Gloucestershire Health and Community Well-being Partnership

A Strategy for Tackling Overweight and Obesity in Gloucestershire

2007 – 2017

A health promoting environment for obesity prevention

Effective and sustainable weight management

Health Improvement at any shape or size

Acknowledgements

This strategy has been led by a small project team, following a strategy development day held in November 2005. Thanks to all those local partners from the wider health community including local government, voluntary sector and education who contributed, on the day, and through the consultation process. Special thanks to the co-authors Frances Clark-Stone and Sue Weaver as well as Shona Arora, Sue Wild, Janet Passey, Sarah Scott and Toni Smith who were all part of the project team. Thanks also to Jill Salvin who co-ordinated the development of the action plans with partner organisations.

This strategy outlines a vision that is shared by the healthcare providers, local authorities, education services, Food Vision and representatives of the voluntary and community sector. Turning this vision into a reality is the joint responsibility of all participating organisations and partners.

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Executive Summary

In the United Kingdom, obesity has increased in adults and children over the last 20 years, leading to widespread concern over costs to human health and well being, and financial costs to the health service and wider economy. Obesity is currently high on the national agenda and is backed by an obesity reduction target.

The rising levels of obesity have multiple, often complex, causes. These can be considered on an individual, social and environmental level and include poor eating habits, a lack of physical activity and psycho-social factors (e.g. poverty, stress, lack of appropriate information, low self-esteem and cultural forces).

Treating and preventing obesity is also highly complex and can be controversial. Although there is some evidence on which to base interventions, and some consistent themes are emerging, the "best practice" model for delivery options needs further research. However, it is clear that a strategy for tackling obesity needs to be delivered in partnership as part of an overall plan to improve the health of our local population (both physically and mentally) and create thriving, socially inclusive communities. In order to be successfully implemented, this strategy needs to be firmly embedded in other related strategies e.g. those that impact on rural and urban planning, transport, food, physical activity, mental well-being and education.

This strategy covers 10 years to align with the countywide and local authority Sustainable Community Strategies (SCS). However, the 3 year action plan aligns with the Local Area Agreement (LAA) and allows for adaptation as progress is made over the 10 year timescale.

Obesity in Gloucestershire needs to be tackled throughout the whole population, supporting all age groups, communities most in need, informing families and the workforce, creating healthy environments and lobbying where we cannot tackle issues locally. The strategy is therefore backed by an action plan which is split into Prevention, Treatment, Support and Advice, Workforce Development and Advocacy, which reflects the broad scope required.

In Gloucestershire, this strategy is being led by the Gloucestershire Health and Community Well-being Partnership (GHCWP) and can only be successfully implemented through the combined efforts of multi-agency partners and individuals. In particular, given the need to address rising levels of obesity, engagement with the Children and Young People's Strategic Partnership (CYPSP) is also critical.

Next Steps
Finalise multi-agency action plan and start implementation

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Section 1 – Introduction

What is obesity?

The terms overweight and obesity, quite simply refer to an excess accumulation of body fat. They are traditionally categorised by body mass index (BMI), a measure relating weight and height whereby the higher BMI, the more the excess weight and the greater the associated health risks (exceptions include people who are very muscular, athletes, pregnant or nursing women).

BMI - Adults

'Overweight'	BMI ≥ 25kg/m^2
'Obese'	BMI ≥ 30kg/m^2.
'Morbidly Obese'	BMI ≥ 40 kg/m^2.

BMI - Children

Presently there is a lack of consensus on the classification of BMI in children. This strategy will refer to the UK National BMI percentile classification. This is in alignment with current Department of Health documentation and guidelines, allowing us to relate Gloucestershire to the national context.

'Overweight'	BMI ≥ 85th centile
'Obese'	BMI ≥ 95th centile

(Jotangia et al 2006, Crowther et al 2007)

How did we get here?

People have always come in a variety of shapes and sizes. However during the last 20 years there has been a sharp rise in the numbers of people in whom excess weight has become a health concern. On one level it is a simple matter of an imbalance between energy intake and output. However, rising obesity rates have shown us that for many people this is not as simple as it might seem. The environment that we live in has become "obesogenic", whereby the plentiful supply of energy dense, tasty food coupled with energy-saving lifestyle practices and devices means that it has become "normal" to gain excess weight.

Genetic, cultural, social and lifestyle factors all play a part in who becomes obese and who does not.

- The extra amount of physical activity required for daily living 50 years ago compared to today, is thought to be the equivalent of running a marathon a week
- Since 1950 confectionary consumption has increased 25 fold, whilst soft drink consumption has increased 30 fold.
- Eating out and take away food is thought to have increased energy intake by 20%

There are a number of factors that seem to contribute towards the development of obesity in individuals:

- In the United Kingdom, obesity is linked with poverty, particularly among women. On an individual level, having a lower income makes it harder to make healthy choices. For example, poorer households are less likely to have access to healthy and affordable food or suitable and safe places to play and be physically active. There is also increasing evidence that obesity is a socially determined condition, with obesity figures highest in the least equitable societies. One reason for this may be the psycho-social stress of being at the bottom of the hierarchy, in which the varied attributes needed to make major behavioural changes are lacking – e.g. a sense of control, a sense of the future, self-esteem, self efficacy (Pickett 2005)
- Obesity is significantly more common in certain ethnic groups, particularly in South Asian and Afro-Caribbean people. In 1999, obesity levels among Black-Caribbean women, and Pakistani women, were 50% and 25% higher than the national average respectively (Health Survey for England 1999)
- Particular circumstances and life events can predispose people to excess weight gain. These include: quitting smoking; during and after pregnancy and during the menopause (NICE 2006).
- Weight gain can be a side effect of a medical problem or treatment; e.g. insulin, antipsychotics and steroids. In children a number of relatively rare syndromes are associated with obesity, often in association with short stature
- Other groups of people known to be at increased risk of becoming obese are:
  - People with physical or learning disabilities
  - Children with at least one obese parent

In summary:

"The causes of obesity are diverse and complex, and, in the main underpinned by what are now entrenched societal norms. They are problems for which no one simple solution exists… (solutions must be) long term and sustainable, recognising that behaviour change is complex, difficult and takes time. An integrated and wide-ranging programme of solutions must be adopted as a matter of urgency, measures which do not promise overnight results, but which constitute a consistent, effective and defined strategy".

