

**CAMBRIDGESHIRE  
OBESITY PREVENTION &  
MANAGEMENT STRATEGY  
2008-2011**

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On behalf of the  
Cambridgeshire Obesity Strategic Group**

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## INTRODUCTION

The huge and rapid increase in the numbers of children and adults who are classified as obese has led to the use of the term “obesity epidemic”. This has resulted in national policies, strategies and directives to address obesity that require the input of a wide range agencies working with their communities.

In Cambridgeshire, the County Obesity Strategy Group is a multi-agency group that was formed initially to address the childhood measurement programme and then develop into a group that is committed to setting the strategic direction for tackling obesity. It has a remit to ensure that obesity is embedded into key local organisational and partnership strategies and to secure its implementation through the support of the commissioning processes.

The purpose of this document is to set the strategic direction and an action plan to guide implementation.

Our **vision** is that:

‘All people living in Cambridgeshire will have the knowledge, skills, opportunities and services to manage their weight, and the weight of their family, and that together we reverse the rising tide of obesity and overweight in the population. Our starting point will be prevention.’

The authors of this local Obesity Strategy have drawn extensively on the following documents and it is recommended that these be read in conjunction with this document:

- Office for National Statistics: The Information Centre (2008). *Statistics on Obesity, Physical Activity and Diet: England, January 2008*
- Government Office for Science (2007). *Foresight: Tackling Obesities: Future Choices – Project Report*.

This Strategy is also underpinned by the Government’s own Obesity Strategy, and again it is recommended that the documents below are used as key reference documents:

- Department of Health (2008): *Healthy Weight, Healthy Lives: A Cross Government Strategy for England*.
- Department of Health (2008): *Healthy Weight, Healthy Lives; Guidance for Local Areas*

- Department of Health (2008): *Healthy Weight, Healthy Lives; A Toolkit for Developing Local Strategies*
- Department of Health (2008): *Healthy Weight, Healthy Lives; Commissioning Weight Management Services for Children & Young People*
- Department of Health (2008): *Healthy Weight, Healthy Lives; Consumer Insight Summary*

Web links to these documents can be found on pages: 55 to 57

## SECTION ONE: THE NEED

### 1.1 Defining Obesity

There are agreed criteria for defining obesity.

#### Adults:

Obesity in adults is defined for epidemiological purposes as body mass index (BMI=weight/(height)<sup>2</sup>) > 30 kg/m<sup>2</sup>. The World Health Organisation (WHO) has proposed a classification of overweight adults based on BMI (Table 1). The BMI does not take account of the distribution of body fat and an alternative would be to measure waist circumference. This is an indicator of abdominal fat and a better predictor of cardiovascular risk (Table 2).

**Table1: Classification of overweight adults (WHO, 2000)**

Classification	BMI (Kg/m <sup>2</sup> )	Risk of co-morbidities
Underweight	< 18.5	Low (but the risk of other clinical problems increased)
Normal weight	18.5 - 24.9	Average
Overweight	> 25	
Pre-obese	25 - 29.9	Increased
Obese class I	30.0 - 34.9	Moderate
Obese class II	35.0 - 39.9	Severe
Obese class III	> 40.0	Very Severe

Source: *Obesity: preventing and managing the global epidemic. Report of a WHO Consultation.* Geneva, World Health Organisation, 2000 (WHO Technical Report Series, No 894)

**Table 2: Sex-specific waist circumferences that denote increased risk of metabolic complications of obesity in Caucasians (WHO, 2000)**

	Risk of Complications	
	Increased	Substantially increased
Men	> 94 cm (~37in)	> 102 cm (~40in)
Women	> 80 cm (~32in)	> 88 cm (35~in)

## **Children:**

There is no generally agreed BMI criterion for classifying overweight and obesity in children. Using the 1990 centile charts for weight for British children, those at or over the 95<sup>th</sup> centile are referred to as obese and those between the 85<sup>th</sup> and 95<sup>th</sup> centile as overweight. There is little or no evidence that cut-off points are related to morbidity or health outcomes. The international classification developed by the International Obesity Task Force uses data from six countries and BMI percentile curves that pass through the adult cut-off values (25kg/m<sup>2</sup> and 30 kg/m<sup>2</sup>) at age 18. Cut-off values are related to risk factors.

### **1.2 The Epidemiology**

Data relating to obesity, physical activity and diet is summarised below and is based on the Office of National Statistics (The Information Centre) national data published in January 2008. This is complemented with local data, where available. Interpretation of this information can be complemented by

- Joint Strategic Needs Assessments
- The National Child Measurement Programme
- Active People Survey (Sports England)
- The new Place Survey (Dept for Communities and Local Government)

The Government's 'Commissioning Framework for Health and Well-being' clearly states that the systematic involvement of people in assessing need and designing services will be crucial to developing innovative and responsive services and self-directed care. A refined understanding of need, and the involvement of local people, will help to prioritise and to implement the strategy.

#### **1.2.1 The National Picture**

- In 2006, 24% of adults (aged 16 or over) in England were classified as obese. This represents an overall increase from 15% in 1993
- Men and women were equally likely to be obese, however women were more likely than men to be morbidly obese (3% compared to 1%)
- Thirty seven per cent of adults had a raised waist circumference in 2006 compared to 23% in 1993. Women were more likely than men to have a raised waist circumference (41% and 32% respectively)
- Using both BMI and waist circumference to assess risk of health problems, of men 20% were estimated to be at increased risk, 13% at high risk and 21% at very high risk. Equivalent figures for women were 14% at increased risk, 16% at high risk and 23% at very high risk

- In 2006, 16% of children aged 2 to 15 were classed as obese. This represents an overall increase from 11% in 1995. Despite the overall increase since 1995, the proportion of girls aged 2 to 15 who were obese decreased between 2005 and 2006, from 18% to 15%. There was no significant decrease among boys aged 2 to 15 over that period. Among children aged 2 to 10, 15% were classed as obese in 2006
- Boys were more likely than girls to be obese (17% compared to 15%)
- Of children aged 8 to 15 who were classed as obese, two thirds (66%) of girls and 60% of boys thought that they were too heavy.

### **1.2.2 Health Inequalities and Obesity**

The Foresight Report on Obesity published in 2007 reported that the prevalence of obesity shows a marked gradient in relation to social class, i.e.:

“The prevalence of obesity among men in 2004 was about 18% in Social Class 1 and 28% in Social Class V. For women, the gap is larger, with 10% prevalence in Social Class 1 and around 25% in Class V in 2004. For women, the social class disparity is longstanding, while for men it has only become pronounced in recent years.”

The factors underpinning the social gradient are currently poorly understood. Comparisons of populations internationally show that, above a basic threshold, both obesity and diabetes are linked less strongly to absolute levels of national wealth than they are to indicators of inequalities within nations. This suggests that links between socioeconomic status and obesity in the UK may be associated with the degree of relative social inequality.

Obese children especially girls are more likely to come from semi-routine and routine households. 17.1% of children from households where the chief wage earner has a job classified as semi-routine or routine were obese compared with 12.4% of those from managerial and professional households. Between 1995 and 2003 levels of obesity increased 11.2% for those on the least deprived fifth of the population and 16.4% for the most deprived. Asian children are four times more likely to be obese than those who are white

*National Heart Forum, Faculty of Public Health - Lightening the Load, tackling overweight and obesity – a toolkit for developing strategies to tackle overweight and obesity in children and adults 2006*

### **1.2.3 Physical Activity**

- Overall, physical activity has increased among both men and women since 1997, with 40% of men and 28% of women meeting the recommended levels

in 2006 (at least 30 minutes of at least moderate intensity activity at least 5 times a week).

- There is a clear gradient across the income quintiles for both men and women, with those in the lowest income quintile more likely to be in the low participation group than those in the highest income quintile. Those with the highest income were also most likely to participate in active sport: 89% of those earning over £50k had done so at least once in the previous 12 months while for those whose income was less than £10k the figure was 61%
- Men and women with low physical activity levels were more than twice as likely as to have a raised waist circumference than those with high levels of physical activity
- Three in ten adults had not participated in active sport in last 12 months in 2005/06. The main reasons for not participating were 'health isn't good enough' (47%) followed by 'difficulty in finding the time' and 'not being interested' (both 18%)
- In 2006, boys were more likely than girls to meet the recommended levels of physical activity with 70% of boys and 59% of girls reporting taking part in 60 minutes or more of physical activity on all 7 days in the previous week
- During 2006/07, 86% of pupils took part in at least two hours of high quality PE and sport a week, a gradual increase since 2003/04 when the figure was 62%.

#### **1.2.4 Diet**

Dietary determinants of obesity have recently been reviewed by the World Health Organization<sup>1</sup>.

##### **Breast feeding**

Several systematic reviews and population-based studies support the association between breastfeeding and lower risk of later adiposity. The effect of breastfeeding is thought to be partly associated with slower growth and relative undernutrition in breastfed infants compared to formula fed infants<sup>2</sup>.

