A healthy weight population health needs assessment for the populations of Cornwall and the Isles of Scilly

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Volume I: Key points and summary report

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The Cornwall and the Isles of Scilly Healthy Weight Strategy (2009-2013)

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Chapter 1  Introduction and background

- Overweight and obesity is a major and worsening public health problem affecting the majority of the population in Cornwall and the Isles of Scilly. The rising level of obesity in children is particularly worrying.

- The resulting NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year.

- On behalf of the local Healthy Weight Group, NHS Cornwall and Isles of Scilly Department of Public Health commissioned this population health needs assessment as part of the updating of the Cornwall and Isles of Scilly Healthy Weights Strategy 2009-2013. This summary report should be read in conjunction with its full technical report.

- The most common method of measuring obesity is the Body Mass Index (BMI). BMI is calculated by dividing body weight (kilograms) by height (metres) squared. An adult BMI of between 25 and 29.9 is classified as overweight and a BMI of 30 or over is classified as obese.

- In children and adolescents BMI varies with age and sex, which makes it harder to classify children as obese, overweight or underweight. For this reason a growth reference must be used. In England, the British 1990 growth reference charts are used to classify the weight status of children for the National Child Measurement Programme and Health Survey for England.

Chapter 2  Methods

- This needs assessment aims to identify the current unmet need for addressing physical inactivity, high-energy unhealthy eating, overweight and obesity in Cornwall and Isles of Scilly taking account of health inequalities and the life course.

- Full details of key definitions, concepts, references and the range of methods used are described in the accompanying full technical report.

Chapter 3  The health effects of overweight and obesity

- People who are obese die on average nine years earlier than those of healthy weight.

- The burden of obesity and its ill-effects has a social gradient and is increasingly worse from higher to lower socioeconomic groups, and in the least deprived areas to the most deprived.

- Globally around 58% of type 2 diabetes, 21% of heart disease and between 8% and 42% of certain cancers are attributable to excess body fat.

- There are many other widespread important health benefits of regular physical activity and regular healthy eating and drinking, apart from preventing overweight and obesity. Physical activity is particularly beneficial to older people.

Preconception and pregnancy

- Obesity in pregnancy contributes to increased morbidity and mortality for both mother and baby.

- Approximately 35% of pregnant women who died are obese. The most deprived pregnant women have a risk of dying which is seven times higher than that of other pregnant women. Approximately 30% of the mothers who had a stillbirth or a neonatal death are obese.

- Overweight and obesity in the pregnant woman also leads to a significant increase in the rate of elective and emergency Caesarean section delivery, more days in hospital and higher costs.

Children and School years
• Overweight and obese children are highly likely to become overweight adults. Overweight and obese children are highly likely to become overweight adults.

• Physical activity from early years through school years affects: maintaining healthy weight; bone mineralization; reducing risk of emotional, psychological and mental health problems; promoting a healthy habit for life; and reducing lifetime risk of six diseases.

**Adult years**

• Physical activity alone and/or preventing obesity can help prevent:
  - Premature death
  - Sleep apnoea
  - Reduce flexibility
  - Gall bladder diseases
  - Lower back pain
  - Complications in surgery
  - Lead to increased stress and less mental and social wellbeing
  - Higher cardiovascular risk - heart disease and stroke and hypertension
  - Higher osteoporosis risk
  - Maturity-onset Type 2 Diabetes - over 75% of newly diagnosed adults overweight or obese
  - Osteoarthritis
  - Some cancers such as breast cancer and colon cancer

**Healthy ageing**

• In older people, physical activity and/or preventing obesity helps prevent all of the above but has a larger effect, and can help prevent:
  - Risk of falls
  - Impaired social benefits
  - Reduced activities of daily living and mobility
  - Impaired cognition

**Chapter 4  The underlying causes of overweight and obesity - physical inactivity, high-energy unhealthy eating, and their complex societal causes**

• Overweight and obesity in individuals results from an imbalance in:
  - Physical activity and energy used up
  - Food and drink consumption and energy taken in
• Complex societal factors contribute to physical inactivity and unhealthy eating.
• There is a notable difference in the weight of research evidence around physical activity compared to the lack assessing the influences on food consumption.