House of Commons Health Committee (Obesity, 2004)

Why we need to act

The impact of overweight and obesity

This section describes some of the consequences and costs of obesity, for individuals and society, which give us good reason to act. Management of obesity has become a national priority, resulting in a shared Public Service Agreement target which is explained at the end of this section.

In the United Kingdom the prevalence of overweight and obesity amongst adults and children of all ages is increasing. In fact, England has one of the highest rates of acceleration of obesity in the world. Currently, well over half of all adults in the UK are overweight, and more than one in five are obese. There is a similar increase in children, with estimated prevalence of obesity at 13.7%. If current trends continue, one quarter of the British population will be obese by 2010, and around a third by 2020.

Overweight and obesity, and their associated health consequences, result in a high financial burden for Government, the NHS and society as a whole. The Health Select Committee has estimated the cost of obesity as £3.3-3.7 billion per year. The estimates for obesity plus overweight are £6.6 -7.4 billion. The National Audit Office figures show that 1 million fewer obese people in this country could lead to approximately 15,000 fewer people with Coronary Heart Disease, 34,000 fewer people developing Type 2

diabetes and 99,000 fewer people with high blood pressure (Department of Health 2006). On an individual level, obesity can seriously limit health, well-being and quality of life.

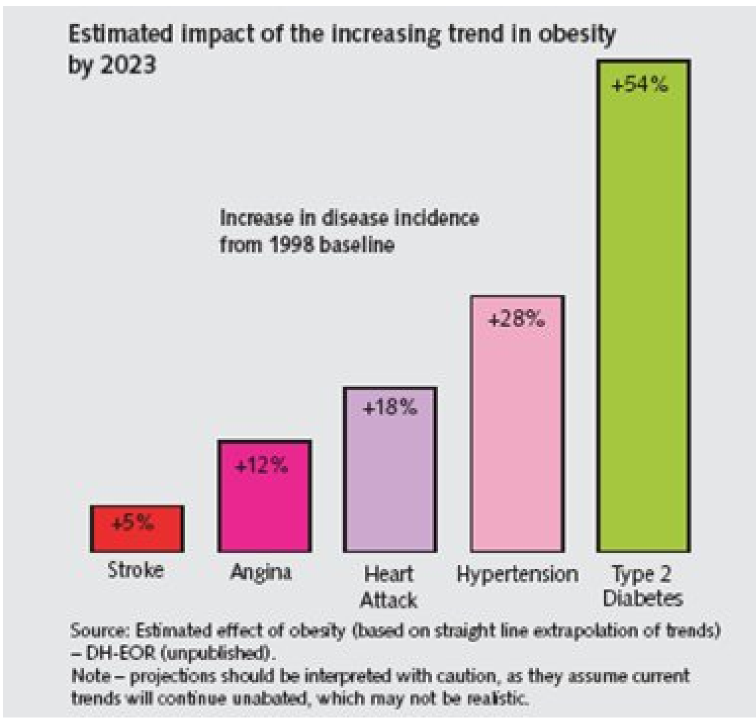
Body weight and mortality

It is estimated that obesity (BMI >30) reduces life expectancy by between 3 and 13 years. Furthermore, within the obese category, the risk of mortality increases sharply as bodyweight rises. The risk also increases the earlier a person becomes obese. These health risks are directly attributable to being obese, although deprivation could be a confounding variable. Overweight (BMI 25-<30) is a risk factor for obesity and morbidity (associated health problems) though not a direct risk for mortality. (Flegal et al 2005).

Body weight and morbidity

In public health terms, the greatest burden of obesity arises from related morbidity. Its physical effects include metabolic syndrome (i.e. insulin resistance, hyperlipidaemia and hypertension), mechanical disorders (including osteoarthritis, respiratory problems, joint and back pain and sleep apnoea) and various cancers (including bowel, breast and endometrium). In addition to its physical effects, obesity has serious psychosocial consequences and can be the cause of much mental distress.

Perhaps the most common obesity-related morbidity, and undoubtedly one of the greatest health burdens, is the link with type 2 diabetes. With increasing weight, the risk of developing type 2 diabetes increases exponentially, particularly in women. Risk increases steadily through the overweight (BMI 25-30) range, and more quickly above BMI 30 until, for women, a BMI of 35 is associated with a 40-fold increase in risk (Colditz 1995)



Source: Estimated effect of obesity (based on straight line extrapolation of trends) – DH-EOR (unpublished).
Note – projections should be interpreted with caution, as they assume current trends will continue unabated, which may not be realistic.

In children the risks to physical health are similar, but they only tend to start appearing around the 95th centile. While officially classified as being 'overweight', children who are between 85th and 95th centile are generally not at risk of health problems. And while a proportion of children over the 95th centile will have health problems, the majority though they are classified as 'obese' are simply at the top end of the normal distribution,

growing normally and not 'sick'. To give this point some perspective, around 4% children over the 95th centile have type-2 diabetes, but 96% do not (O'Dea 2005).

However, a consequence of childhood obesity is its persistence into adulthood. Overweight young people have a 50% chance of becoming overweight adults, and obese 10-14 year olds with at least one obese parent have a 79% chance of becoming obese adults. A longitudinal study in Bristol (Reilly et al 2005) has identified eight risk factors for childhood obesity which included parental obesity amongst time spent watching TV, birth weight and weight gain in infancy. As described previously, the earlier the onset of obesity the higher the risks to health during adulthood (Whitaker, 1997).

Psycho-social issues

Obese adults are no more likely to have mental health problems than non-obese people, though self-esteem can be affected by stigma within a society that favours slimness. (Devlin et al 2000).

Research with clinical sample groups of obese children suggests that the main psychosocial problems associated with obesity are depression, reduced quality of life, low self-esteem and reduced social acceptance. (Strauss 2000, Stunkard et al 2003, Schwimmer et al 2003, Williams et al 2005, Strauss & Pollack 2003, Baker, Gately & Hill 2006). Note that this is association not causation e.g. low self-esteem might lead to obesity or vice versa.

Stigma

Many of the emotional and social consequences of obesity are likely to be due to the impact of stigma. As in children, the negative stigma associated with overweight and obesity may contribute to low self-esteem and depression in adults.

