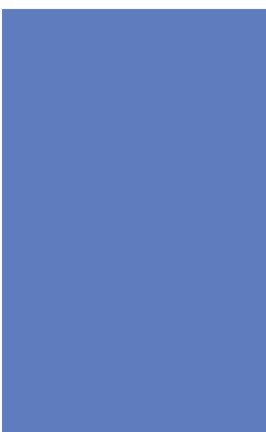
The Health of the Population

A strategy to reduce obesity in Cornwall and Isles of Scilly

2006

The Annual Report of the Directors of Public Health for Cornwall and Isles of Scilly

Central Cornwall PCT
North and East Cornwall PCT
West of Cornwall PCT



Part 2

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Part 2

Improving health through achieving and maintaining a healthy weight

A strategy to reduce obesity in Cornwall and Isles of Scilly

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Introduction

Widespread attention is being given to obesity as a current public health problem.

This is because obesity:

- has serious health consequences,
- affects large numbers of people,
- is affecting increasing numbers of people,
- results in inequalities in health, and
- is, in theory, preventable.

In recognition of the importance of obesity as a public health problem, the public health teams in Cornwall have worked with partners from within and outside the NHS over the past year to agree a strategy to reduce obesity. The strategy is reported here.

This report is divided into three sections:

Section 1 looks at the nature and extent of the problem

Section 2 examines the causes and potential solutions

Section 3 describes the recommended way forward to tackle the problem

Section 1. The nature and extent of the problem

What is obesity?

Overweight and obesity are conditions in which body fat stores are enlarged to an extent that impairs health.[1] In adults the Body Mass Index (BMI) is usually used to measure overweight and obesity. This is a measure of weight in relation to height (box 1). It is important to remember that BMI does not directly measure body fat (adipose tissue). As a result very muscular people may have a BMI that identifies them as overweight even though they do not have excess body fat. BMI may also fail to accurately reflect fat/adipose tissue status in those who are very short or very tall. Hence BMI is used as a guide, not a diagnostic tool. Table 1 shows how BMI is associated with levels of risk of ill health. There is also increased health risk for those who develop what is known as central obesity, that is, they have increased fat around their middle. Waist measurements (box 2), therefore, can give an indication of health risk, as shown in table 2.

TABLE 1. CLASSIFICATION OF HEALTH RISK ASSOCIATED WITH BODY MASS INDEX FOR ADULTS

Classification	BMI	Risk of co-morbidities
Underweight	<18.5	Low – but increased risk of other clinical problems
Desirable weight	18.5 – 24.9	Average
Overweight	25 – 29.9	Mildly increased
Obese – Class I	30 – 34.9	Moderate
Obese – Class II	35 – 39.9	High
Obese – Class III (severely or morbidly obese)	> 40	Very high

SOURCE: DEPARTMENT OF HEALTH. CARE PATHWAY FOR THE MANAGEMENT OF OVERWEIGHT AND OBESITY

Definition of Body Mass Index:
BMI = weight (kg)/height (m)^2
or in imperial measurements:
(weight (lb)/height (inches)^2) x 703

BOX 1. HOW TO CALCULATE BMI

Waist measurements should be taken at a level mid way between the top of the hips and the bottom of the ribs, after breathing out gently. The tape measure should fit snugly around the waist and not be tight.

BOX 2. HOW TO TAKE A WAIST MEASUREMENT

What are the health consequences of obesity?

It has been estimated that obesity accounts for around 30,000 deaths a year in England and this is likely to rise. Obesity is estimated to reduce life expectancy by about nine years.[3]

Six percent of deaths are attributable to obesity. To put this into context, smoking – another major public health problem that has been a regular feature in the annual report of the Director of Public Health – is responsible for 10% of deaths.

Obesity greatly increases the risk of developing type 2 diabetes and coronary heart disease. Obese people are also at increased risk of some cancers, most notably breast cancer in postmenopausal women, but also endometrial, uterine and gall bladder cancer in women and cancer of the colon, rectum and prostate in men.

Table 2. Classification of health risk associated with waist measurement for adults

Waist measurement for	at increased risk	at high risk
European men	94cm (37 inches)	102cm (40 inches)
Asian men	90cm (36 inches)	
European and Asian women	80cm (32 inches)	88cm (35 inches)

Source: British Dietetic Association [2]

Physical symptoms of being overweight or obese include back pain, osteoarthritis, varicose veins and stress incontinence. Obese people are also more likely to suffer from social discrimination and from psychological problems, such as low self-esteem, anxiety and depression. The Department of Health has set out some of the consequences of obesity according to levels of risk, reproduced in table 3.

How many people are affected?

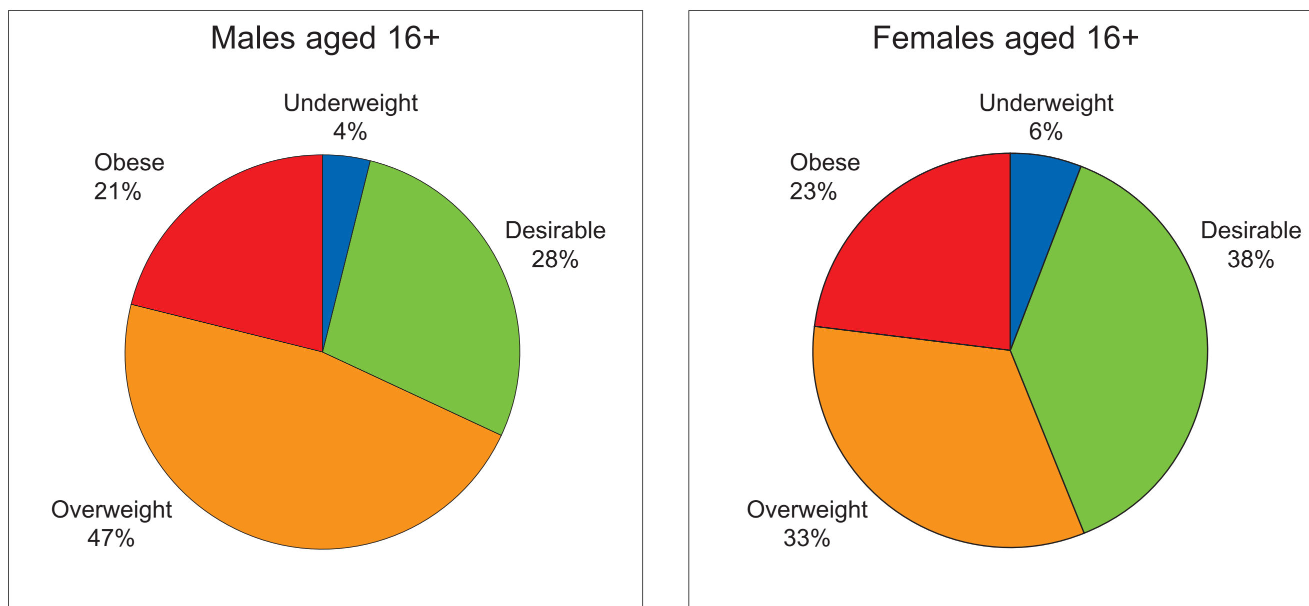
The prevalence of overweight and obesity is high and is rising. In 2001, over a fifth of males and females aged 16 and over in England were classified as obese (figure 1). A further half of men and third of women were classified as overweight.