In England in 2005, 46 % of mothers exclusively breastfed at one week, however, by six weeks only 22% were exclusively breastfeeding. Young women in low-income areas are least likely to initiate and continue breastfeeding.

## **Nutrients**

### **Fat**

Observational and intervention studies show an association between fat intake and weight gain or loss. In the Women's Health Initiative there was a clear dose-response relationship between fat reduction and weight loss<sup>3</sup>.

Fat is energy dense, it contains around twice as many calories than carbohydrate or protein. Energy dense foods (i.e. those high in fat) tend to undermine appetite control and increase the risk of consuming too much energy.

Data from the National Diet and Nutrition Survey of children aged 4 – 18 years (NDNS)<sup>4</sup> shows that only 44% of boys and 40% of girls achieved the dietary recommendation of no more than 35% of food energy derived from fat. In adults only 43% of men and 50% of women in the population achieved the dietary recommendation for fat intake<sup>4</sup>.

### **Carbohydrate**

Carbohydrate intake tends to vary according to fat intake, so it is difficult to determine the impact of carbohydrate intake on weight gain risk. Sugars, in the form of sugar rich drinks have been associated with risk of weight gain<sup>5</sup>. According to the NDNS, children derived around a quarter of their sugar intake from sugar rich drinks.

### **Dietary fibre**

Observational and intervention studies have shown an inverse association between fibre intake and weight gain. Weight control effects of fibre may be related to a number of mechanisms, including incomplete digestion and absorption of energy from fibre-rich foods and gastric distension due to their bulky nature. In adults a population average of 18g of non-starch polysaccharides (NSP) is recommended. According to the NDNS of adults aged 19 – 64 years, the average intake of NSP was 15.2g for men and 12.6g for women. A third of men and half of the women in the survey had intakes below 12g per day<sup>4</sup>. In children there is no recommendation, as there is little data on the physiological effects of NSP in this age group. However, it is recommended that children have proportionally lower intakes.

## **Foods**

### **Fruit and vegetables**

Some limited data suggests that fruit and vegetable intake has a modest protective effect on weight gain. In 2006 28% of men and 32% of women

consumed five or more portions of fruit and vegetables a day, the proportion doing so generally increased with age and income<sup>4</sup>. Among children aged 5 to 15 years around a fifth achieved 5 or more portions each day.

### **Dietary patterns**

There is a move towards studying dietary patterns and weight control rather than specific nutrients or foods. Protective effects of the Mediterranean type diet support dietary patterns rich in vegetables, fruits, legumes, nuts and olive oil, with minimal amounts of protein and dairy products<sup>5</sup>.

Experimental studies also support large portion sizes as a risk factor for weight gain<sup>6</sup>. Larger portion sizes result in higher energy intakes.

### **Income and diet**

The UK National Family Food Survey<sup>7</sup>, shows that low-income groups spend a much larger proportion of their income on food. Higher income households spent around 10% compared to 28% of total income in lower-income families. This may act to deter healthier choices in lower income families due to concerns about wastage or the perception that healthier choices are more expensive. Data from a French survey<sup>8</sup> showed that those who had the least to spend on food tended to select a less healthy diet.

### **School meals**

The School Food Trust (SFT) was set up in 2005 to transform school food and food skills. A registered charity, the SFT is responsible for taking forward school food standards to improve health and education for children and young people.

Evidence for the relationship between school meals and any impact on BMI is lacking. However, following a pilot study in Hull, where 71 schools (22,000 children) were provided with free school meals from 2004 to 2007, the SFT are now embarking on a new £20 million pilot to provide free school meals to children in deprived areas. The study will last for two years and will investigate whether school meals reduce obesity or have any effect on children's BMI<sup>9</sup>.

### **References**

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8. Andrieu E, Darmon N, Drewnowski A (2006). Low-cost diets: more energy, fewer nutrients. *European Journal of Clinical Nutrition*; **60** (3): 434-436.
9. School Food Trust press release ([http://www.schoolfoodtrust.org.uk/news\\_item.asp?NewsId=151](http://www.schoolfoodtrust.org.uk/news_item.asp?NewsId=151)) accessed 24/09/08.

### 1.3 Health Outcomes

Obesity is one of the major public health issues in the developing world. Obese people have an increased risk of dying prematurely and it is responsible for more than 9,000 premature deaths per year in England. It can lead to increased risk of developing Cardiovascular Disease, Type 2 Diabetes, Hypertension, Dyslipidemia, cancers of the oesophagus, pancreas, colorectum, breast (postmenopausal), endometrium and kidney, for which there is now convincing evidence, musculo-skeletal problems and other diseases.

In addition, obese people are more likely to suffer from a number of psychological problems such as low self-image and confidence, social stigma, reduced mobility and a poorer quality of life.

In people aged 35 and over classified as having a raised waist circumference, men were twice as likely and women were four times more likely to have type 2 diabetes.

Again relative risk for mortality for all causes increases for those with a BMI greater than 25 compared with those who lie within the normal range (20-25 BMI). Relative risk increases even more when obesity is present with other long-term risk behaviours.

Children who are obese are more likely to become obese adults and this likelihood increases the more obese a child is as well as increasing if the child's

parents are obese. However there is evidence that the health effects are impacting as there are now cases of type 2 diabetes are being seen in obese children. In children and young it is also strongly associated with poorer educational outcomes, bullying and mental health problems.

#### **1.4 Benefits of Reducing Obesity**

The National Audit Office (NAO) estimated that one million fewer obese people in this country could lead to around 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. Modest weight loss can produce substantial health benefits. A 10% weight loss can lead to some substantial improvements

##### Mortality

20-25% fall in overall mortality

30-40% fall in diabetes-related deaths

40-50% fall in obesity-related cancer deaths

##### Diabetes

Up to 50% fall in fasting blood glucose

Over 50% reduction in risk of developing diabetes

##### Lipids

10% fall in total cholesterol 15%LDL

30% in TG

8 increase in HDL

##### Blood Pressure

10 mmHg fall in diastolic pressures

The National Audit Office has highlighted significant indirect costs due to higher levels of sickness and absence from work that obese people suffer. The Foresight Report details that the Health Select Committee estimate of lost earnings attributable to obesity was £2.3-3.6 billion per year, accounting for an annual total of 45,000 lost working years. Subsequent work suggests that the total impact of obesity on employment may be as much as £10 billion.

#### **1.5 Impact on Health Services**

Over the last ten years there were 17,458 Finished Consultant Episodes (FCEs) with a primary diagnosis of obesity. Almost a quarter of these (4,068) occurred in 2006/07.

In 2006, 1.06 million prescription items were dispensed for the treatment of obesity. Overall, the number of prescriptions in 2006 was more than eight times the number prescribed in 1999, when there were 127 thousand prescription items. Considering the treatment types in 2006, around 73% of prescriptions

were for Orlistat and 25% prescriptions were for Sibutramine, the two main drugs used for treatment of obesity. (See Appendix 2).

## **1.6 The Cost of Obesity**

The Health Select Committee has estimated that the costs of obesity is £3.3 - £3.7 billion per year and of obesity plus overweight at £6.6 - £7.4 Billion. National Audit Office (NAO) figures - one million fewer obese people in this country could lead to around 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. (source DOH website)

The National Audit Office (NAO 2001) Report highlighted the direct and indirect costs of the burden of obesity in the UK. Obesity accounted for 18 million lost working days due to associated illness and 30,000 deaths in 1998 for England. The direct cost of treatment of obesity and associated co-morbidities was conservatively estimated at £480 million. Indirect costs due to lost earnings were estimated for England at £2150 million. This report was unable to evaluate the costs of obesity-related back pain and several other conditions and therefore true costs may exceed the estimates.

The House of Commons Health Select committee report (2004) estimated that the cost of obesity in England in 2002 was £3.3 - 3.7 billion and this was still considered an underestimate. By targeting obesity, potential cost savings can be made in diabetes, hypertension, heart disease, stroke, osteoarthritis and cancer.

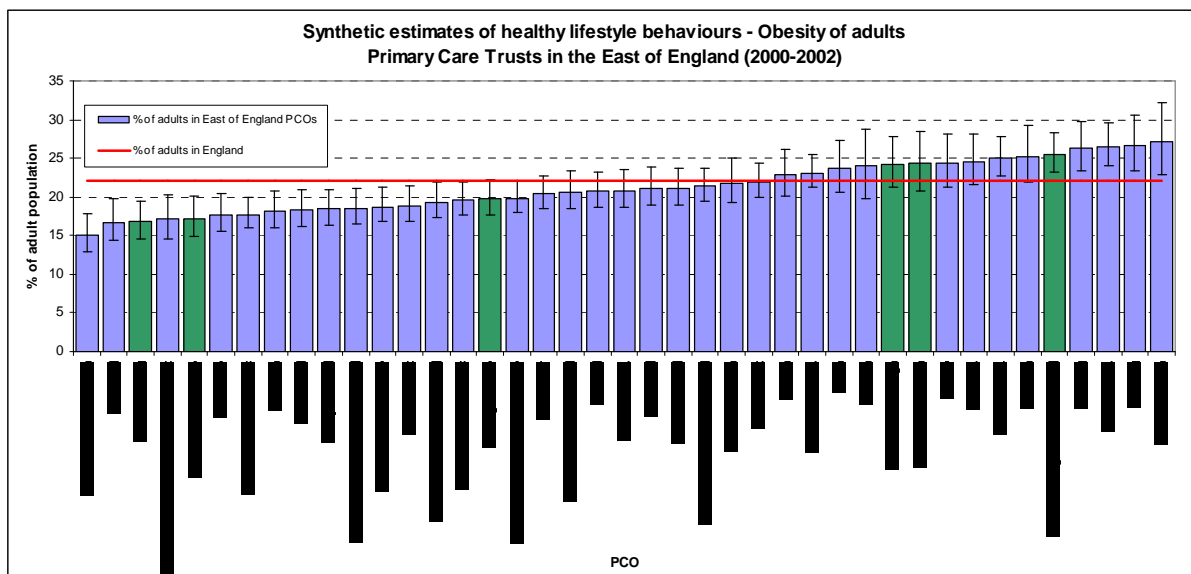
The Counterweight Study, a large study based in primary care, has shown that overweight and obesity more than doubled prescribing costs.

