (by limiting the amount of television a child watches, or visiting the local park, play area or swimming pool).
- 'Positive parenting', eg action to promote breastfeeding, and appropriate weaning and infant feeding, with one-to-one verbal advice by health visitors or lay workers (mother-to-mother schemes); breastfeeding drop-ins and cafés; written support materials; mass media features; Sure Start programmes; National Breastfeeding Awareness Week.
- Action to promote healthy eating and active living for young children including 'positive parenting' advice or classes; training for childminders and playgroup leaders around healthy eating and active play; providing safe play areas.

School

- Creating a whole-school health-promoting environment, eg National Healthy Schools Standard and Healthy Schools Partnerships.
- Developing a 'whole-school food policy' through engagement with the entire school community, including young people.
- Teaching healthy eating and cooking skills, eg slots for nutrition in the curriculum; and slots for teaching healthy cooking skills.
- Providing healthy food and drink throughout the school day – healthier breakfast club provision, implementing guidelines on minimum nutritional standards for school food, replacing drinks and snacks which are high in fat, salt and sugar with healthier alternatives (eg fruit tuck-shops, healthier vending machines, freely available drinking water).
- Healthy catering guidelines written into catering contracts.
- For more information and detailed recommendations for improving food in schools, see www.foodinschools.org and www.schoolfoodtrust.org.uk.

The Food in Schools Programme

The Food in Schools Programme encourages a whole-school approach to healthy eating and drinking. There are two main strands, one of which is the implementation of strategies to support and enhance food education in schools. These include professional development for teachers, and curriculum materials supporting links with science and technology. The other strand is the *Food in Schools Toolkit* which provides schools and other stakeholders with guidance and resources on activities such as healthy breakfast clubs, healthy tuck shops and healthy cookery clubs. The new school food standards will build on this and take schools a step further.

For more information, visit www.foodinschools.org

- Increased uptake of physical activity and sports, eg enjoyable activities, physical education and sports sessions built into the curriculum and after school, including non-traditional forms such as dance in order to develop skills in enjoyable ways; safe routes to schools, and walking buses (schoolchildren walking in supervised groups); cycling training; and other forms of active travel to and from school.
- Provision of personalised support and a range of options for children and young people seeking help to control their weight, eg with the school nursing service able to support children and parents, and to make referrals to relevant community and specialist services when needed.

Workplace

- Interventions to encourage healthy lifestyles among staff include weight control through healthy eating and increased physical activity, eg healthy catering; providing cycle-parking racks, tax-free cycle-to-work schemes, and shower facilities; fitness sessions; providing recreational facilities; occupational health checks; providing information to employers and employees; making stairwells attractive (as an alternative to using lifts); and workplace health programmes.

CASE STUDY

Choosing activity in the workplace – St Helens PCT

Activity in the workplace is featured within the Active St Helens programme. The Metropolitan Borough Council (MBC) and the PCT have set up regular lunchtime walks for staff. They have also set up a 'stepometer league', which has been so successful in the MBC that it has received national media coverage. The PCT organised a unique 'Olympic' stepometer league, with departments being awarded medals for outstanding walking achievements. In addition to this, physical activity opportunities are advertised through PCT and MBC communication channels. The PCT has a policy which entitles staff to take 30 minutes out of their normal working hours to engage in a physical activity of their choice. The MBC is also promoting low-cost corporate passes to leisure centres as incentives for employees, under the branding of 'Go active'.

For more information contact: Neil Davies, Health Improvement Specialist, St Helens PCT. Phone: 01744 697433

Community

- Healthy eating campaigns, eg media campaigns; work with local supermarkets; healthy eating accreditation schemes for restaurants and food outlets; removal of promotion of high-fat and high-sugar foods and drinks from leisure centres, schools and hospitals.
- Strategies to minimise barriers to healthy eating by improving availability and access, eg mapping of 'food deserts'; supermarket pricing policies to encourage healthier choices; and town planning to site food shops selling fruit and vegetables close to areas of deprivation.
- Group work on healthy eating for higher risk or disadvantaged groups, eg identification and mapping of at-risk groups; culturally sensitive group work; and peer education.
- Physical activity and fitness campaigns, eg physical activity for older people; home-based exercise; and campaigns targeted at at-risk groups.
- Encouraging the use of leisure facilities, eg improved leisure facilities at affordable prices.
- Use of community centres and schools for leisure and physical activity. The introduction of extended schools provides opportunities for more community links to be developed.
- Increased walking or cycling to school and to the workplace, eg safe routes to school and the workplace; and walking buses (schoolchildren walking to and from school in supervised groups).
- Local transport policies which encourage walking and cycling, eg provision of reliable, comfortable, frequent, safe and affordable public transport; restriction of use of cars in urban areas; better traffic-calming; creation of safe cycling and walking routes; and wider use of CCTV cameras.
- Local planning to encourage physical activity, eg more parks and open spaces; better street lighting and safe, clean environments.