**Physical activity is affected by:**

**Macro-environment**

• Socioeconomic environment
• Spatial planning and the built environment
• Transport policy and plans, and car use

**Micro-environment**

• Availability and access to local public space and local facilities
• Building design
• Culture and social attitudes toward physical activity, active travel and sedentary activities
• Individual and family factors
  - Parental influence and activity levels
  - Team and peer influences

A healthy weight population health needs assessment - Volume I: Key points and summary report
Knowledge of health benefits of physical activity, and amount/intensity to do
Social/enjoyment
Barriers: sedentary activity; motivation; facilities; time & prioritisation; perceived lack of skills and fitness; health concerns; physical environment (as above)

Healthy eating is affected by:

Macro food environment
- Societal influences:
  - Media and marketing - often un-regulated, and often directly to children
  - Education
  - Peer pressure or culture
- Availability and quality of affordable fruit and vegetables near home - expendable income; spatial and urban planning. But energy-dense foods available 24/7 often near homes.
- Socioeconomic expendable income inequality, pressure on families to minimise food costs.
- Reduced personal food growing and community land availability, decreased shopping/ cooking time have raised proportion of food eaten outside the home (often more energy-rich).
- Large-scale commercial integration of food supply chains. Little external market regulation.
- Not clear to what extent food labelling translates into informed choices of healthy food.

Micro food environment
- Family, parental and peer environment are critical in forming eating habits from a young age.
- When served larger portions for an extended period of time, people consume more food.
- Parental restrictions weaker than advertising and peer pressure in determining actual food and drink decisions of many children.

Individual
- Despite prevalent unhealthy diets, most children and adults regard their diet as healthy.
- A large minority of men do not think healthy foods are enjoyable. More men than women stated ‘I get confused over what’s supposed to be healthy and what isn’t’.
- A higher proportion of men than women agreed that ‘If you do enough exercise you can eat whatever you like’ and that ‘Healthy eating is just another fad’.

Chapter 5 Physical inactivity and high-energy unhealthy eating in Cornwall and the Isles of Scilly

Physical inactivity

Children
- The South West is among the least-worst regions in England for the proportion of children meeting recommended physical activity levels. However, physical activity levels are low in England compared to the best European countries.
- Active travel is the main form of activity in England. Only a minority walk and cycle enough to meet weekly physical activity guidelines.

Adults
- In Cornwall the majority of adults do not exercise adequately five times per week - only 17.6% do so (including via transport). In the least worst South West local authority area, Exeter, 36.3% do so. Men report higher activity levels than women, but for both genders participation is generally low, and decreases with age. Physical activity levels tend to be very low amongst older women.
• The Isles of Scilly, and districts Caradon, Carrick and Penwith are in the 25% of English local authorities with the highest percentage participation (although this is still low). North Cornwall is in the quarter with middle-high participation. Restormel and Kerrier are in the quarter with the lowest participation.

Healthy eating
Preconception and pregnancy
• Breastfeeding rates upon discharge from hospital in Cornwall and the Isles of Scilly are relatively high. However, breastfeeding rates tend to decline in the first two weeks after discharge.

School years
• Most of children’s food is consumed outside of school. However, most available information relates to school time consumption.

• By September 2008, all primary schools in England were required by law to meet new food-based and nutrient-based standards for food provided in schools. Compared with 2005, caterers now provide healthier lunches. However there is scope to:
  o Continue to reduce the number of times that starchy foods cooked in fat and meat products are provided
  o Increase the range of ways in which fruit and fruit-based desserts are provided
  o Encourage more pupils to take fruit and fruit-based desserts at lunchtime
  o Find more ways to include vegetables in recipes

• As a result of limiting the range of foods (not by increasing choice) to healthier options, pupils took healthier lunches in 2009 compared to 2005

• Confectionary, savoury snacks, sugary fizzy drinks and other processed foods (including meats) are large contributors to excessive total energy, extrinsic sugar, total fat and saturated fat for children from low income households.