## **SECTION TWO: OBESITY, PHYSICAL ACTIVITY AND DIET IN CAMBRIDGESHIRE**

### **2.1 Adults:**

- In 2005 National Statistics produced synthetic estimates for several adult lifestyle indicators, namely, obesity, fruit and vegetable consumption and binge drinking. They estimated that Fenland has the highest proportion of obese adults at 29%, which is significantly higher than the national average of 22%. East Cambridgeshire had the second highest proportion at 21% and the remaining Cambridgeshire district rates were significantly lower than the national average. It is estimated that Waterlees has the highest proportion of obese adults at 35%. In fact of the 123 wards in Cambridgeshire Fenland had the top 18 wards with highest estimated prevalence of obese adults.

Figure 1. Synthetic estimates of obesity, by LA



Source: Office for National Statistics, based on Health Survey for England (erpho)

Regional Public Health Observatory estimate prevalence of adult obesity to be:

Locality	Prevalence
Cambridgeshire	25%
Fenland	28.8%
East Cambs	21.4%
Hunts	19.8%
South Cambs	17.1%
Cambridge	16.7%

## 2.2 Children:

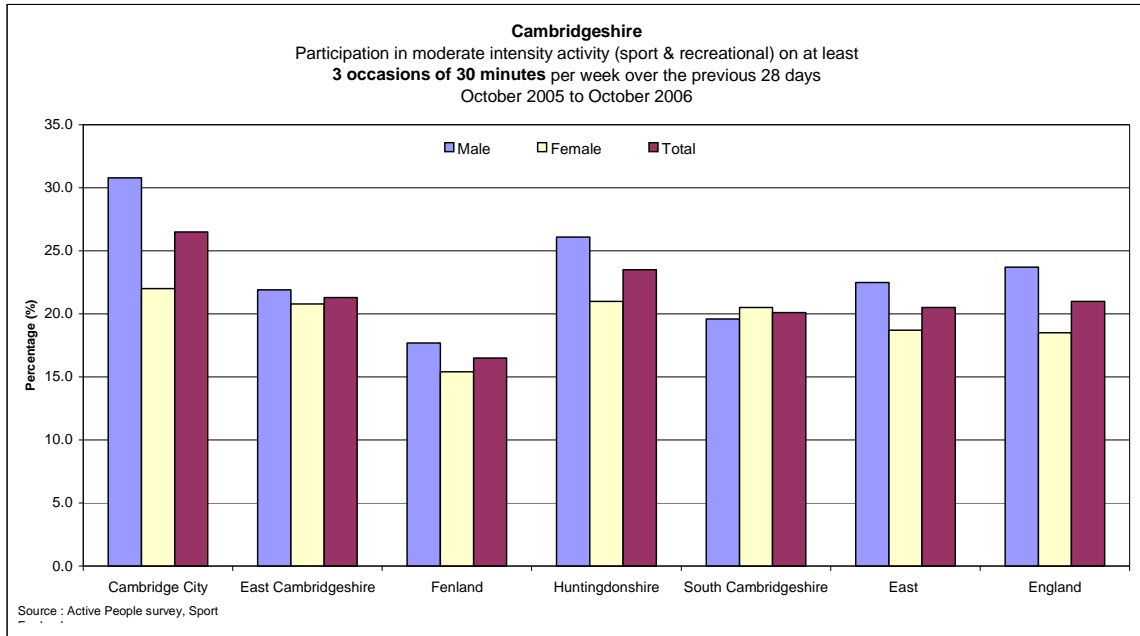
- In February 2008 the results from the National Childhood Measurement Programme 2006/07 were released. These showed that of the children that were measured in Cambridgeshire, 11% of reception children were overweight and 8% were obese and 13% of Year 6 Children were overweight and 16% were obese. All of these percentages are lower than the national average. However, it is important to note that coverage i.e. the proportion of children measured was relatively low in 2006/07 compared to other areas in the country.
- The Cambridgeshire Health Related Behaviour Survey (a lifestyle and behaviour survey of Year 8 and Year 10 pupils) undertaken in 2006 showed that on average 1 in 10 pupils eat 5 or more fruit and vegetables a day. East Cambridgeshire has the highest proportion at 12%. However, East Cambridgeshire, along with Huntingdonshire, had the highest proportion of pupils having no fruit and vegetable intake, at 10%.
- In general, levels of inactivity are similar, at a Cambridgeshire level, for males and females, but males are more likely to do more regular exercise where they had to breathe harder and faster than girls. Fenland Year 10 females appear to have a noticeably higher rate of days where they didn't exercise and had to breathe harder and faster compared to the other districts and the county average.
- The method of travelling to school varies between districts, as would be expected due to the difference in rural and urban areas within Cambridgeshire.

## 2.3 Physical Activity

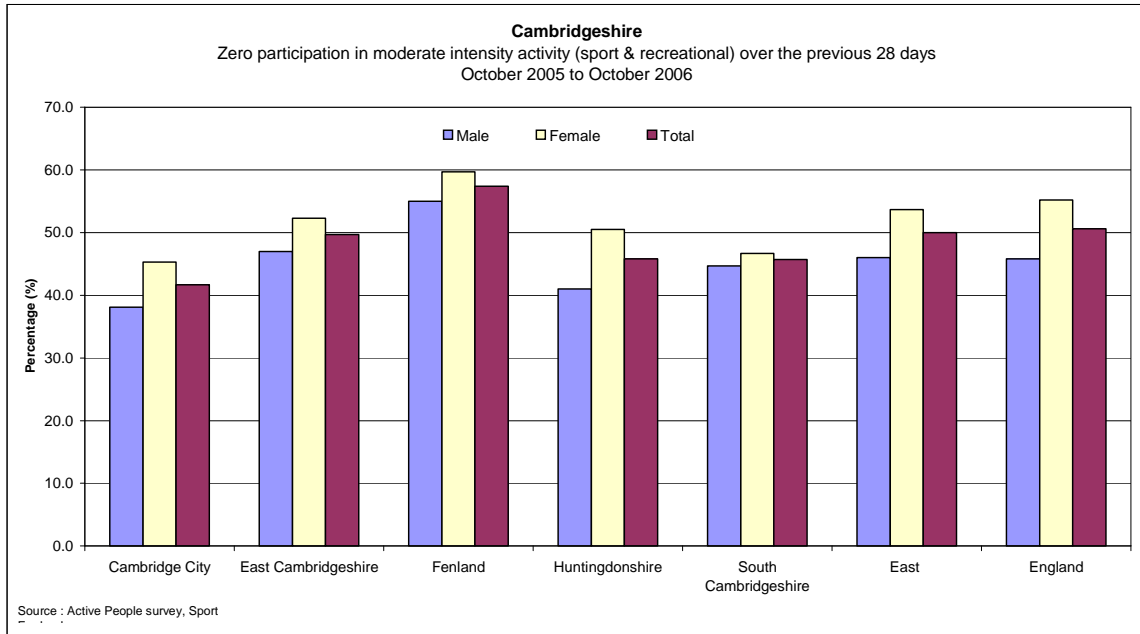
### *Needs Assessment – Active People Survey – Cambridgeshire*

Between October 2005 and October 2006 telephone surveys were undertaken on behalf of Sport England on peoples level of participation in moderate intensity activity (sport & recreational). At least a 1,000 people aged 16 years and over per local authority were interviewed.

The graph below shows the levels of such participation on at least 3 occasions of 30 minutes per week over the previous 28 days. As can be seen, in general, levels of participation are higher amongst males than females, with Cambridge City and Huntingdonshire having the highest levels. Fenland has noticeably lower levels compared to the other districts, East and England.



Fenland has the highest levels of zero participation in moderate intensity activity across the county and compared to the East and England averages. Levels of non-participation are higher in females than males.