A well-known 1960's study (Richardson et al 1961) showed that 10 and 11 year old boys and girls, ranked obese children lowest out of a variety of physical disabilities, in terms of who they liked. This study was repeated by Latner and Stunkard (2003) to see if time and a greater cultural emphasis on diversity had reduced the bias against obese children. Results showed that the bias was stronger in 2001 than in 1961, and that the polarity between the liking for the "healthy" child and the obese child was even greater.

In 2002 a survey of health professionals specialising in obesity found that they exhibited a significant pro-thin, anti-fat bias. They also significantly endorsed the stereotype of lazy, stupid and worthless (Shwartz et al 2002).

Iatrogenic or harmful consequences of weight loss attempts

In a society that values and promotes slimness and dieting methods of weight loss, many people, particularly women, engage in regular dieting. Individual attempts at weight loss can have an iatrogenic effect – that is, an unintended consequence that is harmful and often opposite to that intended. Repeatedly losing weight, followed by weight gain, results in a greater weight gain over time. Failing again and again results in decreased self-efficacy (confidence in one's ability to achieve a specific aim/goal), which in itself predicts poor outcomes for future weight loss attempts
One large study of adolescent girls showed that restraining behaviour aimed at weight loss (e.g. dieting, exercise, laxative and diuretic use) *predicted* future weight gain, irrespective of their starting weight. (S*tice et al 1999)* This is an important consideration in approaching the issue of prevention with overweight young women, as attempts at weight loss may be counter-productive.

Studies also show that dieters (people restricting food intake) are 8 times more likely to develop an eating disorder than non-dieters *(Patton et al 1999)*.

National obesity targets

The Wanless Report (2004), House of Commons Select Committee for Health (2004) and public health white paper 'Choosing Health' (2004) all highlight obesity as a key threat to the nation's future health. Healthcare trusts, in partnership with other agencies, are required to undertake specific action to tackle overweight and obesity.

The Public Service Agreement (PSA) target states that in tackling the nation's health and health inequalities, PCTs should, from April 2005, "halt the year on year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole' (Department of Health 2005).

This target is shared by the Department of Health (DoH), the Department for Education and Skills (DfES) and the Department of Culture, Media and Sport (DCMS). Therefore, at a local level, delivery requires collaboration between health, education and local authorities. In February 2006 a report on delivery was published by the National Audit Office "Tackling Child Obesity – First Steps" , following regional consultations with those likely to be involved. The recommendations of this strategy are adapted from the recommendations of the Tackling Child Obesity report.

In 2006 the National Institute for Health Clinical Excellence (NICE) produced guidance on overweight and obesity prevention and treatment for both adults and children. This guidance was aimed at the NHS, Local Authorities and partners and has also been taken into consideration during the development of this strategy.

Section 2 – Where we are now?

Local figures

Recent guidelines from the Department of Health require Primary Care Trusts to begin routinely collecting height and weight measurements from all school children at school entry and in Year 6, and, as of this year (2007) this is happening in Gloucestershire. These figures are converted into BMI by Primary Care Trusts for the purpose of monitoring population data.

The following tables show the estimated prevalence of overweight and obesity in Gloucestershire. These figures are extrapolated from the Health Survey for England (2003) and Exeter population data (2004) and should be treated as a guide in the absence of truly reliable local data. It is anticipated that local data will be available by December 2007. This local data will inform targeted action.

General population figures for children aged 2-15 in Gloucestershire are: boys 51,308 and girls 48, 475. The reason the given figures are restricted to this age group is so that the relevant overweight and obesity prevalence rates, based on 2-15 year olds, can be used, as given in the Health Survey for England (2003).

Table 1: Estimated prevalence data for overweight and obese children and young people within Gloucestershire

Population October 2004	**Overweight (>85th centile) Including obese**		**Obese (>95th centile)**	
	%	Approximate number of people (rounded to nearest 50)	%	Approximate number of people (rounded to nearest 50)
Boys aged 2-15	21.8	11,200	5.5	2,800
Girls aged 2-15	27.5	13,300	7.2	3,500

Table 2: Estimated prevalence data for overweight and obese adults within Gloucestershire

Population October 2004	**Overweight (BMI >25) Including obese**		**Obese (BMI >30)**	
	%	Approximate number of people (rounded to nearest 50)	%	Approximate number of people (rounded to nearest 50)
Men 18+ n. 228,650	70	160,100	22	50,300
Women 18+ n.239,250	63	146, 500	23	55,000

National trends show that obese and morbidly obese people are more likely to be female, living in rented, council or Housing Authority property; and in areas of high deprivation and to be from manual working groups.
Gloucestershire Health and Lifestyle Survey (2000) recorded that the highest prevalence of overweight and obesity across the county was in Gloucester City and the Forest of Dean (data was represented by Primary Care Group).

Local activities and services

Prevention

We know anecdotally that, within the county, there is currently much activity that could fall under the umbrella of "obesity prevention". However at present this is patchy and uncoordinated, and many of the people who could benefit may be unaware of what is available. Although health improvement work is already targeted towards areas of high need, it is often the case that opportunities for healthy eating, physical activity etc are not taken up by those most in need for a variety of reasons, including finances, perceptions and psychological issues.

In November 2005 local partners from health, education, local authority and the voluntary sector attended a workshop focusing on childhood obesity in Gloucestershire, which included a mapping session (feedback from this event later in this section). Further mapping is needed as part of the action plans.

Below is a small sample of examples of good practice in Gloucestershire, which contribute to the obesity prevention agenda.

- Through the Healthy Schools Programme, many schools have developed policies on food, physical activity, and emotional well-being. Over 100 schools are taking part in a three year programme called "Health 4 Schools", which focuses on active play, cooking and growing food. There is also a Food in Schools project which brings together local partners to focus on how to improve school food in Gloucestershire.
- Partnership Approach to managing weight. Gloucestershire PCT is working in partnership with Cotswold District Council to deliver community based weight management groups to local residents. Three groups are currently being piloted.
- Tredworth 'Be Good to Yourself' Project: Tredworth Early Years Centre is based within a deprived area of Gloucester. Many of the mums who visited the centre expressed an interest in learning more about cooking and healthy eating. The 'Be Good to Yourself' programme was developed and delivered by the Early Years Centre Manager and the Manager of the Living and learning Centre at GL1, a joint funded post between the Gloucestershire PCT, Gloucester City Council and the University of Gloucestershire. The aim of this project was to offer young mums attending a local day centre the opportunity to engage in a health project. The programme covered nutrition, cookery, stress and relaxation, physical activity and alternative therapies. The 12 week course was attended by 15 women, some of whom have since gone on to become regular members of GL1.