• Fruit and vegetable consumption in children aged 5-15 years in the South West of England is the third lowest of all English Regions for boys and girls.

• Fruit and vegetable consumption among children in low income households is very low.

Adults
• Adults who live in low income households are more likely to consume fat spreads, non-diet soft drinks, meat/meat dishes, pizza, processed meats, whole milk and table sugar. White bread and condiments are the most commonly consumed in low income households.

• Only 29% of men and 36% of women in the South West eat 5 or more pieces of fruit or vegetables daily.

Healthy ageing
• The proportion meeting fruit and vegetable guidelines decline among the very oldest age group.

Chapter 6 Overweight and obesity in Cornwall and the Isles of Scilly
Preconception and pregnancy
• Almost one in every 1,100 maternities is in women who are extremely obese.

Young children
• In Cornwall and the Isles of Scilly for children aged 4-5 years in 2008/9, almost a quarter were either overweight or obese (higher than the national and South West average), with 14.4% overweight (higher than the national and South West average) and 9.9% obese.
A strong positive relationship exists between deprivation and obesity prevalence for children in Reception year.

**School years**

- Nearly 50% of boys and over 40% of girls aged 6-10 years are at present forecast to be overweight or obese in England by 2050.
- A strong positive relationship exists between deprivation and obesity prevalence for children in Year 6.
- In Year 6 (aged 10-11 years) pupils in Cornwall and the Isles of Scilly 14.2% were overweight (similar to the national and South West average) and 17.9% obese (higher than the South West average, lower than the average), in 2008/9. Almost one third were either overweight or obese. Kerrier appears to have a significantly higher prevalence of Year 6 obesity compared to other districts.
- Cornwall and the Isles of Scilly has above average child obesity and deprivation compared to the average for PCTs in England.

**Young adults, adult years and healthy ageing**

- By 2007 the majority of men and women in England were either overweight or obese.
- In England, socioeconomic inequalities in obesity are apparent for women, but are not as clear in men, depending on the measure of inequality used.
- The prevalence of adult obesity in Cornwall and the Isles of Scilly over 1.5 times worse than the best in England, but similar to the average for England.
- Adult obesity is highest in the East Cornwall and the West Cornwall locality groups.

**Burden of health effects of obesity in Cornwall and the Isles of Scilly**

- Obesity-related disease cost the NHS Cornwall & Isles of Scilly £200.7 million annually.
- For cancer deaths locally, 8.3% are estimated to be related to obesity. For cardiovascular disease 30.6% of deaths are estimated to be related to obesity.

**Chapter 7 Effective approaches to address overweight and obesity**

- The Marmot Strategic Review of Inequalities in England - Fair Society, Healthy Lives is an appropriate starting point as an over-arching framework for action on physical inactivity.
- “… focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem…… action is required across all these social determinants of health.”
- Finland and Freiburg, Germany provide good case studies of success in more rural and small city areas.

**Physical activity**

*Building health public policy and creating supportive environments*

- These interventions lead to the largest population health impact.
- Evidence suggests that policies and programmes are more effective and have more impact if they primarily modify the physical and social environments.
- Known methods of healthy and sustainable spatial and land-use planning result in a built environment and transport that increase physical activity and active travel.
- Local government can integrate land-use and transport planning for active travel.
Local green spaces, squares, other open spaces, playgrounds and leisure and sports facilities are important as are mixed residential, public service, retail and commercial neighbourhoods.

Several relevant NICE public health guidance reports on healthy spatial planning, physical environments and transport policies are currently available or in development.

**Community action for physical activity**
- Comprehensive and sustained community-wide campaigns that involve many sectors and the public in highly visible, broad-based, multiple interventions in combination (such as media promotion, support and self-help groups, community fairs and events, programmes in the schools and workplaces, and the creation of walking paths and trails) can be highly effective in increasing physical activity.