Table 3. The health consequences of being overweight or obese

Greatly increased risk	Moderately increased risk	Slightly increased risk
• Type 2 diabetes • Gall bladder disease • Dyslipidaemia • Insulin resistance • Breathlessness • Sleep apnoea	• Cardiovascular disease • Hypertension • Osteoarthritis (knees) • Hyperuricaemia and gout	• Some cancers (colon, prostate, post-menopausal breast and endometrial) • Reproductive hormone abnormalities • Polycystic ovary syndrome • Impaired fertility • Low back pain • Anaesthetic complications

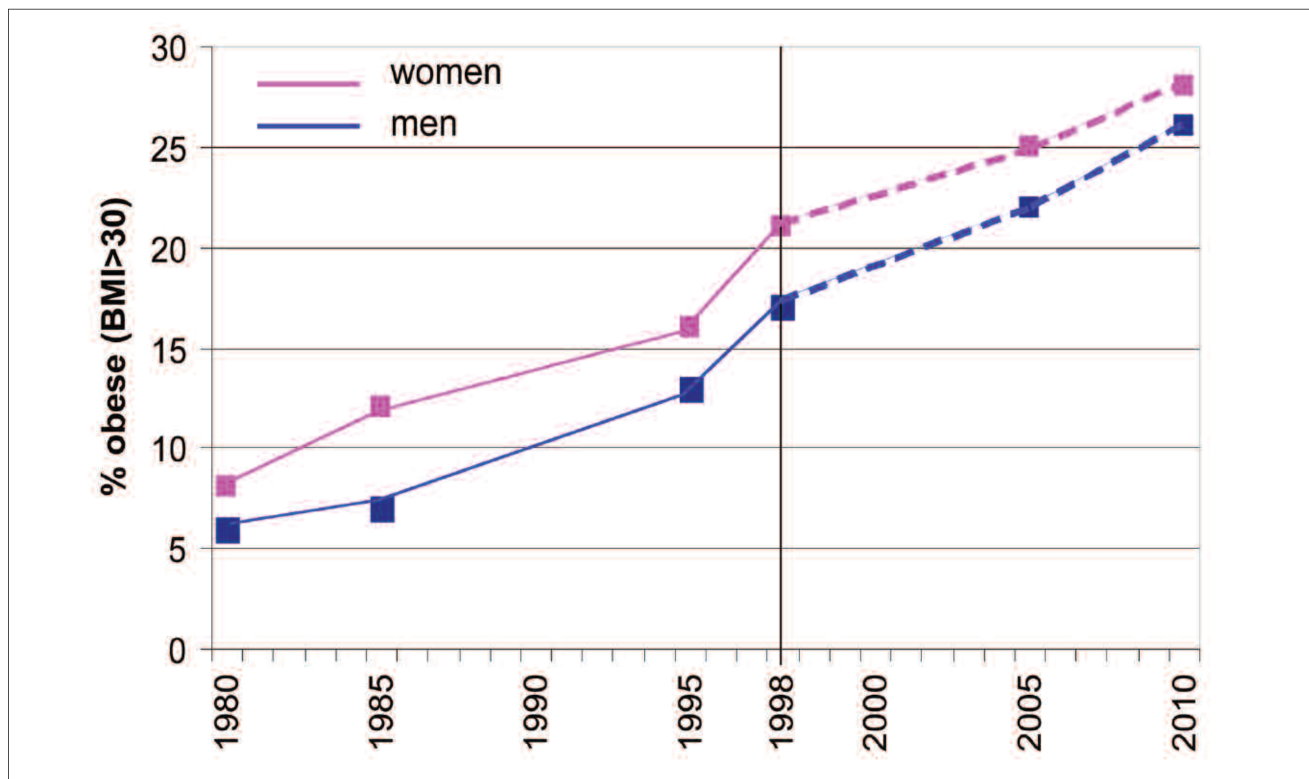
Source: Care pathway for the management of overweight and obesity. Department of Health

Figure 1. Body mass in male and female population, 2001



Source: Health Survey for England

FIGURE 2. TRENDS IN THE PREVALENCE OF OBESITY AMONG MEN AND WOMEN, EXTRAPOLATED TO 2010



SOURCE: HEALTH SURVEY FOR ENGLAND

The prevalence of obesity among adults trebled between 1980 and 1998. If these trends continue it is estimated that over one quarter of the population will be obese by the year 2010. (figure 2).

This public health problem is not confined to the adult population. Around one in four 11 to 15 year olds is considered obese. The number of obese children is rising in all age groups.[i] Obesity prevalence in 11-15 year olds for the period 1995 to 2004 increased from 14% to 24% for boys and from 15% to 26% for girls. Obesity prevalence in boys aged 2 to 10 increased from 10% in 1995 to 16% in 2004 and for girls from 10% in 1995 to 11% in 2004.[ii]

What does this mean in Cornwall?

We do not have data to describe the prevalence of obesity in Cornwall and Isles of Scilly, and can only make estimates based on the prevalence elsewhere. This means that we cannot identify variations within the county or monitor local changes. However, systems have been introduced this year for GPs to keep adult obesity registers and for Primary Care Trusts, in partnership with schools, to monitor obesity levels in reception and year 6 school children. These systems have the potential to reveal the scale of the problem at a local level and to measure trends over time. This will be of value in checking whether action aimed at tackling obesity is working.

[i] A child is classified as being obese when their BMI is in the highest 5% (above the 95th percentile) of values for boys or girls of their age based on a reference population (in this case, the UK BMI reference data), and overweight if it is in the 10% below the highest 5% (85th to 95th percentile).

[ii] There is some disagreement about how obesity should be defined for children. These figures are based on the UK National BMI standards for defining obesity in children, which overestimate the prevalence of obesity when compared with the international classification system. However, the increasing prevalence of obesity is not in doubt.[4]

Who is most likely to be affected?

Research has shown that there are both particular groups and particular points in life where there is an increased risk of weight gain. People at greatest risk are shown in table 4.