Current weight management services in Gloucestershire

Gloucestershire has a small weight management team that operates at a strategic level, and has provided training and support to those already working to help obese patients or clients manage their weight e.g. health care professionals and leisure and community workers.
Evaluation of this work has shown that:

- More comprehensive, skills-based training is needed
- More guidance needed regarding planning and structuring weight management interventions, for individuals and groups
- On-going support and training is essential

Work is underway to develop a self-help guide for treatment of obesity in adults in primary care and community settings

Children and young people

Clinical treatment services for obese children and young people in Gloucestershire are currently lacking.

There is currently no agreed care pathway of treatment services for obese children. Some health visitors, practice nurses and school nurses are involved in delivering front-line advice and support to obese children. Those with more complex needs, or who are severely obese are referred to a paediatrician and then on to a paediatric dietician. Dietetic provision is very limited. Children are seen on an individual basis only. Contact time and frequency of appointments are below what would be recommended as best practice and the service has not been evaluated. Children in whom obesity is the cause or a consequence of a mental health problem may be seen by the Child and Adolescent Mental Health Service (CAMHS).

A countywide multidisciplinary group has developed a preliminary draft pathway and clinical guidelines for local practitioners. This now needs to be finalised and signed off at senior levels in line with NICE guidance.

Adults

In Gloucestershire, weight management services for adults are similarly patchy and underdeveloped, though some progress has been made in developing the primary care workforce to deliver first line treatments more effectively. An integrated care pathway for adults has been drafted by a countywide multidisciplinary group. This needs to be finalised and signed-off and dedicated resources identified for service delivery.

First line treatment options for overweight and obese patients currently include:
- Practice nurse support in primary care
- Commercial slimming organisations
- Self-help

Weight management treatment services are currently aimed at those who are already obese, who wish to access treatment. The cut-off point for entry into such services is dependent on BMI and co-morbidity.
Obese patients living in some areas can be referred from primary care to a local authority led ‘exercise on referral’ scheme, though this service is not available across the county, and evidence of its effectiveness and impact on equity, from programmes elsewhere, is equivocal.

Each of the major commercial ‘slimming’ organisations (Rosemary Conley, Slimming World and Weight Watchers) has groups running at venues across the county. The National Institute of Health and Clinical Excellence (NICE) recommend that such organisations should only be recommended for adults and only if they are: based on a balanced healthy diet; encourage regular physical activity and expect people to lose no more than 0.5-1kg (1-2lb) a week. To date there is no partnership working between the public agencies and private slimming organisations, though this is an area that could be explored.

In addition there are a number of smaller private organisations offering ‘diet’ or ‘exercise’ based interventions including many that promote ‘fad’ dieting methods and/or special products for weight loss. NICE states that: “There is no strong evidence to support the use of meal replacement products over a standard low-calorie diet”
(NICE 2006)

Attempts have been made to set up community based weight management groups in partnership with voluntary organisations e.g. Gloucestershire Neighbourhood Projects Network. Again existing services are very limited. Issues relating to quality assurance, capacity and sustainability need to be addressed for these schemes can make a real contribution to tackling obesity at a local level.
Second line treatment services include:

- The prescription of anti-obesity medication (Orlistat, Sibutramine and Rimonabant) in line with NICE guidance
- Referral into dietetics for 1:1 dietary advice
- Referral option to the eating disorders service for those patients with a concurrent binge eating disorder

NB: Dietetics provision is limited by a lack of dedicated resources for weight management and clinic structures do not currently lend themselves to a behaviour change model. Appointment times are short and follow-ups widely spaced

Patients who request assessment for bariatric surgery are referred to dietetics or a local surgeon to assess their suitability for surgery and their compliance with NICE inclusion criteria. There is currently no in-county surgical service for NHS patients. Some patients who meet suitability criteria are referred out of county for treatment. Beyond this level of care there are no specialist treatment options for obese patients and no multidisciplinary input e.g. for those requiring psychology input.

The following tables show a rough mapping of the work that is contributing towards the prevention and treatment of obesity, and what we think the gaps are.

Prevention: What we've got	Treatment: What we've got
Healthy schools: Food in schools: Health 4 schools: school sports programme, PHSCE programmes	Preliminary draft care pathway for overweight and obese children
Get cooking programmes	Draft care pathway for obese adults
Health 4 schools project	Adults: Limited, basic practice nurse support in primary care for adults
Health improvement work in neighbourhood projects, Children's Centres, pre-school settings, local authorities	Paediatric referral to a dietician for obese children
Health inequalities partnership	Adults: Prescription of anti-obesity medication
Healthy hospitals	Adults: Referral into dietetics for 1:1 dietary advice
Active Gloucestershire Strategic Framework	Adults: out of county referral for bariatric surgery (for morbidly obese)
Strategic transport planning: green travel plans and road safety	Exercise on referral in some areas
Food vision	Slimming groups (commercial)
System of measuring children's BMI	1.5 WTE health improvement specialists for secondary prevention of obesity
0.7 WTE health improvement specialist for primary prevention of obesity	

Prevention: What we haven't got	Treatment: What we haven't got
Generic multi-disciplinary, holistic health improvement programmes for children and families	Children: Specialist evidence-based treatment
Consistent availability of healthier food in public places, e.g. Hospital snack bars, food provision in leisure centres	Adults: Dedicated resources within dietetics for weight management
Partnership working between clinicians, sport and leisure and local authorities with a focus on prevention	Adults: Support for people who have lost weight and wish to maintain lost weight
Countywide coverage of parenting support for families who wish to make changes to family diet and physical activity levels	Adults: Specialist weight management service for morbid obesity
Input to teacher training from trained weight management staff	Adults and children: operational care pathway, protocols and standards for weight management
	Access to NHS in-county surgical referral
	Inconsistency across the county regarding access to evidence-based weight management
	Outcome data on local weight management treatments

Local feedback

This strategy requires a partnership approach which reflects the complexity of the problem. Consultation with all the partners is essential. A workshop was carried out prior to the development of this strategy. A draft strategy and action plan was subsequently sent out to all partners for feedback. The summary of both of these consultation processes is outlined below.