**Develop personal skills for physical activity**
- Approaches focusing solely on changing individual behaviour or small groups have limited population health impact and tend not to have lasting effects.
- Approaches can include mass-media campaigns, health promotion initiatives and social marketing, but they need to be part of larger comprehensive programmes and link to changes in the environment.
- WHO has pioneered the settings approach to health improvement. Key settings include: Schools; workplaces; healthcare settings

**Reorient health and other personal services**
- The key for the health sector is providing local leadership and advocacy.
- Physical activity should have a stronger role in primary prevention.
- There is considerable NICE guidance available on effective interventions.
- The health sector should set the example by promoting physical activity among employees and users of health systems.
- On their own health promotion initiatives are rarely effective in the long-term and have low population health impact. They need to be part of larger comprehensive programmes.

**Healthy eating, overweight and obesity**
- There is more research into interventions that deal with physical inactivity than unhealthy eating.
- A similar approach to the effective physical activity approach is advocated by WHO which complements the Marmot framework.
- There are several current NICE guidelines related to healthy eating, including for preconception and pregnancy.

**Chapter 8 Policies, strategies, plans and services in relation to physical activity and healthy eating in Cornwall and the Isles of Scilly**

**Group 1: Reorient services, developing personal skills and strengthen community actions**
- There is evidence that effectiveness, population health impact and health inequalities are being considered in the following local NHS policy documents:
  - Cornwall and IoS Healthy Weight Strategy 2009-13
  - Looking Ahead - A Healthy Future for All
  - Helping people to stay healthy and live independently
  - Stretching our ambition for a healthy future - The Strategic Framework for Healthcare in Cornwall and the Isles of Scilly 2008 - 2011
• Significant high-level health leadership and advocacy is already occurring in the context of the Health and Wellbeing Partnership.

• There is evidence of considerable healthy weight prevention activity and initiatives across Cornwall and the Isles of Scilly. Services are mainly from NHS health promotion services and from sports and leisure sectors.

• Whilst there are good examples, services tend not to be fully linked to clear research evidence of effectiveness. They tend not to take a whole population approach and tend not to be based on the underlying determinants of healthy weight. There is variation in coverage.

• Some current initiatives do not appear to be coordinated. Where services are available, a very small number of the whole Cornwall and Isles of Scilly overweight and obese population are reached annually.

• As many initiatives are of uncertain effectiveness and impact, they should ideally be part of formal academic research of their effectiveness.

• Current best practice suggests that for Tier 2 clinical services there should be a local care pathway arrangement for a paediatric specialist multi-disciplinary team dealing with children identified with obesity. This care pathway should link Tier 2 services with Tier 1 and Tier 3 services. The Tier 2 team should ideally comprise a community paediatrician, a paediatric dietician and there should be a weight management course available from a specialist exercise advisor in liaison with a child psychologist. A similar service for adults is also advocated.

• In relation to local Tier 2 services a whole family community based approach to childhood healthy weights supported by medical advice is taken. Out-patient appointments are available to see a Consultant Community Paediatrician to ensure there are no underlying medical conditions. From 2010 a Paediatric Dietician will be available with a specific focus upon healthy weights in childhood. However, there is currently no recurrent funding identified for the community based whole family approach.

• Current best practice suggests that for Tier 3 clinical services there should be a local care pathway arrangement for a paediatric endocrinologist and access to specialist medication and bariatric surgery service. Services may be available to the local population but be part of a more regional tertiary service. There is a gap in this service at present.

GROUP 2: Create supportive environments and build healthy public policy

• Relevant policy, strategy and planning documents were identified from the councils of Cornwall or the Isles of Scilly from sectors other than health, leisure or sport. A content analysis was carried out to consider to what extent, if at all, they considered their health impact, on obesity, overweight, physical activity or healthy eating in particular.

• Many relevant documents were identified. The sectors involved had the potential of significantly affecting physical activity across the two jurisdictions. As expected, there was less relevant policy that could potentially affect healthy eating.

• In general, despite potential links to health, almost no document had undergone a formal health impact assessment in its consultation process. Consequently no policy document thoroughly considered its potentially large impact on population healthy weight or health inequalities.