5 A DAY locally

5 A DAY initiatives are taking place across the country in PCTs and can be used for increasing fruit and vegetable consumption among the general population from school through to primary care. Below are some examples of local initiatives. For more information, visit the website www.5aday.nhs.uk

Cook and eat sessions

These generally involve a group of people attending one or a series of practical cookery sessions to learn about preparing fruit- and vegetable-based dishes and other healthy options. In addition to teaching cooking skills, these sessions can also teach food preparation skills, food safety and basic nutrition. They give people the chance to try different foods without the fear of wasting money if they do not like them.

Growing schemes

These include allotment schemes, community orchards and gardens, school-based growing schemes and 'grow your own' initiatives. The produce is used for growers' own consumption, for the community, or to supply other initiatives such as food co-ops or community cafés.

Fruit and vegetable co-ops

Local people group together to buy fruit and vegetables in bulk from wholesalers or direct from local producers. The savings from the bulk-buying are passed on to the co-op members so that the fruit and vegetables are sold at reasonable prices. They can operate in places such as community centres, schools and workplaces, and are generally run by volunteers.

Voucher schemes
Families on low incomes or those at risk of diet-related disease receive vouchers for money off the cost of fruit and vegetables in local shops over a period of time, to encourage purchase and consumption of fruit and vegetables. The vouchers can be given or 'prescribed' by primary health care professionals such as GPs or nurses.

5 A DAY with retailers and caterers
Work with shops and caterers to make fruit and vegetables more accessible by increasing the range on offer, having prominent and eye-catching displays, offering promotional discounts, and providing information on fruit and vegetable preparation and recipes.

5 A DAY in a primary care setting
Activities can include nutrition training for health professionals, offering fruit and vegetables at surgeries and clinics, and fruit and vegetables 'on prescription' for patients.

Leisure outlets

- Offering free or inexpensive access to a wide range of activities, eg use of subsidised access schemes for less wealthy local residents.
- Providing healthy catering at all leisure venues, eg inexpensive healthy choices in leisure centre cafés and vending machines; removing the promotion of less healthy foods and drinks in leisure centres.
- Providing coordinated outreach physical activities for specific groups, eg healthy walks schemes; and exercise sessions for older people in care homes.
- Encouraging more users to walk or cycle to leisure venues, eg providing cycle-parking racks at all leisure venues.
- Closer links with local schools, eg collaborating with local schools to integrate sports and physical activity into the curriculum, organising after-school initiatives, and extending the use of educational facilities as a community resource for physical activity.
- Making the countryside more accessible and attractive for all, to encourage outdoor recreation in the countryside.

CASE STUDY
Walking and cycling – Rushcliffe PCT

The Rushcliffe Walking and Cycling group was formed in 2004 to encourage people to take up these forms of everyday activity. The group includes Rushcliffe Primary Care Trust, Rushcliffe Community Service Volunteers, Rushcliffe Borough Council, Nottinghamshire County Council and local voluntary groups. The group has been involved in the provision of training for volunteer walk leaders to set up local 'walking for health' groups, and is developing an *Easy Walk Guide* for Rushcliffe residents with details of short walks over Rushcliffe.

The 'Easy Rides' cycle programme has been expanded. These are short, led cycle rides along traffic-free and quiet roads in Rushcliffe suitable for cycling novices and those returning to cycling. The group has also continued to work with Ridewise which provides adult cycle training to develop people's skills, knowledge and confidence from riding a bike to route planning.

For more information contact: Lucy Durling, Rushcliffe PCT. Phone: 0115 878 3000

Retail outlets

- Harnessing the power of the retail industry to create a climate where physical activity and healthy eating are considered 'cool' – for example, engaging large chain stores and other local retailers in promotions and campaigns to sell the 'get physical' message to young people; or involving retailers of fruit and vegetables and juices in the same way.

Media

- Harnessing the power of the local media to create a 'buzz' around a series of mass participation events – eg articles, features or interviews in local newspapers and radio or TV programmes to promote local health days, mini-marathons, healthy cook-ins, 'aerobathons' and other events.