Obesity Workshop

This workshop invited local partners to debate the issues surrounding childhood obesity. Those who attended gave these opinions:

- 77% think that parents need more support in helping their children to lead a healthy lifestyle
- 97% think that obesity is a symptom of a wider social condition
- 23% think that obesity is an individual problem caused by eating too much and exercising too little, and 65% disagreed with this view
- 90% think that it is important to tackle the social stigma of being overweight
- 100% disagreed that halting the rise in childhood obesity is a simple task

Draft strategy feedback

A draft strategy (an earlier version of the current document) and action plans were sent out to all local partners for their comments. Partners were asked which actions they felt they could deliver, or lead on. Comments were generally positive though agencies called for clearer links with other strategies and plans and clearly defined 'lead' agencies for each of the actions.
Several responses stated that the PCT should take a lead on this strategy, however this would reflect, neither the PSA responsibilities, nor the far reaching influences of the problem. In order to reflect these, the Gloucestershire Health and Community Well-being

Partnership (GHCWP) will be the lead body as discussed in section 4, and the engagement of the Children and Young People's Strategic Partnership (CYPSP) is also key to the strategies success.

In response to the consultation, this final document has addressed feedback in regards to:
a) the text - offering more clarity in some areas (particularly around the definitions of obesity) and;
b) the action plan – this was restructured to reflect themes rather than age groups to avoid repetition and some actions were amended to enable measurable outcomes.

Recommendations

Recommendations for informing and implementing this strategy are based on evidence and local consultation

- We need to use existing partnerships to build on what we already have and helping people to find ways of making better use of the resources in their own environment
- Local strategic leads within the target holding departments need to understand the relevance of obesity prevention to their own agendas
- Local roles and responsibilities need to be clarified using local planning structures
- There should be PCT board level and local authority champions for addressing obesity
- Locality-based partners should find out what is already happening in their own area, and what capacity, interest and training need there is in the local workforce
- Local parents and children should be consulted about their views on this issue, within existing consultation structures
- Local delivery agents need to target programmes at those most at risk of overweight and obesity
- The needs and sensitivities of obese children must be addressed in any efforts to encourage behaviour change with them and their families
- Training and resources are needed for frontline staff
- For commissioning purposes, it is recommended that:
    - A review of local dietetic services, and for evidence-based and patient-led services to be developed and evaluated around an integrated care pathway, to include specialist clinical services for severely obese children and adults
    - Continuing Professional Development (CPD) programmes for teaching and healthcare staff should include knowledge and understanding of effective weight management methods, the complexity of childhood obesity and local care pathways
    - Health and Social Care Overview and Scrutiny Committees (and other relevant groups, such as Children's services groups) should take obesity related issues into account on a regular basis

Section 3 – Where we want to get to

Strategic vision

The following sums up the shared vision needed to tackle obesity within Gloucestershire:

- Gloucestershire strives to have a health enabling environment where everyone has access to affordable healthy food and physical activity opportunities
- Everyone has the knowledge and skills to make healthy choices
- Appropriate treatments and support are available for those who are affected by obesity (adults and children)
- A whole population and multi-agency approach is taken to tackling overweight and obesity and any associated stigma
- Reduction in health inequalities by providing extra support to those most in need

Aim

To reduce overweight and obesity amongst adults and children within Gloucestershire through supporting lifestyles changes and creating a health enabling environment

Objectives

- To obtain a baseline for childhood obesity across the county by 2008

- Create health enabling environments e.g. through planning requirements (administered by council planning departments) and transport strategies by 2012

- Commissioning and implementation of preventive activities and intervention across the county through:
    - Increase participation in sport, physical activity and physical education amongst school aged children by 2010
    - Increasing provision of affordable physical activity opportunities especially within the 10% most deprived communities by 2016
    - Increase opportunities for deprived communities to acquire the skills required to source and eat a healthy diet by 2015

- To develop, agree and implement an integrated care pathway for the secondary prevention and treatment of obesity supported by appropriate interventions and services by 2010
    - Develop and deliver accredited weight management training
    - Accredited weight management practitioner in all GP practices, council owned leisure centres and other suitable venues (to be piloted and agreed)
    - Specialist weight management services for people with intractable or morbid obesity
    - Develop and implement an audit and outcomes framework for obesity treatment services

- Provide health and voluntary sector professionals with training to better support behaviour change and healthy lifestyles by 2010

- Develop and implement a multi-agency communication, resources and advocacy strategy

Guiding principles

- We recognise that obesity is a complex health condition with social, economic and genetic causes
- We will adopt a multi-agency and multi-sector approach. Partners will commit to the strategy at all levels (senior, strategic and operational) to ensure we work together to achieve the aim for the people of Gloucestershire
- Where possible, we will develop interventions based on evidence of effectiveness. Where this is not possible interventions need to be resourced to allow robust evaluation, thus contributing to the evidence base
- We will work from a position of "first do no harm" which is a founding principle of modern medicine and health promotion
- We will target resources towards those most in need
- We will be clear on what we can and can't achieve locally. Act where we can and lobby when there are issues beyond our direct control
- We recognise that weight is only one aspect of a person's health and well-being and that it is the right of the individual to set their own priorities
- We will adopt a person-centred approach, where the support is adapted to meet the needs of the individual as far as possible

Section 4 – How will we get there?

This is a 10 year strategy which not only reflects the scale of the task but is also aligned with local sustainable community strategies (SCS), which are also 10 year. However, in order to maintain focus and allow for adaptation/flexibility over that timescale this strategy initially has a 3 year plan. This mirrors the Local Area Agreement (LAA), with obesity actions plans being reviewed and re-written in 2010.

Signing up to the strategy demonstrates commitment to the shared vision and a pledge to deliver actions for which organisations are responsible. All partners will be asked for a signatory, this will mark agreement that agencies will lead where they have been identified to do so, commit to delivery where it is their responsibility and to provide data towards the monitoring and evaluation of the strategy.

The Gloucestershire Health and Community Well-being Living Partnership (GHCWP) will be the overall responsible body for this strategy. This is in line with the broad influences of obesity and the complexity of its solutions. A steering group made up of GHWP and CYPSP members will oversee the delivery and monitor progress of the action plan.