Chapter 9 Stakeholder views
In summary, the recurring themes and issues that emerged as dominant included:

Overall approach and framework (and general issues)
• The need for further strategic thinking in the approach to address overweight and obesity.
The need for a more whole population approach, rather than patchy targeted areas or groups, and short-term projects.

No strong sense of leadership for the entirety of the agenda, only from public health,

More evidence-based interventions needed - “Too much emphasis on non-evidence-based short term initiatives to do with marketing themselves rather than substance of intervention”

Partner agencies need to be delivering agenda this with the PCT - not just a health responsibility to fund interventions

The subject seems to be too big and complex - what can I really do about it?

Poor levels of understanding about the problem and about what can be done to improve the situation

Funding - Obesity is at a disadvantage because it is categorised as “preventative” and therefore lower on the list of priorities

A lack of real priority for the issue e.g. overweight/obesity is a top public health issue yet no additional resources have been made available through the LAA to help tackle the issue.

Need shared targets and/or vision across health, LAs and third sector

Problems around integration of current initiatives.

Building healthy public policy and creating supportive environments

Taxation, subsidies and legislation could achieve the desired more quickly.

Poor economic status contributes.

Time and cost are key reasons why people don’t address their health and weight - low wages is a problem for Cornwall.

High debt - huge house prices and fickle industries other than the public sector and the developing third sector result in low paid seasonal work.

Current unhealthy planning and transport planning are very major contributors to obesity locally - “Highly obesogenic built environment at total odds with natural environment....opportunity for active travel is poor due to lack of infrastructure development...” and ....”Planning policy which to date has failed to provide adequate accessible, attractive and usable open space, or to encourage active travel or plan in such a way as to encourage activity.”

New roads don’t have cycle routes.

Children playing less and less outside.

New housing developments with low priority for open space.

Congregation of fast food outlets near to most educational establishments a problem.

Concern for litigation and limited public funds for the maintenance of play equipment and landscaped sites means items are removed. Concerns over child protection result in ‘fear’ that can reduce a child’s world and ability to take risks.

“Superb” natural resources, but Green Gym and Blue Gym initiatives low profile, but very appealing, although difficult to find out information about it.

Access to natural environment and built environment a problem - especially in terms of walking and cycling infrastructure and poor public transport.

Reduced cost entry to leisure facilities for children in need in north Cornwall is helpful
- Fun play areas that engage children for longer i.e. in St Austell is beneficial.

**Community engagement**
- The current frequency of apparent “pet” projects is problematic.
- Issues around health promotion initiatives’ integration, effectiveness, evaluation and population coverage.
- Lack of overall population impact of range of current approaches.
- Issues around role, effect, patchiness and short-term funding of community projects, and nature of role of links of statutory bodies with them.
- Use of the community sector (local people providing local solutions and unlocking more national funding through charity / community interest status) is positive.

**SETTINGS** - This approach is important - the workplace, school, campuses, NHS environment. To involve adults, families, children.
- Making good progress with settings. But some issues are: employers tend to see obstacles rather opportunities; a focus on Work Place Health is required particularly within the public sector (biggest employers - Cornwall Council, NHS and Devon and Cornwall constabulary); schools need more intense intervention and especially in schools more reluctant to participate, rather than the schools which are already working very well. Role of schools in active travel and sport. The continued presence of vending machines in leisure centres, hospitals etc is a problem.

**Developing personal skills**
- Low levels of health literacy
- The current frequency of apparent “pet” projects.
- Issues around health promotion initiatives' integration, effectiveness, evaluation and population coverage.
- Lack of overall population impact of range of current approaches.
- Unclear population impact of current sport facilities and initiatives.
- Eating of fast food (pre-prepared rather than take-aways), people being in a rush - families with both parents working and time stressed meal times.
- The acceptance of overweight/ obesity and inactivity as normal
- Better coordination of all initiatives needed. This seems to work best in W Cornwall with the W Cornwall Healthy living site.
- Many initiatives are thought to be useful, despite patchiness and short term funding, lack of integration, although little reference to effectiveness and inequalities is made by stakeholders:
  - Keep It in the Family, which is a family based Weight Management programme based on MEND delivery with a community based enhancement. This is in early stages of development but seems to be a good model. The negative is that it is expensive.
  - Interventions such as Eatsome project, ‘Keep it in the family using MEND’ with links to natural environment, extended services investment in means tested voucher systems for access to heavily subsidised or free activity programmes, MOBILISE, why weight?, play ranger programmes and recent investment in improving play infrastructure in County.
  - Family based work has had positive results. ‘Change for Life’ social marketing campaign is also positive along with developing ‘Blue Gym’ concept.
Reorienting services