Advice on the choice of interventions for improving diet and nutrition and physical activity are available from two toolkits: *Let's get moving!* [23] and *Nutrition and food poverty*[24] both produced by the Faculty of Public Health and the National Heart Forum.

Tool 13 provides evidence of effectiveness of interventions for tackling overweight and obesity.
Tool 14 provides evidence of cost-effectiveness of interventions.
Tool 15 summarises the NICE recommendations.
Tool 16 provides a comprehensive guide to interventions for the prevention of overweight and obesity in different settings.

The challenge is to make the best use of the opportunities created by action at national level.

For more information

Physical activity

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.

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.publichealth.nice.org.uk/page.aspx?o=PHI002

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.

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/page.aspx?o=505281

Think fit! Be active! A guide to developing a workplace activity programme
British Heart Foundation (2005).
London: British Heart Foundation.
For details see: www.bhf.org.uk/thinkfit/index_home.asp?SecID=1590

Diet and nutrition

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

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

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/downloads/Nut_TkitAll.pdf

Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk/guidance/CG43

General

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 (NIH).
Available from: www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

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/policy_communication/publications/leaflets/healthy_workplaces.asp

The management of obesity and overweight: An analysis of reviews of diet, physical activity and behavioural approaches. Evidence briefing. 1st edition
C Mulvihill and R Quigley (2003).
London: Health Development Agency.
Available from: www.phel.gov.uk/evidence/evidencedetails.asp?recordid=71

Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk/guidance/CG43

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/books/0309091969/html

Obesity guidance for healthy schools coordinators and their partners
Department of Health (2007).
London: Department of Health.
Available from: www.dh.gov.uk/assetRoot/04/14/21/71/04142171.pdf

MANAGING OVERWEIGHT AND OBESITY

As well as prevention, the other basic strand to any local overweight and obesity strategy is assessing and managing overweight and obese patients, mainly in primary care but also in the community and hospital settings. This section focuses on the tools that could help in the development of a comprehensive primary care weight management service.

Clinical guidance

Clinical guidance has been established to ensure that there is a systematic approach to the assessment and management of overweight and obesity. Examples of guidance available are shown in Table 9. In England the National Institute for Health and Clinical Excellence (NICE) has developed evidence-based guidance for the prevention, identification, assessment and management of overweight and obesity in children and adults.[20] The guidance is broad, focusing on clinical and non-clinical management with the following aims: 1) to stem the rising prevalence of obesity and diseases associated with it; 2) to increase the effectiveness of interventions to prevent overweight and obesity; and 3) to improve the care provided to adults and children with obesity, particularly in primary care. The Department of Health has also developed evidence-based guidance for use in England although this has been produced to support primary care clinicians to identify and treat children, young people and adults who are overweight or obese.[25] Included within these sets of guidance are care pathways which direct healthcare professionals to appropriate measures for assessing and managing overweight and obesity.

Tool 17 *Dealing with overweight and obesity – Guidance for health professionals* provides further details of the NICE and Department of Health care pathways for children, young people and adults.
Tool 18 *Losing weight – Information for patients* gives details of sources of information for adults and children who need to lose weight.

Table 9 Clinical guidance for managing overweight and obesity in adults, children and young people

	Adults	Children and young people
England	National Institute for Health and Clinical Excellence (NICE) (2006) [20] www.nice.org.uk/guidance/CG43 Department of Health (2006) [25] www.dh.gov.uk/assetRoot/04/13/45/60/04134560.pdf	National Institute for Health and Clinical Excellence (NICE) (2006) [20] www.nice.org.uk/guidance/CG43 Department of Health (2006) [25] www.dh.gov.uk/assetRoot/04/13/45/60/04134560.pdf
United Kingdom	PRODIGY Knowledge (2001) [26] www.prodigy.nhs.uk/obesity	Royal College of Paediatrics and Child Health and National Obesity Forum (2002) [27] nationalobesityforumorguk.pre-dns-change.com/images/stories/W_M_guidelines/Children_and_adolescents.pdf
	National Obesity Forum (2004) [28] nationalobesityforumorguk.pre-dns-change.com/content/blogcategory/31/125/	
	National Obesity Forum (2005) [29] nationalobesityforum.org.uk/content/blogcategory/18/170/	
Scotland	Scottish Intercollegiate Guidelines Network (SIGN) (1996) [30] www.sign.ac.uk/pdf/sign8.pdf Note: This guidance is currently under review.	Scottish Intercollegiate Guidelines Network (SIGN) (2003) [31] www.sign.ac.uk/pdf/sign69.pdf
United States	National Heart, Lung and Blood Institute (1998) [32] www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf	
Australia	National Health and Medical Research Council (2003) [33] www.health.gov.au/internet/wcms/publishing.nsf/Content/obesityguidelines-guidelines-adults.htm	National Health and Medical Research Council (2003) [34] www.health.gov.au/internet/wcms/publishing.nsf/Content/obesityguidelines-guidelines-children.htm