The steering group will be responsible for setting a reporting mechanism and schedule so that progress can be monitored regularly. This will enable success to be observed and the early identification of actions that are falling behind schedule so that resolutions, or contingency plans, can be put in place.

Resources

Resources for implementing this strategy will come from various sources and will include financial input as well as staff time. There is also opportunity for aligned funding across partner organisations, this is already happening in some areas. The LAA is implemented through aligned budgets and includes an obesity reduction outcome that focuses on physical activity and weight management provision. For some actions it will be appropriate to apply for additional funding/grants.

Statutory organisations, such as the PCT, have budgets that can be used for direct implementation of the strategy actions but also commission other organisations, such as voluntary and community organisations to deliver against the action plans.

There is a large workforce across all partners who will have a role to play either with, or without, additional training. Managers will ensure that opportunities are taken for appropriate professionals to fulfil there contribution to delivering the strategy. Managers will also ensure that staff attend training when necessary.

There are several programmes and strategies currently being undertaken which will contribute to tackling obesity or provide opportunity to do so. Examples of these include:

Children and young people's plan

The Government's Every Child Matters: Change for Children programme brings a significant change in the way services for children and young people are delivered. This change presents an opportunity for obesity prevention and treatment services to be planned within the new framework, according to the needs of children and young people.
In the Children and Young People's Plan, childhood obesity is a suggested priority area for Years 2 and 3. There are other priorities that will also contribute towards obesity prevention, including:

- Parenting support
- Improving emotional health and well-being
- Ensuring community regeneration addresses the needs of children and young people
- Play

The Common Assessment Framework will focus on the needs of the child, and there is an emphasis on prevention. At an individual perspective, it is here that obesity needs to be considered.

Children's centres and extended schools provide an ideal opportunity for preventative services for families and children, both as a resource and as a structure for developing the local workforce. They may also offer opportunities for community-based treatment services, or sign-posting to services.

Healthy Schools

The National Healthy Schools Programme currently gives priority to improving children's health in the most disadvantaged areas. The programme is based on the Health promoting schools philosophy, in which the school aims to become a health promoting system and workplace. The Government has a vision that half of all schools will be healthy schools by 2006, with the rest working towards healthy school status by 2009. This programme will also be extended to pupil referral units and nursery education.

The programme will focus on key health priorities and is one of the engines for delivery towards the PSA obesity target.

In "Choosing Health" it is stated that continuing professional development programmes provide teachers with the knowledge and skills to:

- Identify and support children who may be at risk from obesity, and
- Work in partnership with the health sector to provide appropriate services

School sports strategy

This is a National strategy which aims primarily to achieve the PSA target to "enhance the take-up of sporting opportunities by 5-16 year olds by increasing the percentage of school children who spend a minimum of 2 hours each week on high quality PE and school sport within and beyond the curriculum from 25% in 2002 to 75% by 2006 and 85% by 2008." Government departments consider that this will have a significant impact on meeting the child obesity PSA. As Gloucestershire has already exceeded this 2006 target it is now aiming for the Government aspiration, which is to deliver an additional 2 hours of physical activity and sport beyond the school curriculum. This has been expressed as an LAA target under the reduction of obesity outcome.

Gloucestershire food vision

This strategic agency provides a focal point for all food activity in the county. The Food Vision provides opportunities to help prevent obesity by ensuring that the issues are raised and addressed not only across health and education, but throughout industry, food safety and procurement.

Suggested approaches

There are many models that could be used in approaching the prevention and treatment of obesity on a countywide basis.

The three E's – Empowerment, Education and Encouragement is one way of looking at the range of activity and partners needed to form a joined up approach to managing obesity.

The 3 E's Model showing the range of activity and partners needed to create a joined-up approach to the prevention and treatment of obesity

Empowerment

Family therapy & parenting support
Individual & group support
Community development
Anti-stigma work
Building self-esteem
Building social capital
Supporting & encouraging breastfeeding
Facilitative, well-informed workforce
Taking the morality out of adopting healthy lifestyles
Improving cooking skills
Access to information

Involving people in planning

Reducing inequalities
Social Inclusion

Campaigns
Media
Resources
School curriculum
Widening participation in Physical activity
Green Gyms
Exercise on referral
Arts on referral
Incentive schemes, e.g. for active transport and healthier menus
Health walks
Charity walking/activity events
Personalised support

Food vision

Active transport
Town planning
Playgrounds & parks
Regeneration: planning & design
Healthy schools & nurseries
Healthy workplaces
Widening access to facilities
Social change
Media support for creating ethos that being active is "cool" rather than virtuous
Agricultural policies & food subsidies
Food retailers

Encouragement

Environment

Adapted by Clark-Stone from the report of the Royal College of Physicians, 2005

How will we know we have got there?

In order to determine progress the strategy needs to have a performance management and evaluation protocol. This will include:

- Completion and multi-agency/partnership sign up to the action plan
- Format of annual progress reports
- Schedule and format of reviews of the action plan to report back to GHCWP board
- Research and evaluation policy/strategy for small pilot projects and treatment services
- Agreement for information sharing as required

The development of this protocol will be the responsibility of the GHCWBP steering group