Cambridge City has noticeable higher rate of people with a limiting disability who participate in moderate intensity activity on at least 3 occasions per week over the previous 28 days, at over double the average for England (16.5% compared to 8.8%). Fenland and Huntingdonshire have the lowest participation rates,

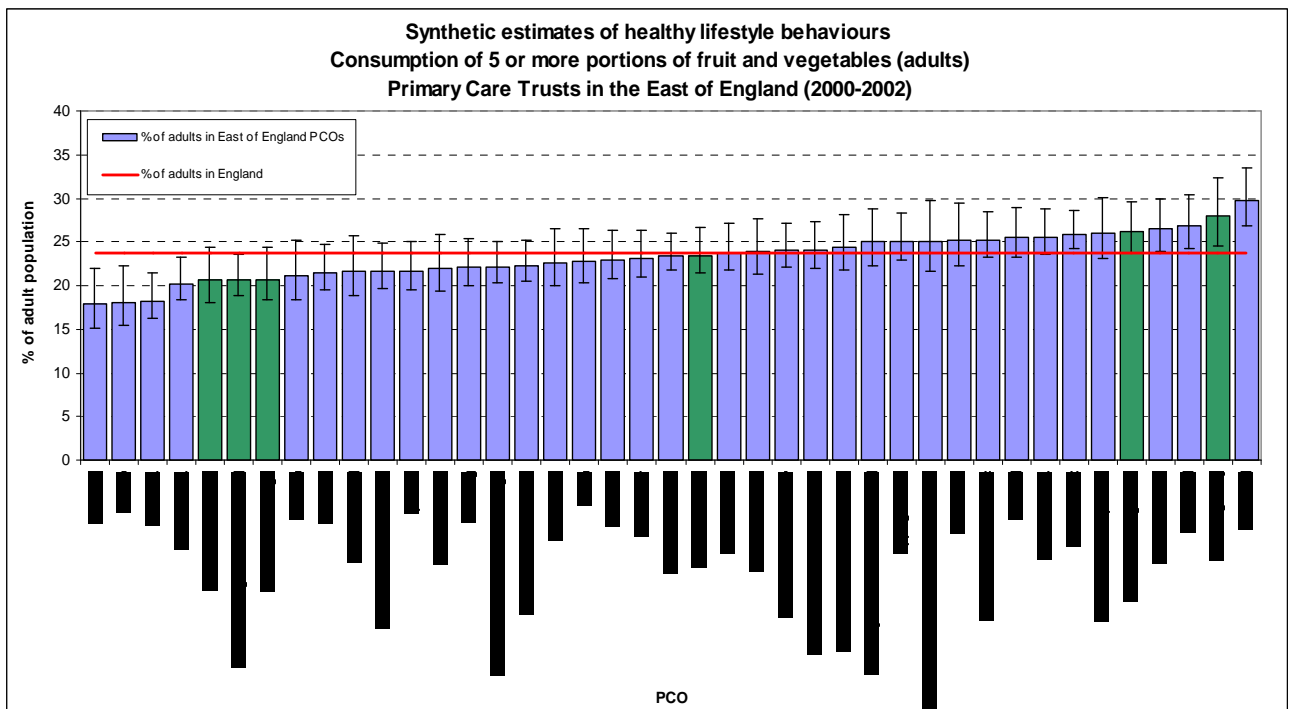
which are around the same rate of the East region average. Huntingdonshire has the highest levels of zero participation in people with a limiting disability, closely followed by Fenland.

Levels of participation are highest in people from higher socio-economic groups. The levels of non-participation are similar between people from the higher and lower socio-economic groups in Fenland, but in all other districts non-participation is highest in the lower socio-economic groups. Levels of participation in the higher socio-economic group in South Cambridgeshire are relatively low compared to the other districts and the national average.

Fenland has noticeably low levels of satisfaction with their local sports provisions compared to the other districts, especially Huntingdonshire and South Cambridgeshire where levels are very high, and the national average. Cambridge City has the highest levels of club membership, people receiving coaching/tuition and people involved in competition. In general all the districts, with the exception of Fenland, have higher levels of walking and cycling than seen nationally.

## 2.4 Diet in Cambridgeshire

- The graph below looks at the percentage of adults who consume 5 or more portions of fruit and vegetables by former Primary Care Trust areas in the East of England. It indicates that South Cambridgeshire and Cambridge City eat a higher proportion and East Cambridgeshire and Fenland a lower proportion of fruit and vegetables than the national average. In all PCTs, less than 30 % of the population eat the recommended amount of 5 portions of fruit and vegetables per day.



## **2.5 Obesity related Long term conditions in Cambridgeshire**

The link between obesity and to long term conditions is well researched. The Foresight Report outlines:

- 20 x risk of development of Type 2 diabetes for obese people compared to lean people
  - 66% of hypertension linked to excess weight
  - Coronary Artery Disease - a relative risk of 2.4 for obese women, 2 for obese men
  - Overweight/obesity and hypertension associated with increased risk of stroke
  - Obesity associated with development of pulmonary hypertension
  - Strong association with osteoarthritis
- Mortality from circulatory disease and cancer in people aged under 75 is lower than the national average throughout Cambridgeshire. The recorded prevalence of diabetes 2004/05 is below the national average of 3.4% throughout Cambridgeshire, with the exception of East Cambridgeshire and Fenland where it is 4%.
  - A Cambridgeshire Long Term Conditions Strategy has been produced by Cambridgeshire PCT and is linked with this document.

## **2.6 Health Inequalities in Cambridgeshire**

- As a whole, Cambridgeshire is an affluent county. In the ODPM Index of Multiple Deprivation 2004, Cambridgeshire ranked 134 out of 149 shire counties and unitary authorities, placing it among the least deprived 20% of authorities in the country.
- Within the county, however, there is considerable variation. Out of the 354 district councils and unitary authorities, Huntingdonshire and South Cambridgeshire score among the least deprived 20%, Cambridge City and East Cambridgeshire score among the least deprived 40% and Fenland scores among the most deprived 40%. Employment rates are relatively good within the county, even in Fenland which has the highest rate of unemployment at 2.2%; this is lower than the national average of 2.4%.
- Below district council level there is considerable variation in deprivation. Four small areas of the county (known as super output areas) fall within the most deprived 20% of super output areas in the country. All of these are in or around Wisbech in north Fenland. A further five super output areas fall among the most deprived 25% nationally. Three of these are in Fenland, one is in the Oxmoor area of Huntingdon and one is part of Abbey ward in Cambridge.

Therefore, while much of the county has relatively low deprivation, there is considerable inequality, with some small areas experiencing high levels of deprivation.

- It is also likely that there is additional deprivation across the county that is concentrated in areas that are too small to be picked up when analysis is carried out at super output area level.

## **2.7 The Cost to Cambridgeshire**

Estimated annual costs of treating obesity in South Cambs and Cambridge City PCTs (adapted from NAO) are approximately £45,010 and over £2 million for the treatment of its consequences. This does not take into account social and indirect costs. (East Cambs, Hunts, Fenland costs to be calculated)

In addition to this, there are increased costs associated with the growing number of patients being referred for obesity surgery (1 referral in 2003, 4 in 2004, 8 in 2005).

## **SECTION THREE: POLICY CONTEXT**

### **3.1 National Context**

Government policy has in recent years has targeted obesity. The Wanless Reports in 2001 and 2003 highlighted the economic argument for re-focusing investment on preventative approaches, reducing the future financial burden on longevity and population change.

The National Service Frameworks (NSF) set standards for the prevention of ill health. For example, the Diabetes (DH, 2000) NSF focuses upon the reduction of overweight and obesity and for the promotion of healthier eating. The NHS Cancer Plan (DH, 2000) and the NHS Plan (DH, 2000) address the importance of increasing access to and the consumption of fruit and vegetables. 'Every Child Matters' is the key government policy, relating to children. Obesity is embedded into Staying Healthy, one of five main themes of the policy.

The public health White Paper Choosing Health published in 2004 had a clear focus on prevention and identified obesity as one of its six key areas of public health to be addressed.

More recent Government papers strongly endorse the need for prevention. 'Our Health, Our Care, Our Say' published by the Department of Health in 2006 stated that "health and social care services will provide better prevention services with earlier intervention for improved health, independence and well being". The 'Commissioning Framework for Health and Well-being' published in 2007 gives a mandate to commissioners for a strategic re-orientation towards promoting health and well-being, investing now to reduce future health costs.

There is now a duty upon Primary Care Trusts and Local Authorities to produce Joint Strategic Needs Assessments. A key aim is to identify the health and well being needs and inequalities of the population. Embedded into this is a focus on identifying the prevention needs.

The central theme found in all the policy documents is that prevention and treatment of obesity can only be achieved through a partnership approach. Local Area Agreements and District Council Sustainable Community Strategies are seen as the key drivers for addressing health and well being.

## 3.2 Obesity Targets

### National Targets

In January 2008 'Healthy Weight, Healthy Lives: A Cross Government Strategy for England' was published in which the Government made a strong commitment to tackle obesity.