The important aspect of assessment is that people with greatest clinical need are prioritised and offered systematic weight management. This is a substantial task and practices will need appropriate support from PCTs and strategic health authorities. It is essential that practices not only record patients' weight details as outlined in clinical guidance, but also maintain a register of these patients including their risk factors. As an incentive to record and store this information, participating practices can use the Quality Management and Analysis System (QMAS) central database. This can also be used for local epidemiological analysis. Furthermore, the addition of obesity as a new area of the QOF is another incentive for GP surgeries to maintain a register of patients who are obese. Eight points are offered to those surgeries who do record patients' weight details. When recording patients' BMI and waist circumference it is important to use a standard template. The National Institute for Health and Clinical Excellence (NICE),[20] the Department of Health,[25] PRODIGY Knowledge,[26] the National Obesity Forum,[28, 29] and the Royal College of Paediatrics and Child Health and National Obesity Forum[27] all provide advice for assessing patients.

Tool 4 provides a height and weight chart for adults.
Tool 6 provides centile BMI charts for children.

Exercise referral schemes

Following on from assessment some patients may benefit from an exercise referral. The Department of Health has published a National Quality Assurance Framework for exercise referral schemes.[35] This provides guidelines with the aim of improving standards among existing exercise referral schemes, and helping the development of new ones. The Framework focuses primarily on

the most common model of exercise referral system, where the GP or practice nurse refers patients to facilities such as leisure centres or gyms for supervised exercise programmes.

The National Quality Assurance Framework provides a range of tools for use in both primary and secondary prevention. See *www.dh.gov.uk/assetRoot/04/07/90/09/04079009.pdf*.

NICE guidance on exercise referral schemes[36]

The Public Health Independent Advisory Committee (PHIAC) determined that there was insufficient evidence to recommend the use of exercise referral schemes to promote physical activity other than as part of research studies where their effectiveness can be evaluated. NICE recommends that practitioners, policy makers and commissioners should only endorse exercise referral schemes to promote physical activity if they are part of a properly designed and controlled research study to determine effectiveness. Measures should include intermediate outcomes such as knowledge, attitudes and skills, as well as measures of physical activity levels. Individuals should only be referred to schemes that are part of such a study.[36]

Walking and cycling schemes

Primary care teams may also consider referring patients directly to walking or cycling programmes.

The Walking the Way to Health Initiative (WHI) of the British Heart Foundation and the Countryside Agency aims to improve the health and fitness of people who do little exercise or who live in areas of poor health. The scheme offers local walks in a wide variety of areas. The National Step-O-Meter Programme (NSP), managed by the Countryside Agency, aims to make it possible for NHS patients (especially those who take little exercise) to have the use of a Step-O-Meter (pedometer) free of charge for a limited loan period. Step-O-Meters are being made available to patients through health professionals. For more information about WHI and NSP see www.whi.org.uk.

Cycling referral programmes are a relatively new innovation, but can be useful for people who prefer cycling to walking or gym-based exercise. For more information, *Health on wheels: A guide to developing cycling referral projects*[37] is available from Cycling England: see www.cyclingengland.co.uk/health9.php.

NICE guidance on pedometers, walking and cycling schemes[36]

PHIAC determined that there was insufficient evidence to recommend the use of pedometers and walking and cycling schemes to promote physical activity, other than as part of research studies where effectiveness can be evaluated. However, they concluded that professionals should continue to promote walking and cycling (along with other forms of physical activity, eg gardening, household activities and recreational activities) as a means of incorporating regular physical activity into people's daily lives.

NICE recommends that practitioners, policy makers and commissioners should only endorse pedometers and walking and cycling schemes to promote physical activity if they are part of a properly designed and controlled research study to determine effectiveness. Measures should include intermediate outcomes such as knowledge, attitude and skills, as well as measures of physical activity levels.

Weight control groups and 'weight management on referral' (or 'slimming on referral')

Other examples of interventions to manage overweight and obesity are weight control groups and, more recently, weight management on referral schemes. Many weight control groups have been set up as part of PCT local obesity programmes. Following an assessment of the patient and if appropriate, the GP refers the patient to a local group. For more on this, see the case studies on pages 74 and 75.