"Why is this so difficult?"
"Go for the burn"
No Pain, No Gain
"Naughty but nice"
"Dieting Makes you fat"
Eat all you want and still lose weight
Aargh!
All you can eat
"Buy one get one free"
"You are what you eat"
"Everything in Moderation"
Social Factors
Cultural Factors
Psychological Factors
Physical Factors
Environmental Factors
Income
'Diet' Products Expensive
Less Choice
Poor Self-esteem
Healthy Lifestyles Cost More
Less Sense of Future
Work
Shift Patterns
Sedentary Occupation
Stress
Stigma
Bullying
Embarrassment
Peer Pressure
Family
Family Activity and Eating Patterns
Use of Food as Reward
Attitudes towards Weight and Dieting
Abusive Relationships
Education and Skills
Cooking Skills
Emotional Literacy
Parenting Skills
Planning and Organisational Skills
Ethnicity/Religion
Western Influences
Attitudes to Obesity
Food Choices and Exclusions
Feasting and Fasting
Moral value attached to thinness
Feelings of Inadequacy
Guilt
Conflicting messages
Promises of a Quick Fix
Dieting Industry
Pressure to be slim
Self-esteem/Confidence
Depression
Binge Eating
Social Isolation
Emotional Literacy
Misconceptions/Unhelpful Attitudes Around Food and Weight
Healthy = Good; Fat = Bad
'All or Nothing' Thinking
Eating Disorder
Starve/Binge Cycle
Life "On Hold" 'til I've lost weight
Low Mood
Comfort Eating
Binge Eating
Sexual Abuse
Self-Efficacy
Not my responsibility
Failed Diets
Access to Affordable Healthy Diet
Energy (Calorie) Intake
Soft Drinks
Accessible Tasty
Energy Dense Food
Marketing/Advertising
Foods to Children
Multibuys
Energy (Calorie) Expenditure
Increased Car Use
Mechanisation - Energy-saving Devices
TV's and Computers
Weight Itself
Pain and Discomfort
Reduced Mobility
Quitting Smoking
Effect of Yo-Yo Dieting on Metabolism
Medication
Steroids
Insulin + Diabetes Tablets
Anti-Depressants/Anti-Psychotics
Mobility Problems
Disability
Arthritis
Ethnicity
Distribution of Fat
Insulin Resistance
Gender
Distribution of Fat
Gender Roles
Age
Reduced Energy Needs
Reduced Activity Levels
Less Muscle Mass
Medical Conditions
Hormonal Problems
Cushings Disease
Insulin Resistance
Polycystic Ovarian Syndrome
Thyroid Disease
Arthritis
Sleep Problems
Congenital Problems
Down's Syndrome
Prader-Willi
Growth Hormone Deficiency

References

Colditz G Willett W Rotnitzky A Manson J 1995 Weight gain as a risk factor for clinical diabetes mellitus in women *Ann Intern Med* 122:481-486

Crowther R Dinsdale H Rutter H Kyffin R 2007 *Analysis of the National Childhood Obesity Database 2005-06* South East Public Health Observatory

Department of Health 2005 *Delivering Choosing Health: making healthier choices easier* London Department of Health

Devlin MJ Yanovski SZ Wilson GT 2000 Obesity: what mental health professionals need to know *Am J Psychiatry* 2000 Jun157(6):854-66

Department of Health 2006 April 20 *Health risks and costs of obesity* www.dh.gov.uk/enPolicyandguidance/Healthandsocialcaretopics/Obesity/DH_4133949

Flegal KM Graubard BI Williamson DF Gail MH 2005 Excess deaths associated with underweight, overweight, and obesity *Journal of American Medical Association* 293(15):1861-7

Gately PJ Cooke CB Barth JH Bewick BM Radley D Hill AJ 2005 Children's residential weight-loss programs can work: a prospective cohort study of short-term outcomes for overweight and obese children *Pediatrics* 116(1):73-7

Gloucestershire Health Authority 2001 Health and Lifestyles in Gloucestershire 2000 *Annual Report of the Director of Public Health*

House of Commons Health Committee 2004 *Obesity: Third Report of Session 2003-04*. *The Stationery Office* London

Joint Health Surveys Unit (on behalf of the Department of Health) (2000). *Health Survey for England, 1999*. *The Stationery Office,* London

Joint Health Surveys Unit (on behalf of the Department of Health) 2004 *Health Survey for England, 2003. The Stationery Office*, London

Jotangia D Moody A Stamatakis E Wardle H 2006 Obesity among children under 11 National Statistics

Latner J & Stunkard A 2003 Getting works: the stigmatization of obese children *Obesity research* 11 (3)

National Institute for Health and Clinical Excellence (NICE) 2006 *Obesity guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* NICE: London

O'Dea J 2005 *Prevention of child obesity and eating disorders:* A workshop in the UK, unpublished Contact author j.odea@usyd.edu.au

Patton GC Selzer R Coffey C Carlin JB Wolfe R 1999 Onset of adolescent eating disorders: population based cohort study over 3 years *British Medical Journal* 318(7186):765-8

Pickett KE Kelly S Brunner E Lobstein T Wilkinson RG 2005 Wider income gaps, wider waistbands? An ecological study of obesity and income inequality *J Epidemiol Community Health* 59(8):670-4

Reilly et al 2005 Early risk factors for obesity in childhood; a cohort study *British Medical Journal*

Richardson et al 1961 Cultural uniformity in reactions to physical handicaps *American Sociological Review* 26: 241-247A

Schwartz et al 2002 Weight bias among health professionals specializing in obesity *Obesity Research* 11(9)

Schwimmer JB Burwinkle TM Varni JW 2003   Health-related quality of life of severely obese children and adolescents *Journal of American Medical Association* 289(14):1813-9

Stunkard AJ Faith MS Allison KC 2003 Depression and obesity *Biol Psychiatry* 1;54(3):330-7
Strauss R 2000 Childhood obesity and self esteem *Pediatrics* 105(1)

Strauss RS, Pollack HA 2003   Social marginalization of overweight children *Arch Pediatr Adolesc Med* 157(8):746-52

Stice E Cameron RP Killen JD Hayward C Taylor CB 1999 Naturalistic weight-reduction efforts prospectively predict growth in relative weight and onset of obesity among female adolescents *J Consult Clin Psychol* 67(6):967-74

Williams J Wake M Hesketh K Maher E Waters E 2005 Health-related quality of life of overweight and obese children *Journal of American Medical Association*   293(1):70-6

Whitaker RC Wright JA Pepe MS Seidel KD Dietz WH 1997 Predicting obesity in young adulthood from childhood and parental obesity *N Engl J Med* 337(13):869-73