***Our ambition is to be the first major country to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight. Our initial focus will be on children: by 2020, we aim to reduce the proportion of overweight and obese children to 2000 levels.***

To drive forward the agenda to address obesity the Government has set a childhood obesity target

**PSA target: *by 2020 we will have reduced the proportion of overweight and obese children to 2000 levels***

The Department of Health is responsible for overall policy on obesity and is jointly responsible with the Department for Children, Schools and Families (DCSF) for tackling child obesity. Consequently they are both responsible for the achieving the childhood measurement programme which has been established to monitor progress against the target and to increase understanding at a population level of the problem.

## 3.3 Supporting Targets

### Child Health PSA

Although the ambition covers a period of 12 years, progress for the first three years 2008-11 will be monitored through the inclusion of child obesity as one of the indicators in the Child Health PSA (PSA 12). This will provide a solid platform upon which to expand efforts to reduce the proportion of overweight children, as well as the proportion of obese children in order to fulfil the 2020 ambition.

### 3.4 Local Targets

#### 3.4.1 Childhood Obesity Targets

The PCT has set local childhood obesity targets which will also be included in the new Local Area Agreement currently in development (2008-2011) (Please note these targets have yet to be agreed within the Cambs LAA)

	2008-09	2009-10	2010-11
Percentage of children in reception with height and weight recorded who are obese	10%	10%	10%
Percentage of children in Reception with height and weight recorded	88%	89%	90%
Percentage of children in year 6 with height and weight recorded who are obese	17%	17%	17%
Percentage of children in year 6 with height and weight recorded	88%	89%	90%

#### 3.4.2 Current Cambridgeshire Local Area Agreement (LAA)

The current Cambridgeshire LAA includes these related targets that support the achievement of the obesity target.

- incidence of obesity among children under 11 – to halt the year on year rise in childhood obesity. (block 1, 1.3)
- young people reporting that they exercise at least 3 times a week (block 1, 3.2)
- percentage of adults participating in at least 30 minutes moderate intensity sport and/or active recreation on three or more days a week (block 2, 6.2)
- percentage of 5-16 years olds in school sports partnerships engaged in two hours a week minimum on high quality PE and school sport within and beyond the curriculum (block 2, 6.6)

At the time of writing the new Local Area Agreement (2008-2011) is being agreed. The focus of the new LAA will be 35 indicators selected from the 198 found in the National Indicator Set, plus 5 local indicators.

### 3.4.3 Cambs Obesity related National indicator Set:

NI 8	Adult participation in sport
NI 47-48	People killed or seriously injured in road traffic accidents (safe environments)
NI 56	Obesity among primary schools age children in Year 6
NI 69	Children who have experienced bullying
NI 110	Young people's participation in positive activities
NI 120	All age all cause mortality rate
NI 152-3	Working age people claiming out of work benefits
NI 186	Per capita CO2 emissions in the LA area
NI 188	Adapting to climate change
NI 198	Children traveling to school – mode of travel usually used

#### Other obesity related National Indicators include:

NI 17	Perceptions of anti-social behaviour
NI 48	Children killed or seriously injured in road traffic accidents (safe environments)
NI 50	Emotional health of children
NI 52	Take up of school lunches
NI 53	Prevalence of breastfeeding at 6-8 weeks from Birth
NI 55	Obesity among primary school age children in Reception Year
NI 57	Children and young people's participation in sport
NI 119	Self reported measure of people's overall health and wellbeing
NI 121	Mortality rate from all circulatory diseases at ages under 75
NI 122	Mortality from all cancers at ages under 75
NI 137	Healthy life expectancy at 65
NI 173	People falling out of work and on to incapacity benefits
NI 175	Access to services and facilities by public transport, walking and cycling

### 3.4.4 Children and Young People's Strategic Partnership

In Cambridgeshire the Children and Young People's Strategic Partnership has "The Big Plan" which is the local delivery vehicle for Every Child Matters. Obesity related targets are found in the Plan and the area plans.

### 3.4.5 Sustainable Community Strategies

The District Council Local Strategic Partnerships oversee Sustainable Community Strategies that in turn are reflected in the Local Area Agreement. These drive forward partnership work to improve the health and well being of their communities. All of the Cambridgeshire Strategies include targets relating to obesity.

### 3.4.6 Cambs Food & Health Strategy

The Cambs Food & Health Strategy was finalised in 2007 and priority actions will be taken forward by the Cambs Food & Health Strategy Group. This Group reports to the Cambs Obesity Group. Priorities for 2008-09 are:

- Increasing breast feeding initiation
- Food labelling: national advocacy
- Contributing to the delivery of paediatric/obesity care pathway
- Accessing to food at reasonable cost
- Delivering of cooking skills initiatives
- Work Place Food Policy development
- Introducing Healthy Start

### 3.4.7 Primary Care – Quality & Outcomes Framework (QOF) Obesity targets:

Target PSA10b requires a contribution by GP Practices to the delivery of a Broader Strategy on Obesity by registering their practice population as:

PSA10b4	Total number of people aged 16 and over on GP list, recorded as having a BMI of 30 or greater in the last 15 months
PSA10b5	Total number of people aged 16 and over on GP list, with a BMI recorded in the last 15 months
PSA10b6	Total number of people aged 16 and over on GP list
PSA10b7	The proportion of people aged 16 and over on GP list, with a BMI recorded in the last 15 months recorded as having a BMI of 30 or greater
PSA10b8	The proportion of people aged 16 and over on GP list, with a BMI recorded in the last 15 months

### 3.4.8 Performance Monitoring

The measurements in Reception and Year 6 will be taken as indicators of progress, but the government wants to ensure that action is not solely focused on these age groups. They are therefore committing to publishing an annual report setting out performance against these and other BMI indicators:

- Children in Reception Year: overweight and obesity levels
- Children in Year 6: overweight and obesity levels
- Young adults: overweight and obesity levels (based on Health Survey for England data)
- Adults: overweight and obesity levels (based on Health Survey for England data)

Because changes to population measures of BMI can take some time to become apparent, the government will complement these with a range of early indicators of success which it is yet to finalise.

## **SECTION FOUR: THE EVIDENCE BASE:**

There is strong evidence that the main reason for the rising prevalence of overweight and obesity is a combination of less active lifestyles and changes in eating patterns. Both these factors must be tackled to produce reductions in obesity with even a modest weight loss of 5-10% of body weight in an obese or overweight person resulting in health and well-being benefits.

Evidence also tells us that increasing physical activity and healthier diets in the population is extremely complicated. It includes environmental interventions and behavioural changes that are not always amenable to change and are not fully understood.

However there is a growing body of evidence as more attention has been focussed upon obesity.

The two most influential documents at the time of writing this Strategy are outlined below. This indicates the breadth of the interventions that are required if obesity is to be tackled effectively.

### **4.1 National Institute of Health and Clinical Evidence (NICE)**

The **National Institute of Health and Clinical Evidence (NICE)** has published the following evidence to guide local action. Guidance is published on the NICE website which can be found at: <http://www.nice.org.uk/>.

Published NICE Guidance relevant to preventing obesity includes:

- Obesity – the prevention, identification, assessment and management of overweight and obesity in adults and children
- Obesity – guide for local authorities, schools and early years providers
- Physical activity - brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling
- Physical activity – and the built environment
- Behaviour Change
- Community Engagement

NICE guidance in development relevant to preventing obesity includes:

- Physical activity and the workplace
- Maternal and child nutrition
- Promotion of physical activity in children

## 4.2 The Foresight Report: Tackling Obesities: Future Choices

**The Foresight Report** published in October 2007 by the Government's Office for Science produced a long term vision of how the UK could deliver a sustainable response to obesity over the next 40 years.

The project gathered scientific evidence from across a wide range of disciplines to inform a strategic view.

Five core principles were identified for tackling obesity:

- A system-wide approach, redefining the nation's healthy as a societal and economic issue
- Higher priority for the prevention of health problems, with clearer leadership, accountability, strategy and management structures
- Engagement of stakeholders within and outside Government
- Long-term sustained interventions
- Ongoing evaluation and a focus on continuous improvement

## SECTION FIVE: The OBESITY STRATEGY

The development of this strategy reflects consideration of the following information and directives:

- An understanding of national and local need
- Mapping of existing Cambridgeshire initiatives, links with key policy areas and opportunities for future action against NICE Obesity Guidance (Food & Health, Physical Activity & Health, Mental Health and Social Inclusion)
- National and Local policy and targets
- Evidence

These have generated strategic priorities and interventions that have been incorporated into an overarching Strategy that provides organisations and communities in Cambridgeshire with a focus and direction for working together to tackle obesity.

### 5.1 Determining Priorities

The Government's Obesity Strategy 'Healthy Weight, Healthy Lives: A Cross-Government Strategy for England' (2008) published in January 2008 lays out five priority areas that should be addressed to tackle obesity. These have been adopted as the priority areas for Cambridgeshire.

- Children – healthy growth and healthy weight
- Promoting healthier food choices
- Building physical activity into our lives
- Creating incentives for better health
- Personalised advice and support

The key government commitments are summarized in *Appendix One*.