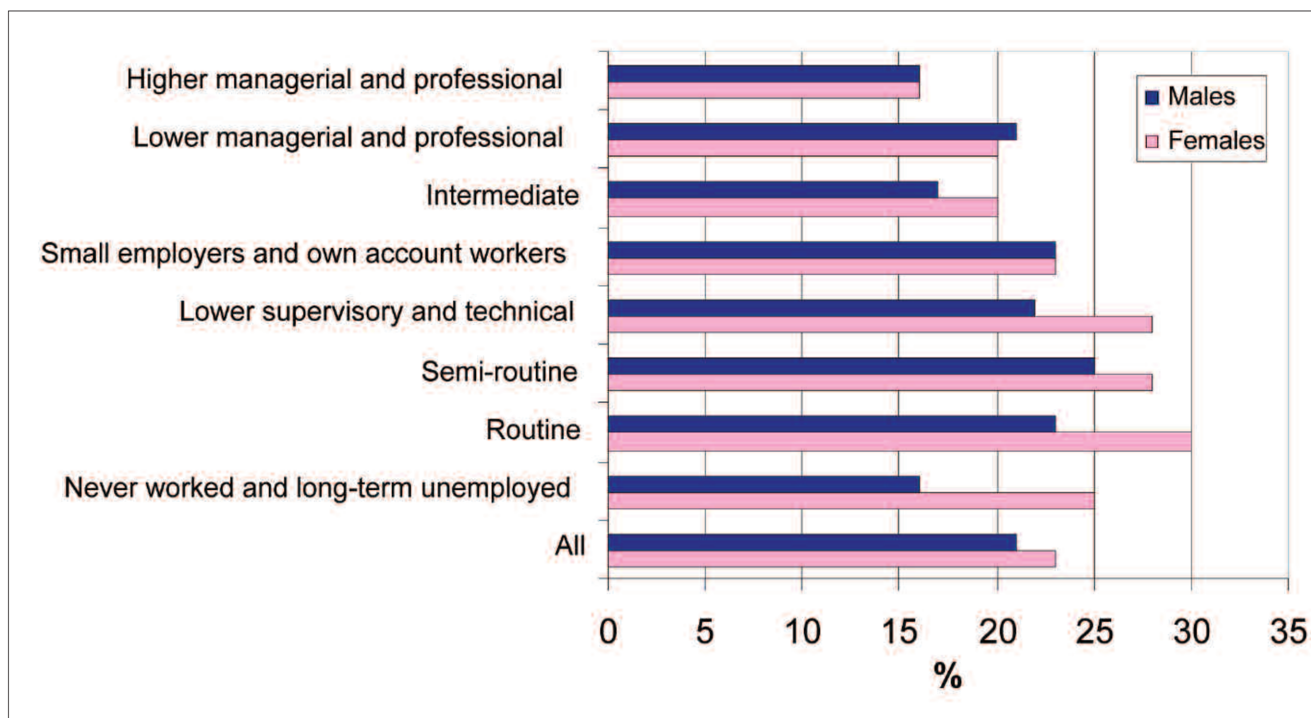
High risk groups	High risk times
• People in lower socioeconomic groups • Some ethnic groups • Those who are/were overweight as children • Children with at least one obese parent • People with mental or physical disability	• Women in late adolescence, pregnancy and menopause • Men between the ages of 35 and 40 • After marriage and retirement • After stopping smoking

TABLE 4. INCREASED RISK OF GAINING EXCESS WEIGHT

Using BMI as a measure, Irish and Black Caribbean men, and Black Caribbean, Black African and Pakistani women are more likely than the general population to be overweight and obese.[5] Asian populations experience greater morbidity from being overweight or obese; they may be at risk with a BMI of >22 to >25 (in different Asian populations) and at high risk with a BMI of >26 to >31. Similarly, the waist circumference at which health risk becomes significant is lower for Asian men (see table 2).

Obesity is linked to social class, being more common among those in the routine or semi-routine occupational groups than the managerial and professional groups. The link is stronger among women (figure 3). In 2001, 30% of women in routine occupations were classified as obese compared with 16% in higher managerial and professional occupations.

FIGURE 3. THE PREVALENCE OF OBESITY, BY SEX AND SOCIOECONOMIC CLASSIFICATION



SOURCE: HEALTH SURVEY FOR ENGLAND 2001.

Section 2. The causes and potential solutions

Why do people become overweight or obese?

People gain weight when their energy input (calories consumed) exceeds their energy expenditure (physical activity and basal metabolic rate). People vary in their propensity to put on weight; for each individual, body weight is influenced by a combination of genetic, metabolic and behavioural factors. Behaviour, in turn, can be influenced by cultural, environmental and socioeconomic influences.

Why has the prevalence of overweight and obesity increased in recent years?

The fact that the prevalence of obesity has risen dramatically within just a few generations suggests that the cause is behavioural, due to lifestyle changes. The two behavioural factors that influence body weight – diet and physical activity – have both changed considerably in recent decades.

Changes in physical activity

People are leading increasingly sedentary lifestyles. In 1986 the number of young people performing two or more hours of physical activity within the school curriculum was 46%. In 1996 it was 33%. In the 1960s the average person watched TV for 13 hours per week, compared with over 26 hours in the mid 1990s.

Car usage is increasing for ever-smaller journeys. Between 1994 and 2004 the proportion of children walking to school declined from 61% to 50% and there was an increase from 30% to 41% in the proportion being driven to school.[6]

Labour saving devices have reduced the amount of physical activity that is required to maintain the home, and the electronic revolution has reduced the effort required to access information and entertainment.

Box 3. Recommendations

Diet	Alcohol consumption
Recommendations taken from *The balance of good health* (summarised by the FSA): • Base your meals on starchy foods. • Eat lots of fruit and vegetables. • Eat more fish – including a portion of oily fish each week. • Cut down on saturated fat and sugar. • Try to eat less salt – no more than 6 g a day for adults*. • Get active and try to be a healthy weight. • Drink plenty of water. • Don't skip breakfast. • And remember to enjoy your food! *The maximum amount of salt recommended for children is less than that for adults – see www.eatwell.gov.uk for specific recommendations.	The Department of Health advises that men should not drink more than 3 to 4 units of alcohol per day, and women should drink no more than 2 to 3 units of alcohol per day. These daily benchmarks apply whether individuals drink every day, once or twice a week, or occasionally. A unit is half a pint of standard strength (3 to 5% ABV) beer, lager or cider, or a pub measure of spirit. A glass of wine is about 2 units and 'alcopops' are about 1.5 units.

Dietary changes

As people are exercising less they need fewer calories, and there has been a small decrease in average daily calorie intake over the last decade, and a small increase in fruit and vegetable consumption. However, these findings are based on self-reported eating patterns. People tend to under-report the amount they eat, particularly with regard to foods perceived to be 'bad' for health.

Regardless of changes in reported calorie intake, there have been changes to eating patterns. As a society we are spending an increased proportion of the family food budget on food consumed outside or delivered to the home. We are increasingly relying on highly processed 'convenience' foods, which tend to be high in calories.

Adults and children are exposed to large numbers of TV advertisements for highly processed, high calorie snacks, drinks and confectionery.