A number of PCTs are working with commercial slimming organisations to produce weight management on referral schemes.

NICE guidance on weight management on referral schemes[20]

NICE suggests that primary care organisations and local authorities should recommend to patients, or consider endorsing, self-help, commercial and community weight management programmes only if they follow best practice by:

- helping people assess their weight and decide on a realistic healthy target weight (people should usually aim to lose 5-10% of their original weight)
- aiming for a maximum weekly weight loss of 0.5-1kg
- focusing on long-term lifestyle changes rather than a short-term, quick-fix approach
- being multicomponent, addressing both diet and activity, and offering a variety of approaches using a balanced, healthy-eating approach
- recommending regular physical activity (particularly activities that can be part of daily life, such as brisk walking and gardening) and offering practical, safe advice about being more active
- including some behaviour-change techniques, such as keeping a diary and advice on how to cope with 'lapses' and 'high-risk' situations
- recommending and/or providing ongoing support.

Tool 19 provides information on setting up a 'weight management on referral' scheme with a commercial slimming company.

CASE STUDY

Slimming on referral – Southern Derbyshire Health Authority

A slimming on referral programme was set up in to investigate the feasibility of referring patients to a local commercial slimming organisation. 107 obese patients from two GP practices were offered vouchers covering free membership and 12 weeks' attendance at a local group. After the free period, participants were able to continue attending but had to pay their own weekly fees. Follow-up arrangements were made in the primary care setting at both three and six months. An important element of the slimming on referral scheme was that referred patients were not made to feel any different to paying members. The approach is designed to empower members to have the skills and confidence to make healthy lifestyle changes over a sustained period of time. Of the 91 patients who enrolled, 62 completed the 12 weeks and 47 participants continued to pay weekly fees. Of the 62 patients who completed 12 weeks, mean weight loss was 5.4kg (6.4% weight loss).[38] In those who continued after 12 weeks by self-funding their attendance, mean weight loss was 11.1kg (11.3% weight loss) at 24 weeks. Significant improvements were also observed in mental well-being at 12 and 24 weeks.

For more information contact: Amanda Avery. Phone 01773 546084

CASE STUDY

Healthy eating service: Weight Wise programme – Rushcliffe PCT

A Weight Wise programme of education and information has been developed following a pilot. The Weight Wise group in Cotgrave sees patients who have been referred by their GP and who have additional problems associated with being overweight, such as high blood pressure or diabetes. Each person is set the target to lose 10% of their weight and once this is achieved and celebrated, the next target is set. Priority is given to those who are obese and cannot afford to join a commercially-run weight reduction group. At weekly appointments, patients are weighed and measured and have their blood pressure checked. They then have the opportunity to discuss progress and ask questions. Different topics are discussed each week such as eating low-fat foods, cutting down on sugar, eating smaller portions, eating more fruit and vegetables and becoming more active.

For more information contact: Julie Rippon, Head of Communications, Rushcliffe PCT.

Phone: 0115 878 3013 or 0115 956 0300

CASE STUDY

The MEND Programme – for overweight and obese children and their families

The MEND Programme is a community, family-based programme for overweight and obese children aged 7-13 and their families. The multi-component programme puts equal emphasis on Mind, Exercise and Nutrition … and Do it! It combines all the elements known to be vital in treating and preventing overweight and obesity in children, including family involvement, practical education in nutrition, increasing physical activity, and behavioural change. As such, it is in line with all the key recommendations stipulated in the NICE guidance for management of overweight and obesity in children.[20] MEND does not advocate dieting for children, but instead aims to educate and empower families by providing them with the tools or foundation for healthy living for life.

The core MEND Programme consists of 18 two-hour sessions over nine weeks. Each session includes an hour of discussion – alternating between 'mind' (behaviour change) and nutrition topics – and an hour of fun exercise. The discussion sessions emphasise practical, hands-on learning using specially designed games, visual demonstrations and activities, including a supermarket tour and a recipe-tasting session. At least one parent or carer must accompany each child at every session.

The Programme has been designed so that it can be delivered and taught by a broad range of frontline staff, and not just health care professionals. A comprehensive trainer's manual with detailed lesson plans enables non-health-professionals (with appropriate 'on call' support from specialists, if needed) to be fully equipped to lead the Programme. MEND also provides a full 'kit' containing all the teaching aids (posters, games, demonstration aids, and stationery) needed to run the programme, as well as more than 100 pages of colour handouts for the participants to keep.