### 5.2 Strategic Objectives

The Foresight Report indicates that a strategy to tackle obesity needs a comprehensive portfolio of interventions. The following strategic objectives have been based on the Ottawa Charter and will be used to ensure that the priority areas are addressed comprehensively across all organisations and communities

- **Influence public policy** across Cambridgeshire (Local Area Agreements, Sustainable Community Strategies, Children & Young People's Plan, Transport and Road Safety Policy, Land Use Planning etc) to ensure the need to tackle obesity is understood and embedded

- **Create supportive environments** to ensure that environments such as the transport environment, early years, schools, the workplace etc promote physical activity, access to healthy food and inclusion
- **Promote action within communities** to ensure that communities have an opportunity to identify and tackle barriers to change
- **Engage people in their own health (Wanless)** by offering individuals and families opportunities to increase their knowledge, skills and access to weight management services
- **Embed prevention into the work of the NHS** as well as deliver services to people who are obese; this includes work on Long Term Conditions

### 5.3 Determining Priorities for Action:

Both the Foresight Project Report on Tackling Obesity, and NICE Obesity Guidance reinforce the message that effective obesity interventions must be:

- Multi-component
- Avoid a dependence on fragmented solutions
- Avoid focusing too heavily on one element of the obesity system, or on one population group

To complement these principles, priorities for action in Cambridgeshire will:

- Be needs led and evidenced based
- Reduce inequalities
- Contribute to delivery of the five areas of the national Obesity Strategy, national indicator (NI), Cambs LAA and Long Term Conditions targets
- Demonstrate working in partnership, including with local people
- Build capacity and engage people in their own health
- Be sustainable i.e. delivery can be resourced and sustained
- Embed robust evaluation and performance monitoring

All objectives and supporting actions will reflect the messages found in these documents.

### 5.4 The life of this Strategy:

This Strategy outlines objectives and actions to be delivered over three years – 2008-2011. Priorities are identified for Year One (Summer 2008-Summer 2009). Performance will be monitored every quarter and used to influence the choice of priorities for subsequent years.

## **SECTION SIX: IMPLEMENTING THE STRATEGY**

The following plan and appendices identify headline actions required to meet the strategic aims of each of the key areas.

It also identifies what is currently taking place in Cambridgeshire and highlights the gaps.

Actions and gaps have been identified using the mapping of existing Cambridgeshire initiatives, links with key policy areas and opportunities for future action against NICE Obesity Guidance (Food & Health, Physical Activity & Health, Mental Health and Social Inclusion).

This Strategy is for the next three years and each year it will be revised and priorities for action identified.



<p><b>Create supportive environments</b></p>	<ul style="list-style-type: none"> <li>• Encouraging Head Teachers &amp; Chairs of Governors in collaboration with parents &amp; pupils to assess the whole school environment and ensure the ethos of all school policies help children &amp; young people to maintain a healthy weight - in line with standards &amp; guidance. Includes school travel plans (<i>see NICE guidance for details</i>)</li> <li>• Implementation of the Cambs Breast Feeding Strategy</li> <li>• Promotion of Family Learning initiatives</li> </ul>		<p>Healthy Schools Programme PHSE (CCC)</p> <p>Cambs Community Services</p> <p>Cambs County Council</p>
<p><b>Promote action within communities</b></p>	<ul style="list-style-type: none"> <li>• Strengthening Government action by implementation of Cambridgeshire Lunch Box Challenge programme</li> <li>• Implementation of DES, FSA guidance on food procurement and healthy catering – Early years, Nurseries, Child Care facilities</li> <li>• Cambs Catering Service (CCC): develop a whole school approach to healthy eating</li> </ul>	<ul style="list-style-type: none"> <li>• Developing a Lunch Box Challenge Programme</li> </ul>	<p>Cambridgeshire County Council</p>

<p><b>Engage people in their own health</b></p>	<ul style="list-style-type: none"> <li>• Obesity training for staff across the partnership initiated – LPSA Reward grant pending</li> <li>• Through childhood measurement programme provide targeted support to children and their families in line with obesity pathway</li> <li>• Ensure that that there is equity of provision of MEND/TEAM (or comparable evidence based programmes) across the county for all age groups</li> <li>• Active signposting families to programmes eg MEND/TEAM</li> <li>• Increased use of opportunities to promote healthy messages and services through Bookstart and Library Outreach Services</li> <li>• Provide information to all parents from the childhood measurement programme in line with national guidance</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Implementing the National Child Measurement Programme</i></li> <li>• <i>Delivering the TEAM (To Energize And Motivate) programme in South Cambridgeshire to overweight children and their families</i></li> <li>• Piloting Teen-TEAM in South Cambridgeshire</li> <li>• Supporting the delivery of the MEND (Mind, Exercise, Nutrition, Do It!) programme in Cambridge, Hunts, East Cambs and Fenland</li> </ul>	<p>PCT Cambridgeshire County Council District Councils</p>
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<b>Embed prevention and management into the work of the NHS</b>	<ul style="list-style-type: none"><li>• Secure clinical and commissioning support for obesity pathways</li><li>• Embed into contracts with providers</li><li>• Provide training for NHS staff</li><li>• Embed into commissioning objectives</li></ul>	<ul style="list-style-type: none"><li>• Paediatric Obesity Care Pathway developed with key clinicians</li></ul>	PCT
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## Delivering the Obesity Strategy 2008-11

	Priority Area	Lead Partnership: Cambs Food and Health Group	
	Promoting Healthier Food Choices		
Strategic Objective	Actions	Current Activity in Cambs	Lead Organisation (s)
<b>Influence public policy</b>	<ul style="list-style-type: none"> <li>• Influencing national food policy – food labeling</li> <li>• Land Use Planning: local authorities managing the proliferation of fast food outlets in particular areas, eg near parks or schools</li> </ul>	<p>In Cambridgeshire partners are already delivering: see Appendix 1 – Obesity and Food &amp; Health Framework which identifies:</p> <ul style="list-style-type: none"> <li>• NICE recommendations</li> <li>• Existing initiatives being delivered in Cambridgeshire</li> </ul>	



<p><b>Promote action within communities by:</b></p>	<ul style="list-style-type: none"> <li>• Delivering cooking skills initiatives: (1) Cambs Catering Service to set up parent and child cooking sessions in partnership with Extended Schools (2) Cambs ACRE</li> <li>• Introducing Healthy Start</li> <li>• Identifying and promote Local Authorities in Cambs providing locally approved Nutrition Courses</li> <li>• Check Food Hygiene Courses also delivering key messages re: healthy eating</li> </ul>		<p>Cambs Catering Service Cambs ACRE</p>
<p><b>Engage people in their own health by:</b></p>	<ul style="list-style-type: none"> <li>• Reviewing (1) MRC Healthy Living /Social Marketing evidence review and (2) Foresight Report on Obesity – to strengthen the understanding of Partners re: barriers to change</li> <li>• Working with EoE Strategic Health Authority to identify opportunities for procuring Social Marketing support for developing an Obesity Campaign programme</li> <li>• Linking to Books on Prescription project with GPs and Library Service – recommended self-help books prescribed by GPs</li> <li>• Identifying training needs of teaching, support &amp; catering staff – School Meals Service</li> </ul>		<p>Cambs PCT</p> <p>Library Service</p> <p>Cambs Catering Service</p>

<p><b>Embed prevention into the work of the NHS by:</b></p>	<p>As part of the work of the Cambs Food &amp; Health Group a review of :</p> <ul style="list-style-type: none"> <li>• Healthy eating advice offered by primary care and professionals to patients</li> <li>• Catering facilities and access to healthy eating by NHS patients, visitors and staff</li> <li>• Link the work of Cambs. Obesity Group with the Cambs. &amp; Peterborough Mental Health Care Trust</li> </ul>		<p>Cambs PCT</p>
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## Delivering the Obesity Strategy 2008-11

	Priority Area	Lead Partnership: Lead Partnership: Cambs Obesity Group together with Cambs Living Sport	
	Building Physical Activity into our Lives		
Strategic Objective	Actions – to reduce levels of physical inactivity	Current Activity in Cambs	Lead Organisation (s)
<b>Influence public policy</b>	Embed the need to tackle obesity via physical activity into: <ul style="list-style-type: none"> <li>- Sustainable Community Strategies</li> <li>- Cambridgeshire Living Sport Business Plan</li> <li>- Cambridgeshire 2012 Olympics Action Plan</li> <li>- Land use Development Frameworks</li> <li>- Cambs Long Term Transport Strategy and locality Transport &amp; Access Strategies</li> <li>- Cambridge Transport Innovation Fund Study (TIF)</li> <li>- Cambs Older People Strategy</li> <li>- Cambs Road Safety Strategy</li> <li>- Cambs and District Play Strategies</li> <li>- School Travel Plan &amp; Safer Routes to School programmes (active travel)</li> <li>- Building Schools for the Future programme</li> <li>- Crime &amp; Disorder Strategies (safe play and leisure areas)</li> <li>• Develop a Physical Activity Strategic Approach for Cambridgeshire (Living Sport &amp; Cambs Obesity Group partners)</li> </ul>	Physical activity embedded into Sustainable Community Strategies	All