Formal family meals are being replaced by a grazing or snacking style of eating, and cooking, menu planning and food shopping skills are decreasing. Added to this, portion sizes have got bigger and alcohol consumption has increased.

Physical activity

Adults

- **For cardiovascular health**, all adults are advised to take 30 minutes moderate activity on at least 5 days of the week. Activities that improve strength, coordination and balance are particularly beneficial for older people.
- **To prevent obesity** in the absence of an energy intake reduction, 45–60 minutes moderate activity on at least 5 days of the week may be needed.
- **To prevent regaining weight** following weight loss, 60–90 minutes moderate activity on at least 5 days of the week may be needed. This will depend on energy intake.

Children and young people

- For **general health benefits** from a physically active lifestyle, children and young people should take at least 60 minutes of at least moderate intensity physical activity each day, although this may be inadequate to prevent obesity. 60-70% of children meet these recommendations yet the prevalence of obesity continues to rise.

What can be done?

In theory, most people could control their weight by reducing the calories consumed and increasing the calories they use, i.e. they could eat and drink less and exercise more. Box 3 lists relevant recommendations for following a healthy lifestyle.

Although simple in description, this is not easy to achieve; behaviour is influenced by external factors. It can be difficult to change behaviour and even more difficult to sustain the changes.

What is the evidence for what works?

There is evidence that obesity-associated health risks can be reversed with weight loss. Therefore the strategy should address the need to prevent weight gain in some and to assist weight loss in others.

Even small changes in diet and daily physical activity can significantly increase a person's lifespan. Evidence of this has led to the *Small Change, Big Difference* campaign, supported by the Department of Health.[7]

The National Institute for Health and Clinical Excellence (NICE) has published guidance on the use of anti obesity drugs and the use of surgery to aid weight reduction.[8-10] This guidance should be reflected in care pathways for overweight and obese patients.

NICE has also recently reviewed the evidence for what works in preventing and managing obesity, published as draft recommendations for consultation.[11,iii] This guidance recognises that there is no simple – or single – solution. Multifaceted approaches are likely to be most effective. Action that addresses both diet and physical activity is likely to be more effective than tackling one or the other in isolation.

[iii] Final guidance is due to be published in November 2006.

Section 2. The causes and potential solutions

The following recommendations have been identified by NICE as priorities for implementation.

Organisation	Recommendations
NHS	All primary care settings must ensure that systems are in place – through the establishment of a local obesity strategy – to enable appropriate healthcare professionals in all settings (singly and as part of multidisciplinary teams) to implement ongoing multi-component interventions to prevent obesity, addressing both diet and activity.
Local authorities and partners	Local authorities should engage with local partners to consider the quality and layout of the local environment and consider options for maximising users' activity levels and creating safe spaces for incidental and planned physical activity (including cycling and walking routes and integrated play areas). As such: • Local authorities should actively promote new and existing schemes, with tailored information and support, particularly for inactive, vulnerable groups. Facilities should be in place to support such schemes (for example, benches, bike stands, area maps). • The design of all buildings and spaces should encourage users to be more physically active (for example, positioning and promotion of stairs and walkways).
Pre-school settings	All nurseries and childcare facilities should take action to improve children's dietary intakes and physical activity levels by: • minimising sedentary activities during leisure time; providing regular opportunities for active play and providing structured physical activity sessions • implementing the Department for Education and Skills (DfES) and Food Standards Agency (FSA) guidance on food procurement and healthier catering. All action should be supported by ongoing advice for parents.
Schools	All head teachers and chairs of governors should undertake a full assessment of the whole of the school environment and consider the implication of all school policies on the ability of children and young people to maintain a healthy weight, eat a healthier diet and be physically active, in line with existing guidance. This includes policies relating to selection processes, new and existing building layout and the provision of open/recreational spaces, catering provision (including vending) and the food that children bring into school, the taught curriculum (including physical education), all before- and after-school clubs, school travel plans and policies relating to the national *Healthy Schools* programme and extended schools, as appropriate.
Work places	Work places should provide opportunities for staff to eat a healthier diet and be more physically active. As such, all food provision for staff and clients should actively and continuously promote healthier choices, in line with existing guidance from the Food Standards Agency. Work places should implement tailored physical activity programmes, which include ensuring a supportive physical environment (such as stairs, showers, cycle parking), working practices and policies (such as active travel policies) and recreational opportunities (such as supporting out-of hours social activities, use of leisure facilities/groups).

Table 5. Public Health recommendations

What has been happening in Cornwall?

Current services and programmes are varied. Numerous preventive projects and initiatives aim to increase physical activity and healthy eating, but many rely on short term funding. The prevention and management of overweight and obesity in the health services has evolved without strategic direction.

Although there are examples of good practice, overall there are variations in quality and capacity. Secondary care provision in Cornwall (for specialist assessment of the morbidly obese, appropriate medical or surgical treatment, and follow up) is extremely limited.

Age group	Recommendations
Children and adults	Multi-component interventions are the treatment of choice. These should encompass behavioural change to: increase physical activity, decrease inactivity, improve eating behaviour, quality and/or quantity of the diet.
Children	Interventions for childhood obesity must address lifestyle changes within the family and social settings. Body mass index (BMI) is recommended as a practical estimate of general adiposity in children and young people and should be related to the UK 1990 BMI charts to give age- and gender-specific information. However, this needs to be interpreted with caution as it is not a direct measure of adiposity. Referral to a paediatrician should be considered for children who are overweight or obese and who have significant co-morbidity or have complex needs (for example, learning or educational difficulties).
Adults	Pharmacological treatment should usually be recommended only after diet and exercise advice have been tried. The decision to initiate drug treatment, and the choice of drug, should be made after discussion with the individual about potential benefits and limitations (including adverse effects and monitoring requirements). When drug treatment is offered, arrangements should be made for appropriate healthcare professionals to offer specific concomitant advice, support and counselling on diet, physical activity and behavioural strategies. Surgery is recommended as a treatment option for severely obese people provided all the following criteria are fulfilled: • There is evidence that all appropriate non-surgical measures have been tried but have failed to achieve/maintain adequate clinically beneficial weight loss for at least six months. • The person has been receiving intensive management in a specialist obesity service.[iv] • The person is generally fit for anaesthesia and surgery. • The person commits to the need for long-term follow-up. • Bariatric surgery is recommended as a first-line option for people with a BMI greater than 50 kg/m^2, and in whom surgical intervention is considered appropriate.

Table 6. Clinical recommendations

[iv] The White Paper *Choosing Health. Making healthy choices easier* stated that 'each PCT area will need a specialist obesity service with access to a dietitian and relevant advice on behavioural change' and that innovative clinical models should be used to improve access. (*Choosing Health. Making healthy choices easier* (2004) Department of Health. London: The Stationery Office. p143.) The GDG considered that such a service could be based in either secondary care or in community settings, depending on local arrangements.