The feasibility study for the MEND Programme showed statistically significant improvements in key outcome measures such as BMI, waist circumference, fitness and self-esteem.[39] The programme is currently being researched in the form of a large, multi-site randomised control trial under the auspices of the Institute of Child Health at Great Ormond Street Children's Hospital, London.

MEND will be rolling out more than 300 Programmes across the country from 2007.

For more information visit www.mendprogramme.org. Phone: 0870 609 1405. Email: info@mendprogramme.org

Roles of health professionals

The roles of health professionals are extremely important for ensuring that interventions can be developed and actioned effectively. Mulvihill and Quigley[40] found that there is evidence to support improving the role of health professionals in the management of overweight and obesity, in particular by:

- reminding GPs to recommend healthy eating plans
- a brief educational training intervention on obesity management delivered to GPs by behavioural psychologists
- encouraging shared care between GPs and a hospital service
- use of inpatient obesity treatment services, and
- training for both health professionals and leaders of self-help weight loss clinics.

Furthermore, NICE has identified that health professionals play an important and highly cost-effective role in providing brief advice on physical activity in primary care. They recommend that primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on five days of the week (or more).[36]

Health professionals in a range of settings have an important role in providing advice to overweight and obese patients. Examples may include: dentists who provide support relating to oral health; health trainers who work within communities promoting healthy lifestyles; and pharmacists who come into contact with patients who may not seek advice from their GP. The Royal Pharmaceutical Society of Great Britain[41] has produced guidance for community pharmacists who provide advice on overweight and obesity. See www.rpsgb.org.uk/pdfs/obesityguid.pdf

In addition, the government has recognised the importance of developing the advice-giving role of health professionals, in order to improve local services to patients. Research undertaken for the *Choosing health* consultation found that some healthcare professionals, including GPs, were uncomfortable about raising the issue of weight with patients. They lacked confidence when it came to giving patients advice and also they were unaware of what weight loss services were available. Improving the training of front-line primary care staff – in terms of nutrition, physical activity and helping patients to change lifestyles – is an important requirement.

Dietitians in Obesity Management UK (DOM UK)[42] have produced a directory providing details of a range of training. The directory specifically targets obesity management and provides contact details of trainers. The directory will continue to expand and broaden its focus over time and as more information and training courses become available. The intention at this stage is to provide a selection of examples of training courses.

CASE STUDY

Local Health Link Workers – Coventry Training Primary Care Trust

Local Health Link Workers are being employed to act as a bridge between services provided and local communities, to act as key message-bearers within the community, and to provide signposting for local people enabling them to access services appropriate to their needs. These workers, who are employed from the local community, have the potential to reduce the workload of GPs and primary care workers, and support access to services. One of the services they provide is to offer up-to-date information and consistent messages on lifestyle issues – including healthy eating and physical activity – signposting residents to services where appropriate, or simply reinforcing sensible messages.

For more information contact: Rebecca Blyth, Partnership Recruitment Lead.

Phone: 02476 246114. Email: rebecca.blyth@coventrypct.nhs.uk

The following tools can also help with choosing interventions:
Tool 13 *Evidence of effectiveness*
Tool 14 *Evidence of cost-effectiveness*
Tool 15 *Preventing overweight and obesity – NICE recommendations*
Tool 16 *Preventing overweight and obesity – Interventions guide*

Tool 20 provides a proforma for developing a local action plan for the prevention and management of overweight and obesity.

For more information

CLINICAL GUIDANCE: UK

Children and young people

Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk/guidance/CG43

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

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/pdf/sign69.pdf

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: nationalobesityforumorguk.pre-dns-change.com/images/stories/W_M_guidelines/Children_and_adolescents.pdf

Adults

Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk/guidance/CG43

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

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 and The Stroke Association (2005).
Heart; 91; Suppl V: v1-v52.
Available from: heart.bmj.com/cgi/content/extract/91/suppl_5/v1

National Obesity Forum obesity care pathway and toolkit
National Obesity Forum (2005).
London: National Obesity Forum.
Available from: nationalobesityforum.org.uk/content/blogcategory/18/170/

National Obesity Forum guidelines on management of adult obesity and overweight in primary care
National Obesity Forum (2004).
London: National Obesity Forum.
Available from: nationalobesityforumorguk.pre-dns-change.com/content/blogcategory/31/125/

Practice guidance: Obesity
Royal Pharmaceutical Society of Great Britain (2005).
London: RPSGB.
Available from: www.rpsgb.org.uk/pdfs/obesityguid.pdf