- Issues around health promotion initiatives’ integration, effectiveness, evaluation and population coverage.
- Lack of overall population impact of range of current approaches.
- Breastfeeding peer mentoring for certain women is positive. But peer mentoring for breastfeeding, services and facilities not consistent across the county.
- A greater focus is required on maternal obesity and being healthy for pre-conception.
- Medicalising overweight/obesity - takes the responsibility away from the individual and places emphasis on medical interventions.
- “Get schools 100% behind the weighing and measuring programme.”
- GP exercise referral lack mentioned (but no reference to its evaluation, effectiveness, population health impact.)
- Health Promotion offer training in a great 8 week course called Shape up but they struggle to involve many practices. “…..low levels of interest within General Practice.”
- GP’s would engage better with the whole concept of obesity if there was an easy to use structured referral pathway.
- An unstructured obesity service at present- “no paediatrician with an interest in obesity and the adult physician with an interest is leaving Cornwall…..” and “We don’t have a comprehensive service in place for children identified as obese / overweight at all age groups.” Two paediatric dieticians for the county (1 may not be full time) but significant activity already. Having to consider not taking “simple obesity” referrals.
- Another endocrinologist will take over the clinic after the current adult physician with an interest leaves. For many patients referral to this clinic represents the 1st time they have seen a dietician or even had involvement with LEAP (Local exercise action plan - Health promotion). Currently have no “talking therapies” involved in weight management apart from the occasional prebariatric patient who is referred for psychological assessment. There is a local bariatric surgeon. He offers gastric banding. Any patient who requires gastric bypass is referred to Exeter.
- Lifestyle Consultations delivered by Health Promotion as a brief intervention in partnership with the Barriatric Assessment team at RCHT seem to work well. This is a model that could be looked at for other areas.

Chapter 10  Inequalities in unmet need for preventing overweight and obesity in the populations of Cornwall and the Isles of Scilly

Approach and framework for action

High priority (likely high population health impact and/or less cost)
- The overall strategic approach to healthy weight in Cornwall and the Isles of Scilly is effective.
- There is a tendency to focus on, or target, only the most deprived areas or groups. But the Marmot Report reiterates that focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.
- Similarly, the current focus of the local strategic approach appears to be on discrete, and sometimes patchy, programmatic clinical or health promotion service. They will not achieve the most population health impact on their own.
• Whilst action in non-health sectors is included, this does not appear to be the focus of the local strategic approach, where the most population health impact could be achieved.

• The Healthy Weight Strategy appears to be primarily embedded within the Health and Wellbeing Partnership and its Healthy Weight Group, although inclusion of all local authority sectors is achievable by extending its reach to local vision, goals, strategies and partnerships that overarch most if not all sectors.

Leadership and advocacy

High priority (likely high population health impact and/or less cost)
• Significant public health leadership and advocacy is already occurring locally, but with limited public health resource support at present.

• Parallel advocacy of the healthy weight issue by senior council officers and leading local elected members, across all sectors, is not as extensive as it could be in order to achieve maximum population health impact.

Building healthy public policy & Creating supportive environments

High priority (likely high population health impact and/or less cost)
• Some action is already occurring within the NHS, sports and leisure sectors and in partnerships.

• There are occasional brief links between health strategy and plans, and those of other sectors, but they are not explicit or extensive at present.