Appendix 1

Action Plan

Obesity Strategy Action Plan 2007-2010

Key

Colour	Meaning
Yellow	Children
Blue	Adults
Green	Children and adults

Action		Lead Partner	Links	Timescale
Prevention				
1.1	Map current activity regarding prevention	Voluntary Sector		April 09
1.2	Ensure healthy food policy within all schools, children's centres and children's homes	Gloucestershire County Council - Children and Young Peoples Directorate	Gloucestershire Food Vision	2010
1.3	Implement the breast-feeding strategy	PCT and GHNHSFT (Midwifery and Health Visiting)	LAA	On-going
1.4	Ensure family eating and physical activity is included in all antenatal and postnatal education	PCT and (Midwifery and Health Visiting) Children's Centres	Parenting strategy	
1.5	Use 12 week maternity assessment to advice on healthy weigh gain for mothers who are identified as overweight or obese	GHNHSFT		2008
1.6	Adopt NICE guidelines on obesity prevention (Clinical Guideline 43) and behaviour change (Public Health Guidance 6)	PCT		Dec 2007
1.7	To improve access to healthy food and physical activity provision within communities, particularly in disadvantaged areas	Gloucestershire Food Vision District/Borough Councils Sport Development Teams PCT		2009
1.8	To promote the 5 a day programme with whole population	All partners	Gloucestershire Food Vision: Taste and Health Programme	On-going
1.9	To improve food skills including the growing, shopping for and cooking of fruit and vegetables	Gloucestershire County Council: Children and Young People's Directorate Voluntary sector Adult Education	Gloucestershire Food Vision Get Gloucestershire Cooking Health4schools Children's centre's Extended Schools	On-going
2.0	Improve food in schools by:	Food in Schools Strategy Group	Gloucestershire Food Vision	Awaiting

	❑ Meeting the Government targets for school meals ❑ Work towards the standards for food other than school meals ❑ Ensure every school has a Food in School policy		Gloucestershire's Children & Young People's plan	government direction
2.1	Meet National and Local targets for National Healthy Schools status (80% of schools by 2009, LAA stretch 93% March 2010)	Healthy Schools Partnership	LAA CYP 1(i) Gloucestershire's Children & Young People's plan	2010
2.2	Develop and implement play strategies including a play rangers scheme in each of the districts	Local Authorities - Community Services		2008
2.3	To increase opportunities for physical activity within and outside of school, including children and young people with disabilities ❑ Reach National target of 2 hours per week within school ❑ Increase the percentage of young people (aged 5-16) who achieve at least 5 hours of sport, physical education and physical activity ❑ Widening access ❑ Promoting sport and physical activity as an everyday activity e.g. Active Start ❑ Promoting sport within the framework of preparing for the Olympics ❑ Improve access to safe playing spaces through partnership working	Healthy Schools School sports Partnerships Active Gloucestershire District/Borough Councils Sports Development Teams Further education colleges	LAA - HCOP 1b Active Gloucestershire Strategic Framework District/Borough council Play and Sports Strategies Health4schools CSPANs (or Health and Wellbeing Partnerships where CSPANs don't exist)	2010
2.4	Increase provision of healthy lifestyle interventions (healthy eating, physical activity and positive mental health) within youth settings.	Gloucestershire County Council - Children and Young People's Directorate District/Borough Councils Sports Development Teams Hear by Rights	Active Gloucestershire Strategic Framework Local Authority cultural/leisure/sports/play strategies	
2.5	All schools and statutory organisations (e.g. PCT and local authorities) to have travel plans.	Gloucestershire County Council -		2009
2.6	Planners to consider healthy living impacts in terms of 'enabling factors' i.e. Physical activity/active transport, safety, when designing open spaces, buildings and overall urban design	Local Authority planning departments Gloucestershire First Facilities strategy and planning group		
2.7	Improve the health of the workforce by: ▪ Offering and promoting healthy eating options ▪ Developing physical activity interventions or	PCT		2009

	having policies in place that allow flexible working to allow staff to build physical activity into their daily living ▪ Written protocols in place, for ordering food for events/meetings, ensuring that healthy options are always available			
Treatment				
2.8	Establish baseline data for obesity amongst reception year and year 6 children	School Nursing and Child Health	MAIDeN	Dec 2007
2.9	Increase the number of children measured through the National Child Measurement Programme to 80%	Gloucestershire County Council - Children and Young People's Directorate School Nursing		September 2008
3.0	All partners committed to giving clear, evidence based weight management messages including information on local services	All Partners		
3.1	Extend the provision of exercise referral schemes to the whole county in line with evidence based practice, including evaluation.	District/Borough councils sports Development Teams	Active Gloucestershire University of Gloucestershire (evaluation)	October 2008
3.2	All GP surgeries to have a weight management practitioner.	PCT - Public Health (Weight Management Service)		April 2010
3.3	Local authority leisure centre staff to receive weight management training	PCT - Public Health (Weight Management Service) Local Authority leisure facilities		April 2010
3.4	Agree and implement care pathways for both obese adults and children to include lifestyle approaches, prescribing (anti-obesity medication), specialist treatment and bariatric surgery.	PCT - Public Health GHNHSFT		December 2008
Advice and Support				
3.5	To provide support and guidance on healthy eating, active lifestyles, maintaining self-esteem, safe weight management and behaviour change ❑ As part of parenting programmes ❑ Within written resources ❑ Within workplaces		Parenting strategy Family Learning	On-going
3.6	To support the mental and emotional well-being of		Emotional and Well-being	

	families: ❑ Post natal depression ❑ Building self esteem and communication skills in parents ❑ Implement the emotional and well-being commissioning strategy ❑ Deliver LAA target for increasing the number of children and young people who perceive that they are 'happy' or 'quite happy' using the pupil on-line survey.		Strategy LAA – HCOP 2	
3.7	Provide parenting programmes that include support and guidance on healthy eating, cooking skills and promoting active families (including play).		Family learning Extended Schools	
Training				
3.8	Workforce development: ❑ Public health and behaviour change (including motivational interviewing) training for school nurses, PE, PHSE and food tech teaching staff and community staff delivering physical activity ❑ How to support behaviour change in the sensitive area of obesity. ❑ Specialist training for those working with children and adults with special needs ❑ Awareness, signposting, responding appropriately to concerns, developing positive role models ❑ Training and support for health and non-health workers with a role in delivering weight management treatment to obese adults and children	PCT – Public Health LEA Village agents	Regional Training Centre for Public Sector caterers British Nutrition Foundation Chef4schools programme (launching summer 2007) Community safety/neighbourhood wardens	On-going
Advocacy				
3.9	Lobbying for action in areas beyond local control i.e. food advertising	Gloucestershire Healthy Living Partnership		
4.0	Build close working relationship with local media to ensure all obesity related information is factually correct, consistent and adheres to strategy vision	Local print and broadcast media PCT communications team	Active Gloucestershire led media campaign	

Further copies of this strategy can be obtained from Gloucestershire Primary Care Trust at:

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