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

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/pdf/sign8.pdf

CLINICAL GUIDANCE: INTERNATIONAL

Australia

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/internet/wcms/publishing.nsf/Content/obesityguidelines-guidelines-adults.htm

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/internet/wcms/publishing.nsf/Content/obesityguidelines-guidelines-children.htm

United States

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/guidelines/obesity/prctgd_c.pdf

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/guidelines/obesity/ob_gdlns.pdf

NICE OBESITY 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/guidance/CG43

INTERVENTION GUIDANCE

Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children
National Institute for Health and Clinical Excellence (NICE) (2006). London: NICE.
Available from: www.nice.org.uk/guidance/CG43

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.publichealth.nice.org.uk/page.aspx?o=PHI002

Obesity training resources

Directory: Obesity training courses for primary care
Dietitians in Obesity Management UK (2005). London: DOM (UK).
Available from: www.domuk.org/obesity_training.php

National Obesity Forum training resource for health professionals
National Obesity Forum. London: National Obesity Forum.
Available from: nationalobesityforum.org.uk/content/blogcategory/62/133/

GP CONTRACT

Standard General Medical Services contract (2006)
Available from: www.dh.gov.uk/assetRoot/04/13/72/68/04137268.pdf

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/primary/index.cfm

GENERAL

Diabetes Commissioning Toolkit
Department of Health (2006).
London: Department of Health.
Available from: www.dh.gov.uk/assetRoot/04/14/02/85/04140285.pdf

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/publications/nao_reports/05-06/0506801.pdf

Weight management in primary care: How can it be made more effective?
A Maryon-Davis (2005).
Proceedings of the Nutrition Society; 64: 97-103.
www.ingentaconnect.com/content/cabi/pns/2005/00000064/00000001/art00013

Understanding barriers and facilitating change

The main barriers to eating a healthier diet and being more physically active have been extensively considered in the public health white paper, *Choosing health: Making healthy choices easier.*[1] They include psychological, social, cultural, environmental and economic barriers. Overcoming such barriers is clearly key to success.

Social marketing

Social marketing is about gaining an understanding of people and their 'relationships' with an issue and using that understanding to help design something you want them to interact with – such as a service, intervention or piece of communication. The objective is to support them in changing their behaviours to deliver improved health outcomes.

We all recognise that, in our daily lives, people are not all the same. People's attitudes, behaviours, peers, cultural heritage, incomes, education and knowledge, and other influences, determine the way they interact with other people and the world around them. These factors determine both what influences people, and the sources from which they will either seek or accept this influence. Social marketing is about developing this understanding and translating that knowledge into the design of initiatives in order to support people in changing their behaviours to deliver improved health outcomes. For more information on social marketing go to the National Social Marketing Centre's website on www.nsms.org.uk.

In relation to the national obesity programme, the social marketing team at the Department of Health has developed an understanding of the relationships of the target audience – families with children under 11 – with food and physical activity habits. This work has identified six groups of families, which appear to have markedly different attitudes and claimed behaviours. The groups vary in how susceptible they are to factors such as lack of access to inexpensive, energy-dense foods or to an environment which promotes sedentary behaviour and, as a result, some groups are more at risk of unhealthy weight gain than others. This work has also provided an understanding of the behaviours that need to be influenced for each of these groups and the barriers that stand in the way of people achieving positive change. This understanding underpins the overall obesity programme and should be reflected in the development of any local strategies aimed at preventing obesity.

The national obesity social marketing team can support local developments by working with colleagues to 'map' local populations and thereby identify the priority groups and behaviours that any initiatives should focus on. The national team will also be developing Health Improvement Partnerships with external organisations such as retail outlets. There will be significant opportunities to use these initiatives as a platform on which to build local activities. For more information, go to www.dh.gov.uk/obesity.

Public and patient involvement

One mechanism for helping to overcome barriers is through the involvement of the public and patients in the planning of healthy lifestyle programmes. For example, in England local residents are represented on Local Strategic Partnerships in three important ways: through direct representation on community councils; through elected members (councillors); and through the voluntary sector. There are also statutory requirements for effective patient and public involvement (PPI) throughout the NHS in all parts of the UK.

See **Tool 21** *Ways of involving patients and the public in tackling overweight and obesity.*

Communicating effectively

Information given to individuals by a variety of health professionals must be consistent. Delivering good information is also a matter of repeating it as often as the person needs to have it reaffirmed, timing it to be useful at the right moment, and allowing the person the opportunity to scrutinise and ask questions about any information given.