Section 3. The way forward

A consultation paper, outlining Cornwall's strategy to tackle obesity, was circulated to stakeholders in February 2006.

The actions agreed through the consultation process are summarised on the following pages (recommendations are set out in more detail in the consultation paper[12]).

There was wide support for:

1. a life course approach, to ensure that appropriate support was provided to meet varying needs at different stages of life
2. an inter-agency strategy, that recognised the existing and potential contribution of different organisations and professions
3. the need both to 'halt the rise' in obesity by supporting healthy lifestyles and to 'reduce the prevalence' of obesity by providing appropriate treatment options for the existing obese population.

The implementation of the strategy will be driven through two routes.

1. Partnership approaches to halting the rise in obesity will be taken forward by the Cornwall Local Area Agreement.
2. The implementation of a care pathway for those presenting to the NHS will be led by the Cornwall Obesity Management Group.

By and large this means that the Local Area Agreement will focus on preventing obesity through lifestyle change and the Obesity Management Group will focus on ensuring that people who are already obese, or overweight with co-morbidities, receive appropriate treatment. There will be some overlaps, in that the care pathway includes options for supporting behaviour change as well as treatment.

Action agreed through the strategy consultation

1. Early years and families

It is important to maintain a healthy weight during pregnancy and in the early years of life. Lifestyle influences in early years can have an impact on the child that is sustained into adulthood.

Breast feeding provides a range of positive health effects, including a reduced risk of later obesity for the child and the nursing mother. Women in low income groups are least likely to breast feed – a factor that contributes to health inequalities.

What must be done?	By whom?
Breast feeding support to be provided in line with UNICEF *Baby Friendly* standard.	Sure Start Children's Centres, health visitors, midwives, LAA.
Accurate information on healthy eating and physical activity to be provided for early years settings, including guidelines on: • Antenatal and postnatal diet • Weaning and under 1s • Infant diet	Health Promotion Service, Eatsome, paediatric dietitians, health visitors.
Best practice standards re healthy eating and physical activity to be set for all Sure Start Children's Centres in Cornwall.	Sure Start Children's Centres obesity lead, Health Promotion Service.
Healthy Start welfare food programme to be introduced.	Health visitors, midwives, pharmacists, participating food shops.
Specialist smoking cessation support to continue for pregnant women, to reduce the incidence of low birth weight.	Stop Smoking Service, midwives.
The potential for *Healthy Schools* standards to be rolled out to nursery schools to be explored.	Health Promotion Service, *Healthy Schools* team, early year settings.

These actions will be linked to the Children and Young People's Strategy and the Children and Young People's outcome strands of the Local Area Agreement.

2. Children and young people

Obesity prevention at school age is supported by a number of government initiatives such as *Healthy Schools*, school fruit schemes, healthy tuck shops and PSA targets around increasing physical activity. It is relevant to the *Every Child Matters* health and safety outcomes. In May 2006 new minimum nutrition standards were published for school food to ensure healthier eating throughout the school day.

Multifaceted school based programmes can be effective. Family involvement increases effectiveness, particularly for younger children.

What must be done?	By whom?
All schools in Cornwall and Isles of Scilly to work towards gaining the *Healthy Schools* standard, which has core components of healthy eating, physical activity and preventing bullying. Standards for vending machines, snack bars and access to water are included (*Food in Schools* toolkit).	*Healthy Schools* team, schools, *Anti bullying Cornwall* (victim support).
Schools to implement the new school food and drink standards.[13]	Schools, School Meals Forum, *Health Schools.*
All schools to have a travel plan in place that encourages sustainable travel to school and healthy lifestyle choice with regard to travel in general.	Travel awareness team (Cornwall County Council), schools.
Extracurricular opportunities for physical activity to be provided as an alternative to traditional competitive sport. Particular focus to be given to local access and opportunities, and to those on low incomes and in routine and semi–routine occupational groups.	LEAP Active, HALP, Cornwall Leisure Officers Group, Cornwall Sports Partnership.
Opportunities to promote healthy lifestyle through extended schools to be explored, with a focus on families and communities in deprived areas.	Cornwall Leisure Officers Group, Family Learning Unit, Local Education Authority, Health Promotion Service.
BMI of children in reception and year 6 to be monitored annually, coordinated by school nurses, following Department of Health guidance.	PCT, school nurses, schools.
The role and capacity of school nurses to be reviewed, taking account of their role in the monitoring programme and the children's obesity care pathway.	PCT, school nurses.

These actions will be linked to the children and young people's strategy, the draft sports strategy and the children and young people's outcome strands of the Local Area Agreement.

3. Adults and vulnerable groups

The workplace has been selected as the key setting for health promotion activities for adults, not forgetting the need to also target the unemployed. Workplace programmes are most likely to succeed if they have employee participation in planning, and support from management.

There is little evidence as to what works with vulnerable groups. Local initiatives designed to meet specific needs may be most effective. The needs of lower socioeconomic groups, ethnic minorities, and people with learning disabilities, physical disabilities and mental health problems should all be considered.

What must be done?	By whom?
Local toolkits and award schemes for healthy and active workplaces to be developed. Include: • Active travel plans and supportive facilities • Policies, subsidies, corporate discount schemes • Health and fitness and assessments (only as part of an integrated programme).	Health Promotion Service, Cornwall Sports Partnership, environmental health officers, Cornwall Leisure Officers Group.
Large employers, such as local authorities and NHS to set an early example of good practice.	PCTs, local authorities.
Training in healthy eating and lifestyles to continue for those who care for people with disabilities.	Health Promotion Service, carers.
Encourage all adults to periodically check that they are not gradually gaining excess weight.	Health Promotion Service, LAA partners, the public.

4. Older people

People tend to become less active as they age. Also, life events (e.g. bereavement), deteriorating health or reduced income can lead to dietary changes. Eating a balanced diet and being moderately active will help to maintain health and mobility.

In addition to the life course approach, general recommendations were made about health promotion in the community and obesity management by the health services.

What must be done?	By whom?
Local initiatives of proven effectiveness to continue, e.g. *Activate the inactive* training, *Bones in mind* and *Keep on your feet* group sessions.	Health Promotion Service, voluntary organisations (e.g. Age Concern, Women's Institute), Cornwall Leisure Officers Group, care homes.
Leisure services to review their provision for older people, and explore opportunities to form partnerships with voluntary organisations and clubs to improve access to opportunities for physical activity.	Cornwall Leisure Officers Group, voluntary organisations, clubs.
Training to be provided for health and social care staff to deliver key messages and to signpost to support and activities.	Health Promotion Service, PCT, Social Services.
Voluntary sector organisations to expand mentoring/ buddying/befriending schemes and include training to encourage physical activity and healthy eating advice.	Voluntary organisations (e.g. Age Concern, Darby and Joan), health trainers and champions, Health Promotion Service.