<p><b>Create supportive environments by:</b></p>	<ul style="list-style-type: none"> <li>• Understand barriers to change, especially for those who are physically inactive, to inform a social marketing approach (DOH &amp; Sports England social marketing initiatives)</li> <li>• Develop a local programme to promote physical activity through the creation and management of safe spaces for incidental and planned activity in public places and in schools (Land Use Development Frameworks, Open Spaces Policies and School Sports Partnerships)</li> <li>• Implement, as a partnership, NICE Guidance – Physical Activity and the Built Environment.</li> <li>• Ensure adequate provision of child care facilities</li> </ul>	<ul style="list-style-type: none"> <li>• Cambs PCT: delivery of NICE Guidance (Physical Activity) Brief Interventions in GP Practices in Fenland with support from Local Authority Leisure &amp; Sports Development professionals</li> </ul>	<p>Cambs PCT</p>
<p><b>Promote action within communities by:</b></p>	<ul style="list-style-type: none"> <li>• Maintain levels of investment in locality Leisure and Sports Services – community based activities</li> <li>• Review ‘Invigorate’ multi-sports activity for mental health service users in Cambridge and consider roll-out across other Cambs areas</li> <li>• Link with local Transport Plans to ensure they support initiatives to reduce car use</li> </ul>		

<p><b>Engage people in their own health by:</b></p>	<ul style="list-style-type: none"> <li>• Locally implement the 'Small change, Big Difference' population based campaign</li> <li>• Review (1) MRC Healthy Living /Social Marketing evidence review and (2) Foresight Report on Obesity – to strengthen the understanding of Partners re: barriers to change</li> <li>• Work with EoE Strategic Health Authority to identify opportunities for procuring Social Marketing support for developing an Obesity Campaign programme</li> <li>• Families with children – learning and doing activities together</li> </ul>		
<p><b>Embed prevention into the work of the NHS by:</b></p>	<ul style="list-style-type: none"> <li>• Implement NICE Guidance – Four commonly used methods to increase physical activity</li> <li>• Link with development of Cambs Mental Health Promotion Strategy</li> <li>• Link the work of Cambs. Obesity Group with the Cambs. &amp; Peterborough Mental Health Care Trust</li> </ul>		

## Delivering the Obesity Strategy 2008-11

	Priority Area	Lead Partnership: Area Improving Health Partnerships	
	Creating Incentives for Better Health		
Strategic Objective	Actions	Current Activity in Cambs	Lead Organisation (s)
<b>Influence public policy</b>	<ul style="list-style-type: none"> <li>• Influence wider roll-out of workplace policies to tackle obesity via the Cambridgeshire Together (Cambs Local Area Agreement) based on the Smoke Free Cambridgeshire model) – and via locality Improving Health Partnerships/locality Obesity Groups</li> </ul>	In Cambridgeshire partners delivering: see Appendices 4, 5, & 6 - which identify: <ul style="list-style-type: none"> <li>• NICE recommendations</li> <li>• Existing initiatives being delivered in Cambridgeshire</li> <li>• Opportunities for future action</li> </ul>	All

<p><b>Create supportive environments by:</b></p>	<p>Implement NICE Obesity Guidance 43 for Local Authorities etc in <b>partner workplaces</b>.</p> <ul style="list-style-type: none"> <li>• Provide opportunities for staff to be physically active – and which includes active travel policies for staff and visitors, improvements to stairwells, provision of showers and secure cycle parking</li> <li>• Support out of hours activities such as lunchtime walks &amp; the use of local leisure facilities</li> <li>• Provide sustainable incentive schemes as part of a wider programme to encourage physical activity eg travel expenses policy, contributions to gym membership</li> <li>• Ensure employee checks address weight diet and activity and provide ongoing support</li> <li>• Beginning with Cambs Obesity Group partner organisations, audit existing Hospitality &amp; Catering Policies (inc Vending Machines) to identify models of local best practice in promoting opportunities for staff, visitors and service users to eat a healthy diet – and roll-out</li> </ul>		
<p><b>Promote action within communities by:</b></p>	<ul style="list-style-type: none"> <li>• Reviewing NICE Guidance – Physical Activity and the Workplace – to be published Summer 2008 and considering implications for workplaces – as ‘communities’</li> <li>• Together with Living Sport, review outcomes from local ‘Fit for Business’ pilots</li> </ul>		

<b>Engage people in their own health by:</b>	<ul style="list-style-type: none"> <li>• Offer staff tailored education &amp; promotion to support action to improve physical activity and healthy eating</li> </ul>		
<b>Embed prevention into the work of the NHS by:</b>	<ul style="list-style-type: none"> <li>• Developing a model NHS Obesity Workplace Policy for patients, staff and visitors – and encouraging roll-out to Acute Trusts, Cambs &amp; Peterborough Mental Health Care Trust, Cambridgeshire Community Services and Primary Care Practices</li> </ul>		

## Delivering the Obesity Strategy 2008-11

	Priority Area	Lead Partnership: Cambs Obesity	
	<b>Personalised Advice and Support – Weight Management in the Community</b>		
Strategic Objective	Actions	Current Activity in Cambs	Lead Organisation (s)
<b>Influence public policy</b>	<p>Ensure that the management of obesity is embedded in to</p> <ul style="list-style-type: none"> <li>• Sustainable community strategies</li> <li>• PCT Clinical Policies – and the Clinical Policies of other local NHS organisations</li> <li>• Commissioning Intentions – PCT &amp; Partners</li> </ul>		PCT and Partners

<p><b>Create supportive environments by:</b></p>	<p>Build a consistent approach to weight management, in line with NICE Obesity Guidance 43, across Cambridgeshire linking prevention, primary and secondary care by:</p> <ul style="list-style-type: none"> <li>• Developing, implementing and evaluating a Cambridgeshire Adult Obesity Care Pathway, in line with NICE Obesity Guidance 43 – and linking with relevant Long Term Conditions and Mental Health care pathways</li> <li>• Reviewing obesity drug prescribing in Cambridgeshire</li> <li>• Reviewing ‘Coping with Coming Off ‘ initiative – raising awareness, providing support, promoting choice about psychiatric drugs and their side-effects, which can include weight gain</li> <li>• Adult Obesity: ongoing evaluating outcomes from Fit for the Future, CHIPS and Fenland Weight Management pilots to inform commissioning in 2009-2010</li> <li>• Considering the role of other NHS professionals, such as community pharmacists, in offering weight management advice</li> <li>• Assessing the feasibility of delivering a specialist, intensive obesity service in community settings</li> <li>• Reviewing the evidence linking mental health promotion, social inclusion and obesity to influence future intervention design</li> </ul>	<p>Existing management programmes at different stages of evaluation.</p> <p>Clinical policy for Obesity Surgery in place for Cambs. PCT.</p>	<p>PCT and District Councils</p>
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<p><b>Promote action within communities by:</b></p>	<ul style="list-style-type: none"> <li>• Develop a community development approach to weight management which complements the CHIP and Fit for the Future approaches, in partnership with Local Authorities</li> </ul>		
<p><b>Engage people in their own health by:</b></p>	<ul style="list-style-type: none"> <li>• Integrate Books on Prescription Service into weight management interventions to support self-help, learning and engagement</li> <li>• Social Marketing (see previous sections)</li> <li>• Implement a training programme that will enable staff from different organisations to make appropriate preventative and treatment interventions (LPSA reward funding application)</li> </ul>		
<p><b>Embed prevention into the work of the NHS by:</b></p>	<p>Ensure primary and secondary obesity prevention and management is integrated into other key strategies and initiatives, such as the:</p> <ul style="list-style-type: none"> <li>• Cambs PCT Long Term Conditions Strategy (which includes COPD, Diabetes, Vulnerable Older people, Mental Health, CHD)</li> <li>• Service Redesign</li> </ul> <p>Review the ‘Commissioning Weight Management Programmes for Children and Adults Toolkit’ being published by the Cross-Government Obesity Unit in Summer 2008</p>		

## **SECTION SEVEN: PERFORMANCE MONITORING & AUDIT**

### **7.1 Local Monitoring**

**The implementation of this Obesity Strategy will be monitored by:**

	<b>INDICATORS</b>	<b>FREQUENCY</b>	<b>REPORTER</b>
1.	National obesity related indicators – see page 8	Quarterly	
2.	Cambs LAA obesity related indicators – see page 8	Quarterly	
3.	National PSA target – childhood obesity – see page 8	Annually	Cambs PCT
4.	NICE Obesity Guidance 43 – Audit Criteria	Annually (baseline audit – 2008)	Cambs PCT
5.	Primary Care Obesity QOF data – see page 8	Quarterly	Cambs PCT
6.	Annual Cambs Obesity Strategy Check – see page 38	Annually	Cambs Obesity Group

**Performance will be reported to:**

- Cambridgeshire Together – Local Area Agreement Board
- Cambridgeshire Obesity Group
- Locality Local Strategic Partnerships
- Locality Improving Health Partnerships
- Locality Obesity Groups

## 7.2 Models for Monitoring

The Foresight Report offers a checklist of 'critical dimensions' which partners may wish to use to ensure annual priorities for action will maximise effectiveness. These are:

### **Does the strategy:**

- Contain interventions that act at different levels with varying but cumulative degrees of impact?
- Influence a broad set of systems levers (physiological/psychosocial/food related factors and the physical activity environment)?
- Obtain a balance between population-level measures and targeted interventions?
- Act at multiple levels, from the national through the local to the individual?
- Take time into account (e.g. life-course and generational effects)?
- Have interim targets and measures, as well as a long-term obesity goal?
- Actively seek alignment with other policy agendas, recognising synergies and conflicts?
- Engage a broad range of stakeholders?
- Consider the balance between cost-effectiveness and achievability?
- Consider the impact on and implications for health inequalities?