The Expert Patients Programme

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 tackling overweight and obesity, patients with diabetes or heart disease can learn how to start and maintain an appropriate exercise or physical activity programme. Set up in 2002, the Expert Patients Programme is based on research from the US and UK over the last two decades which shows that people living with long-term conditions are often in the best position to know what they need to manage their own condition. Provided with the necessary 'self-management' skills, people with long-term conditions can make a tangible impact on their own condition and on their quality of life more generally. EPP courses are being run by primary care trusts throughout England.

For more information

Children and healthy eating: A systematic review of barriers and facilitators
J Thomas, K Sutcliffe, A Harden, A Oakley, *et al* (2003).
London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
Available from: eppi.ioe.ac.uk/EPPIWebContent/hp/reports/healthy_eating02/Final_Report_web.pdf

Children and physical activity: A systematic review of barriers and facilitators
G Brunton, A Harden, R Rees, J Kavanagh, *et al* (2003).
London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
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Expert Patients Programme
For details see: www.expertpatients.nhs.uk

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Infrastructure support

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

- involve the public, patients and carers
- build capacity in terms of staff, equipment and facilities
- set up appropriate education and training programmes
- ensure effective IT systems in primary care
- ensure good communications, and
- provide sufficient funding for all elements of the strategy.

See **Tool 21** *Ways of involving patients and the public in tackling overweight and obesity.*

Monitoring and evaluation

Evaluation of strategies and programmes for overweight and obesity is essential for:

- clinical governance
- audit and quality improvement
- providing information to the public
- strategy and performance development
- assessing value for money
- assessing sustainability, and
- increasing the evidence base.

There are two basic rules for successful evaluation:

- The evaluation process must be thought through from the start, at the same time as you develop the strategy's aims, objectives and targets.
- Adequate funding must be set aside for the evaluation. A good guide is 10% of the total budget.

Evaluation of community projects is not easy and not everything can be evaluated. The rationale for evaluation can include:

- to inform the day-to-day running of the project, to try to improve interventions and possibly to develop new ones
- to demonstrate worth and value for money to the funder, in order to support requests for continued or additional funding
- to define and examine successes and failures with all stakeholders, and to know how and why something works, as well as attempting to understand why it may not
- to assess behavioural change and environmental improvements
- to develop models of good practice that are then disseminated to others
- to contribute to the debate on obesity, and
- to assist with performance improvement.

The key areas to evaluate must be agreed among the partners, including the participants, to reflect their different agendas. Evaluation will include:

- measuring indicators of progress, including progress towards any targets
- assessing how well various aspects of the strategy were perceived to work from the viewpoint of professionals from all sectors and by communities, and
- assessing whether the changes were a result of the intervention.

It is essential to include in the overweight and obesity action team someone with expertise in the evaluation of community projects. This could be someone from the health or environment departments of a local university or further education college, a local dietitian, or someone from the nutrition department of a hospital or the community.

Tool 22 gives details of the HEBS *Research and evaluation toolbox,* produced by the Health Education Board for Scotland.

Audit criteria for NICE guideline on obesity

NICE has developed audit criteria for the clinical guideline on obesity. The aim of the audit is to help health services and local authorities to determine whether they are implementing the guidance. The implementation of the audit will help organisations meet developmental standard D13 of *Standards for better health* set by the Department of Health. Standard C5(d) states that "*Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.*" [20] To download the NICE audit criteria, go to www.nice.org.uk/guidance/CG43.

For more information

Obesity: Audit criteria
National Institute for Health and Clinical Excellence (NICE) (2006).
London: NICE.
Available from: www.nice.org.uk/guidance/CG43

Evaluation resources for community food projects
P McGlone, J Dallison and M Caraher (2005).
London: Health Development Agency.
Available from: www.nice.org.uk/download.aspx?o=503365

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

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

Mainstreaming and sustainability

A perennial problem facing local healthcare planners and providers is ensuring that effective practice is sustainable and 'mainstreamed' in terms of continued funding. Many innovative approaches are piloted using short-term funding streams and then, despite favourable evaluation, it is difficult to build them into budget baselines due to intense competition for mainstream funding. This is particularly true of preventive lifestyle initiatives which often have less measurable, less attributable, and shorter-term outcomes than interventions to manage overweight and obesity. However, a clear national focus on tackling overweight and obesity will strengthen the delivery of increased life expectancy, the prevention of avoidable illness, a reduction in health inequalities and an improvement in accessing healthcare services.

The challenge is to develop an overweight and obesity action plan.

Tool 20 provides a proforma for developing a local action plan for the prevention and management of overweight and obesity.

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