5. Health promotion in the community

Health promotion in the community is important to enable people to make healthier choices and manage their weight. It is important to make sure that actions are in place to prevent widening of existing inequalities, which is a risk if those with greatest need are not supported to take up the opportunities provided.

Links will be made with the actions of the Local Area Agreement Reduce health inequalities outcome and the Beating Diabetes group, an interagency group that emerged from an Overview and Scrutiny committee investigation into diabetes, and is led by the County Council Beating Diabetes champion.

What must be done?	By whom?
Partnership engagement and commitment to tackling obesity to be strengthened through a Local Area Agreement to 'halt the rise in obesity'. A portfolio of projects to be agreed through this partnership.	PCTs (public health, health promotion), Cornwall Sports Partnership, local authorities (leisure officers, environmental health officers), Arts for Health, Sure Start Children's Centres, Family Learning Unit.
Provision of simple, clear and accurate information – 'key messages' to be developed for consistent use in health promotion programmes and events.	Health Promotion Service, LAA partners, PCT staff, pharmacists.
Improving access to healthy food, and improving skills in buying food and cooking – successful programmes to be continued and expanded. Small grants scheme to continue.	Health Promotion Service, Eatsome, healthy boxes.
Improving skills in delivery and take up of physical activity and improving access to physical activity – successful programmes to be continued and expanded.	Health Promotion Service, LEAP Active, *Stroll back the years, Pedal back the years, Walking for health,* Cornwall Sports Partnership.
The role of health trainers and health champions in the community to be defined, and recruitment planned.	PCT, health trainers.
County-wide accreditation scheme - Cornwall Healthier Eating and Food Safety Award (CHEFS) - for catering outlets (including workplaces) to be promoted.	Local authorities, environmental health officers, Health Promotion Service.
Ensure the provision of less intensive activity by leisure services – walks, dance etc.	Local authorities, Cornwall Leisure Officers Group, Cornwall Sports Partnership.
Develop a supportive culture, recognising the role of social capital as a precursor to healthy lifestyle choices – continue and build on community development programmes.	*Connecting Communities* programme, LA community development teams, Local Area Agreement to 'reduce health inequalities'.

6. Obesity management in the NHS

Some people may need the support or advice of health professionals, especially if their excess weight is causing associated health problems. Appropriate advice to overweight and obese individuals in primary care and hospital settings should become a normal part of NHS practice.

Weight loss drugs are available, but are not effective unless combined with an appropriate weight loss programme and change of lifestyle. Surgery may need to be considered for patients for whom weight loss programmes have repeatedly failed and for whom there is significant morbidity and risk of mortality. NICE guidance has been published for the use of weight loss drugs[8,9] and surgery to aid weight reduction.[10]

What must be done?	By whom?
Evidence based pathways to be developed and implemented.	Cornwall Obesity Management Group, GP practices.
Use of pedometers in primary care to be piloted through the national *Step-o-meter* programme.	The Countryside Agency, PCTs, frontline health professionals.
Registers to be kept in GP practices of all patients aged 15-74 with a BMI>30 recorded in the previous 15 months.	GP practices.
Exercise referral programmes to be rolled out across Cornwall. To follow NICE guidance.[14]	PCTs, GPs, local authorities, Cornwall Leisure Officers Group
District directories of pathway referral options for physical activity, healthy eating and weight loss support to be produced.	Health trainers, healthy living centres, Cornwall obesity management group, Cornwall Leisure Officers Group, LEAP Active, Eatsome.
Local specialist services to be planned – a specialist clinic supported by a multidisciplinary team. To follow NICE guidance.[10]	PCT, peninsula specialised commissioning team, RCH, PHT.
Staffing capacity to support the pathway to be addressed, acknowledging the need for specialist assessment, surgical, psychological and dietetic input, and the role of school nurses, health trainers and GP practice staff.	Cornwall Obesity Management Group, PCT, acute hospitals, GPs.
A portfolio of education and training opportunities to be developed, to encourage multidisciplinary engagement in tackling obesity, and increase effective capacity.	PCT public health and health promotion teams, RCH diabetes and dietetic teams.

3.1. Implementing obesity care pathways

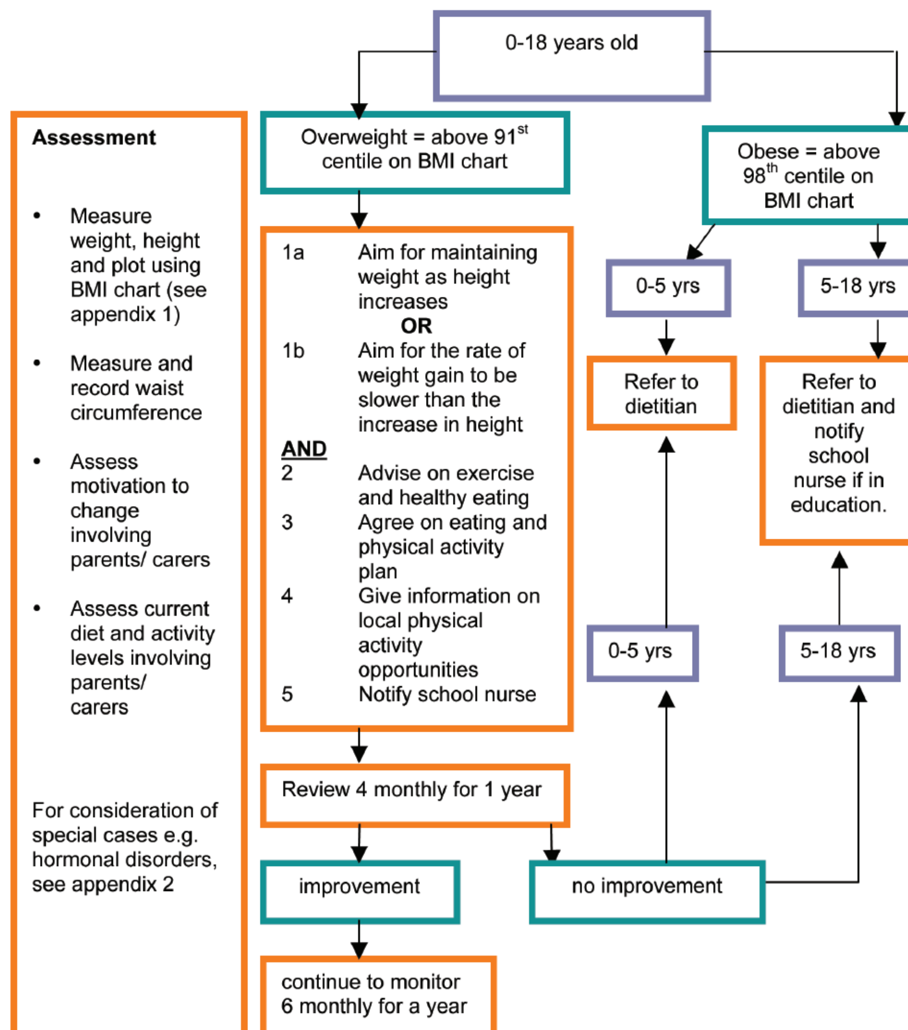
Care pathways for adults and children were developed by the Cornwall Obesity Management Group in 2005. The pathways aim to assist healthcare professionals in identifying, assessing, then referring or treating patients who need to lose weight. They are based on existing evidence[3,8,9,15-19] and local consultation. These were followed in 2006 by the publication of pathways produced by NICE (in draft)[11] and the Department of Health.[20] The pathway algorithms are reproduced on the following pages; the complete versions with explanatory appendices were sent to all practices in February 2006.[v]