### **Is the strategy supported by:**

- An ongoing strategy development process underpinned by expert analysis, data-gathering processes and a robust evaluation framework?
- Suitable (local government, PCT) management structures to enable clear leadership, strategy formulation and co-ordination of action across partnerships and with other key stakeholders?
- Underpinning risk analysis (for management of unexpected consequences)?
- Sufficient resources to enable a scaled-up response?

## **APPENDIX ONE**

### **Department of Health Obesity Strategy: Healthy Weight, Healthy Lives (published 2008)**

Government action outlined in this Strategy includes (see: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_082378](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378))

#### **Children – healthy growth and healthy weight:**

- Identify at risk families as early as possible and promote breastfeeding as the norm for mothers
- give better information to parents about their children's health by providing parents with their child's results from the National Child Measurement Programme (NCMP)
- invest to ensure all schools are healthy schools, including making cooking a compulsory part of the curriculum by 2011 for all 11–14 year-olds
- ask all schools to develop healthy lunch box policies, so that those not yet taking up school lunches are also eating healthily
- develop tailored programmes in schools to increase the participation of obese and overweight pupils in PE and sporting activities
- invest £75 million in an evidence-based marketing programme which will inform, support and empower parents in making changes to their children's diet and levels of physical activity
- invest in improving cycling infrastructure and skills in areas where child weight is a particular problem, as part of the recently announced package of further funding of £140m for Cycling England

#### **Promoting Healthier Food Choices:**

- Finalise a Healthy Food Code of Good Practice, in partnership with the food and drink industry, and other relevant stakeholders. This code would challenge the whole industry to adopt practices to reduce consumption of saturated fat, sugar and salt among other measures
- Promote the flexibilities contained within planning regulations, so that local authorities are able to manage the proliferation of fast food outlets in particular areas, eg near parks or schools
- Ask Ofcom to bring forward its review of restrictions on the advertising of unhealthy foods to children, to begin in July 2008 and report early findings as soon as possible

#### **Building Physical Activity into our Lives:**

- Invest in a 'Walking into Health' campaign, aiming to get a third of England walking at least 1,000 more steps daily by 2012

- Invest £30m in 'Healthy Towns' – working with selected towns and cities to build on the successful *Ensemble prevenons l'obesitie des enfants* (EPODE) model used in Europe, with infrastructure and other best practice models to validate and learn from whole-town approaches to promoting physical activity
- Set up a working group with the entertainment technology industry to ensure that they continue to develop tools to allow parents to manage the time that their children spend playing sedentary games online
- Review the overall approach to physical activity, including the role of Sport England, to develop a fresh set of programmes ensuring that there is a clear legacy of increased physical activity leading up to and after the 2012 Games

### **Creating Incentives for Better Health:**

- Work with employers and employer organizations to develop pilots exploring how companies can best promote wellness among their staff and make healthy workplaces part of their core business model
- Launch a number of pilots of wellbeing assessments throughout the Spring 2008, where individual staff are offered personalized health advice and lifestyle management programmes linked to personal assessments of their health status
- Pilot and evaluated a range of different approaches to using personal financial incentives to encourage healthy living, such as individuals losing weight and sustaining weight loss, eating more healthily or being consistently more physically active

### **Personalised advice and support – weight management in the community:**

- Seek to develop the NHS Choices website to give highly personalized advice to all on their diet and activity levels, with clear and consistent information on how to maintain a healthy weight
- Support the commissioning of more weight management services by providing extra funding for this over the next three years

## **APPENDIX TWO WEIGHT MANAGEMENT IN PRIMARY AND SECONDARY CARE – PRESCRIBING –**

### **NICE Obesity Guidance 43:**

NICE Guidance proposes that drug treatment for Obesity should be considered:

- only after dietary, exercise and behavioural approaches have been started and evaluated
- for patients who have not reached their target weight loss or have reached a plateau on dietary, activity and behavioural changes alone

### **In Cambridgeshire:**

- The prescribing of the two well-established anti-obesity drugs (orlistat and sibutramine) is as set out in the December 2006 NICE Clinical Guideline on managing obesity.
- In line with NICE, treatment with anti-obesity medications is for a limited period (usually up to 12 months per patient) and is stopped if the patient does not benefit by losing weight or if they, as happens occasionally, suffer side-effects
- 12, 000 prescriptions in a twelve-month period means that about 1,000 to 1,500 people each year (almost all adults) in Cambridgeshire are receiving these medications to help them lose weight (out of an adult population of about 500,000)
- The prescribing in Cambridgeshire is very similar to the picture in the rest of England; this is known because the data on use in England was set out by NICE in its review of the implementation of this clinical guideline
- Approximately 12,300 prescription items were dispensed in 2007 at an approximate cost of £430,000 (data on prescribing in December 2007 is not yet available and so this figure is an estimate)

## APPENDIX THREE OBESITY SURGERY

### **NICE Obesity Guidance 43:**

Surgery is recommended as a treatment option for adults with obesity if all of the following criteria are fulfilled:

- they have a BMI of 40 kg/m<sup>2</sup> or more, or between 35 kg/m<sup>2</sup> and 40 kg/m<sup>2</sup> and other significant disease (for example, type 2 diabetes or high blood pressure) that could be improved if they lost weight
- all appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least 6 months
- they have been receiving or will receive intensive management in a specialist obesity service
- they are generally fit for anaesthesia and surgery
- they commit to the need for long-term follow-up

Surgery is also recommended as a first-line option (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m<sup>2</sup> in whom surgical intervention is considered appropriate.

### **The Criteria for Referral of Morbidly Obese Patients for Surgical Assessment in the East of England are:**

Morbidly obese individuals (BMI>40) with type 2 diabetes and/or severe sleep apnoea (excludes hypertension)

**AND**

Who are in the 18-60 years age group.

**AND**

Have been receiving intensive obesity management for at least 6 months and have tried all appropriate and available non-surgical measures adequately, but have not been able to maintain weight loss. (See definition of obesity clinics below).

*Proposed referrals for individuals with other co-morbid conditions or other significant health issues who might benefit from bariatric surgery (for example a young person with BMI>50 with no co-morbidity) may be sent to the East of England Specialist Commissioning Team (EOESCT) for clinical consideration or facilitation within any appeals process by the patient's PCT.*

### **Cambridgeshire & Peterborough Public Health Network – Bariatric Surgery Policy:**

See:

<http://www.cambsphn.nhs.uk/documents/Lower%20Clinical%20Policies/Bariatric%20Surgery.pdf?preventCache=15%2F01%2F2008+07%3A28>

## BIBLIOGRAPHY, RECOMMENDED READING & WEBLINKS

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## **CAMBRIDGESHIRE OBESITY GROUP**

### **Member organisations include:**

- Cambridgeshire County Council – Office of Children & Young people
- Cambridgeshire County Council – Catering Services
- Cambridgeshire County Council – Library Services
- Cambridgeshire County Council – Trading Standards
- NHS Cambridgeshire (Commissioning) – Public Health
- NHS Cambridgeshire (Commissioning) – Children & Young People
- Cambridgeshire Community Services – Dietetic Department
- Cambridgeshire Community Services – Public Health
- Cambridgeshire Community Services – Children Services
- Cambridgeshire Health Promoting Schools
- Cambridgeshire Living Sport (Sport England)
- Hunts Locality Obesity Group
- Huntingdonshire District Council – Environmental Health
- Huntingdonshire District Council – Leisure & Sports Services
- East Cambs & Fenland Locality Obesity Group
- Fenland District Council – Leisure & Sports Services
- Cambridge & South Cambs Locality Obesity Group
- Cambridge City Council – Leisure & Sports Services
- South Cambs District Council – Environmental Health
- South Cambs District Council – Sports Development Services
- East Cambs District Council – Leisure & Sports Services
- Addenbrookes Hospital – Specialist Obesity Service
- Medical Research Council – Epidemiology Unit
- Education – Head Teacher Representatives

This partnership group is administered by NHS Cambridgeshire  
For further information about the administration of this group contact:

Julie Istead, NHS Cambridgeshire  
Email: [julie.istead@cambridgeshire.nhs.uk](mailto:julie.istead@cambridgeshire.nhs.uk)  
Tel: 01480 372022