Primary care provides a potentially ideal setting for weight management interventions for adults. About 75% of the population see their GP in the course of one year, and about 90% in five years. There is clear evidence of the health benefits of achieving and maintaining an ideal weight and there are a number of enthusiastic and committed health professionals providing advice and support to patients who are motivated to lose weight. However, a number of concerns have been raised about tackling obesity in primary care:

- Pressure of time in consultations
- A lack of appropriately-trained primary care staff
- A shortage of community dietitians
- The potentially enormous caseload
- A lack of evidence of what works
- A high rate of relapse.

[v] available on request from the PCT Public Health directorate

Weight management guidelines in primary care treatment plan for obese and overweight children under 18 years



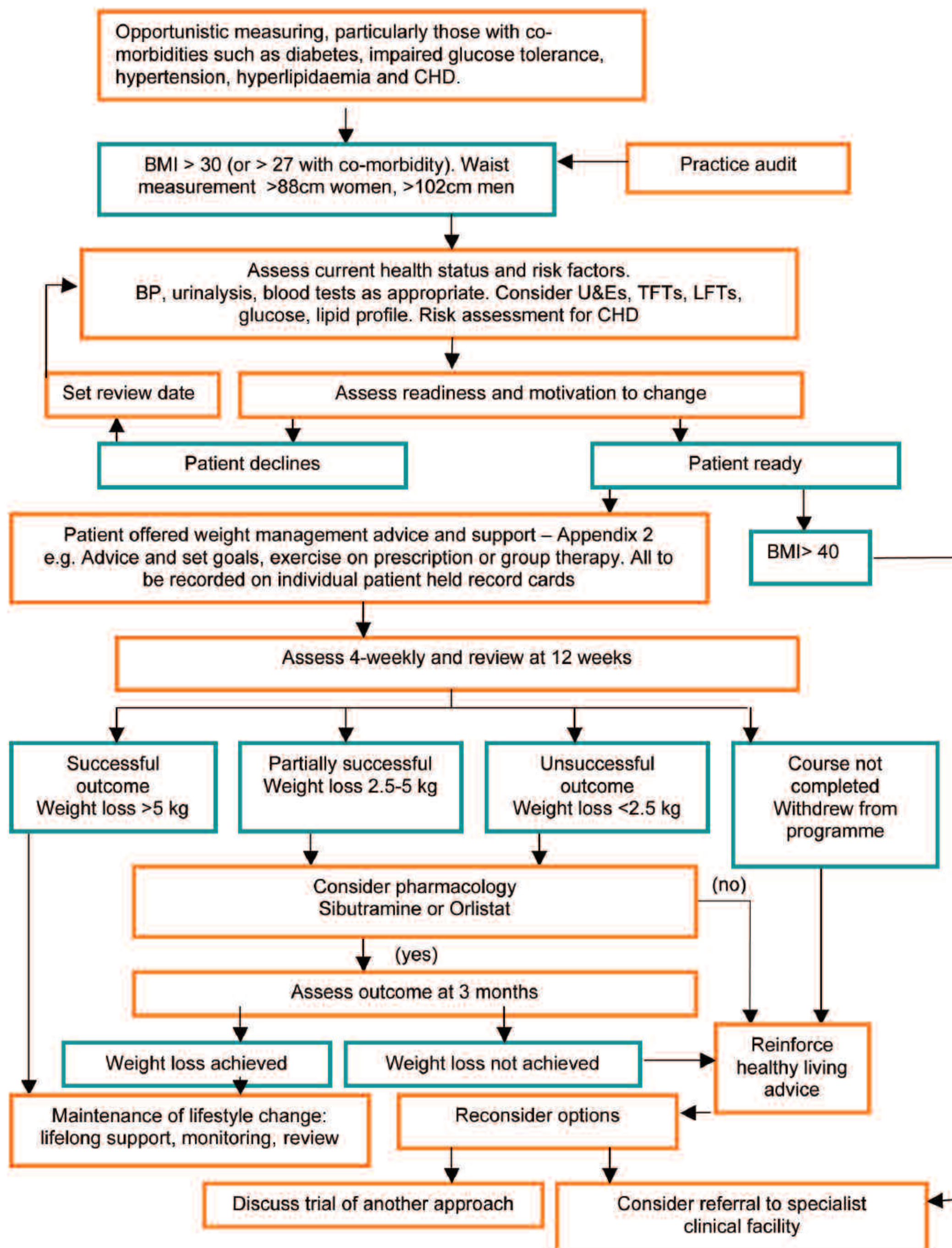
3.1. Implementing obesity care pathways

General practice staff have been invited to work with the Obesity Management Group to explore ways to overcome these obstacles.

For patients who meet the criteria for progression through the pathway to referral to a specialist clinic, the options for patients in Cornwall are very limited. Surgery should not be considered without specialist assessment and a regular specialist clinic offering multidisciplinary assessment and management is not currently provided. Surgery to aid weight reduction is a specialised commissioning issue and is being reviewed by the Peninsula Specialised Commissioning team.

The pathways cannot be fully implemented without the development of medical and surgical treatment options. The Obesity Management Group will work with health service commissioners to achieve this.

Cornwall & IoS weight management guidelines for adults 18+ years



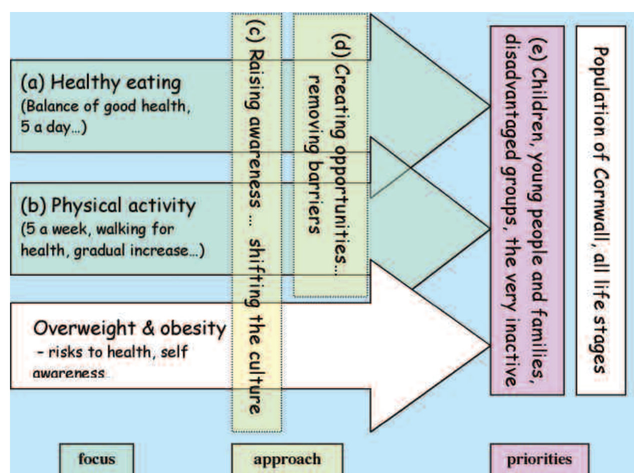
Why are we using a Local Area Agreement to tackle obesity?

A wide range of organisations can influence people's lifestyles - as employers, as the responsible bodies for education, travel, leisure or the environment, or as providers of goods and services. A Local Area Agreement (LAA) provides the opportunity for organisations to establish firm partnerships with commitment to shared goals, and for action to be coordinated across the county. Existing strategies, such as the county strategy to tackle obesity, the children and young people's strategy and the sports strategy can be aligned through the LAA.

How will the LAA attempt to 'halt the rise in obesity'?

The LAA work plan closely follows the recommendations from the obesity strategy. However, there will be an added emphasis on awareness-raising through mass media and mass participation events, to engage large numbers of people. Opportunities will be taken to link to national campaigns and health promotion days, in order for publicity to have maximum effect. The LAA approach is illustrated in figure 4. The letters in the diagram are referred to in the explanatory text below.

FIGURE 4. THE LAA APPROACH TO HALTING THE RISE IN OBESITY IN CORNWALL



Focus: Recognising that the population as a whole is eating more than it needs and the solution is to eat less and exercise more, the focus will be on

(a) improving diet, or

(b) increasing physical activity, or both.

Approach: Lifestyle changes are not easy to achieve, and are even harder to maintain. The most effective approach has been shown to be a multifaceted one, not only reaching individuals but also:

(c) Raising awareness and gradually shifting the culture in the community. This includes awareness about the health risks of excess body weight and of the lifestyle factors that can contribute to a healthy weight and hence a healthy life.

(d) Creating opportunities for (or removing barriers to) healthier living, and making them available and accessible to people in their local environment.

Untargeted health promotion campaigns can result in health inequalities as lower risk groups tend to be more motivated to change. There will be an emphasis on removing environmental obstacles to healthy lifestyles through lobbying for policy change; this approach relies less on the motivation and engagement of individuals so it has the potential to reach groups with high risk and low motivation.

Priorities: Although the ultimate target group is the population of Cornwall, there will be an emphasis on reaching those with high needs, those at risk of exclusion, and those with potential for added benefit. Although obesity can be a problem for both adults and children there is benefit to be gained from addressing the problem at an early age, while behavioural habits are developing. There is the potential for additional benefit from involving families because, without family support, it is difficult for young people to make the change alone.

Over one third of adults achieve less than 30 minutes moderate activity per week. For these sedentary people, walking is ideal as a gentle introduction to exercise. It is something that all but the most seriously frail or disabled can do, it can cost nothing and it offers a host of health and social benefits.

(e) Therefore, while not being exclusive, there will be a focus on engaging children, young people and families, and looking for ways to reach excluded sections of society and the very inactive.

Will it work?

Where possible, evidence based practice will be followed as this will increase the chance of success. Where evidence is lacking, evaluation should be planned within the project.

How will the work be coordinated?

The delivery partner for the LAA outcome 'halt the rise in obesity' will be the Cornwall Sports Partnership, which has been identified as meeting the criteria of internal governance and accountability required. The 'halt the rise in obesity' steering group will coordinate activity and monitor progress. Partner organisations will be responsible for implementing and monitoring their own contributions, and reporting to the steering group.

The Isles of Scilly

The Local Area Agreement only covers the area under the authority of Cornwall County Council, so excludes the Isles of Scilly. However, the islands are not excluded from the Health Promotion Service or partnership projects and they have been included in the obesity strategy consultation. The Council of the Isles of Scilly runs a programme of relevant activities through its Lifelong Learning and Community Sports Development departments.

How will progress in implementing the strategy be monitored?

The LAA has its own evaluation procedures, which will look at process and outcome measures. There are also some existing targets and indicators that can be used to measure progress.

Targets relevant to this strategy:

- 100% of schools to enrol on the *Healthy Schools* programme by 2009.
- 50% of schools to achieve *Healthy School* status by December 2006.
- Children to take part in two hours of quality PE and out of school sport, moving to four hours by 2010.
- Adult participation in sport and physical activity to increase by 1% each year (baseline under measurement).
- Adult obesity as recorded in GP registers to reduce from 23% in 2005/06 to 22% in 2006/07 and 21% in 2007/08.
- Halt the year-on-year rise in obesity among children aged under 11 years – measured as the percentage of children in reception and year 6 who are obese.

Conclusions

In conclusion, the high and rising prevalence of overweight and obesity in the population is of public health concern. Local data are needed to describe the problem in the local population and to measure the effectiveness of action taken to tackle obesity. The collection of local data has begun, through the schools height and weight monitoring programme and the GP practice obesity registers. These datasets will become more useful as they become more complete.

The strategy reported here has been developed through consultation with a range of professionals, organisations and interest groups over the past year. The strategy distinguishes between (a) partnership action to raise awareness and support healthy lifestyles and (b) action specific to the NHS, to provide health care for people who are obese or suffering from obesity-related health problems. The NHS faces a financial and organisational challenge as a result of the large numbers of individuals affected by overweight and obesity, and the specialist care needed by some morbidly obese patients. However, long term benefits in terms of health improvement and financial savings are potentially enormous.

On conservative estimates obesity costs the NHS £0.5 billion a year in patient care (this would equate to approximately £5 million a year in Cornwall) and a further £2 billion cost to society more widely.[3] The bulk of the NHS cost arises from treating conditions caused by obesity, mainly hypertension, coronary heart disease and type 2 diabetes.

This strategy describes the way forward to tackle a complex problem. It will not easily be overcome, but the potential benefits to individuals and to society make the attempt worthwhile. The greatest chance of success comes from widespread engagement and commitment to supporting healthier lifestyles.

Recommendations

- The obesity strategy should continue to be promoted throughout Cornwall and the Isles of Scilly.
- Partner organisations within Cornwall should engage with the strategy through participation in the Local Area Agreement to halt the rise in obesity.
- NHS services should be developed to allow full implementation of the obesity care pathways.

Acknowledgements

The following people have contributed to this strategy:

- Members of the Cornwall Obesity Management Group (development of the care pathways)
- Members of the Cornwall Obesity Strategy Steering Group (development of the broader strategy)
- All who took part in consultation between February and June 2006
- Members of the LAA 'Halt the rise in obesity' steering group

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Acronyms

BMI	Body Mass Index
DfES	Department for Education and Skills
FSA	Food Standards Agency
GP	General Practitioner
HALP	Healthy Active Lifestyles Project
LAA	Local Area Agreement
LA	Local Authority
NICE	National Institute for Health and Clinical Excellence
OMG	Obesity Management group
PSA	Public Services Agreement
RCH	Royal Cornwall Hospital
PHT	Plymouth Hospitals Trust