• Action to create settings with healthier environments in schools and workplaces is occurring. Whilst successful and expanding, they are not always explicit in terms of using evidence-based approaches, addressing related infrastructure issues and barriers, and strategically implementing according to the health gradient.

• Formal and structured Health Impact Assessment of non-health sectors’ policies, strategies and plans, with professional public health input and support, and community and stakeholder involvement, is not occurring routinely to any great extent at present.

• Awareness of knowledge and skills in public health issues in disciplines and professions within non-health sectors may be currently inadequate.

• It is not apparent that regular formal advice is sought by non-health sectors from evidence-based guidance, from external consultants and academics, and from case studies with experience in successfully tackling healthy weights in non-health sectors.

Strengthen community action and develop personal skills

Medium priority (likely low to moderate population health impact and/or moderate to high cost)
• A few health promotion and sport and leisure initiatives are occurring that have some evidence of effectiveness, but small population health impact.

• A social marketing initiative to address barriers to healthy lifestyles is being developed.

• There is evidence of patchy community initiatives developed from local grass roots action.

• It is not clear whether the few effective initiatives that are occurring according the health gradient. Some appear to be targeted at the most deprived areas only.

• The few effective initiatives that are occurring in this category seem historic, and do not appear to yet form part of a coordinated and sustained programme.

Reorient (health care and other personal) services

Medium priority (likely moderate population health impact and/or moderate cost)

Lower priority (likely less population health impact and/or higher cost)
• Effective NICE guidance action is already occurring to increase breastfeeding rates.
A few health promotion and sport and leisure initiatives are occurring that have some evidence of effectiveness, but small population health impact.

Although of low population health impact, some clinical services to treat obesity in children and adults are available at the Tier 2 level, although there is no recurrent funding for the children’s service. Tier 3 services appear limited.

Whilst important action is taking place in school and workplace settings, the NHS should also lead by example.

It is not apparent whether antenatal health promotion includes significant emphasis on current NICE (and forthcoming) guidance on nutrition and obesity in pregnancy, and not only on breastfeeding post-natally.

Local efforts to recruit schools to the NCMP are worthwhile. However there remain gaps, especially in deprived areas and according to the health gradient. Teachers’ and parents’ perceive concerns about the programme.

Neither the NCMP, nor primary care in general, currently appear to be linked to a well developed local tiered care pathway, that would allow identified children to be further assessed and managed in terms of effective health promotion and clinical treatment.

It is not currently clear whether all local primary and secondary care clinical staff follow existing NICE guidelines on how to routinely assess most of their patients for the presence of overweight or obesity.

NICE recommends that exercise referral schemes are of uncertain effectiveness. This suggests that they should form part of a more formal research of effectiveness framework. Currently 14 practices are taking part in Cornwall.

Chapter 11 Recommendations

Approach and framework for action - inequalities and priority groups

High priority (likely high population health impact and/or less cost)

1. The Marmot Strategic Review of Inequalities in England - Fair Society, Healthy Lives is an appropriate starting point as an over-arching framework for action on physical inactivity, unhealthy eating, overweight and obesity. This should be adopted as the overall approach of the revised local Healthy Weight Strategy.

2. The existing local Healthy Weight Strategy’s life-course approach should be re-emphasised in the revised version, as in the Marmot Review.

3. The two core themes of the Marmot Review should be wholeheartedly embraced within the revised local Healthy Weight Strategy, namely:
   
   o “To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.

   o “A central message of this Review, therefore, is that action is required across all these social determinants of health and needs to involve all central and local
government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities.

4. Recommend that the framework of the World Health Organizations’ Ottawa Charter for Health Promotion is used within the overarching Marmot framework. It forms the next level of practical scaffolding within which to position interventions. It comprises:

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient (health care and other personal) services

5. Recommend that any intervention considered must be based on research evidence of effectiveness and where possible cost-effectiveness. New or unproven interventions should be considered experimental. They should only occur within a time-limited formal research context. Effective interventions with low population impact should be given lower priority for investment. Interventions proven to be ineffective should be stopped. Any intervention implemented should be evaluated against pre-agreed and accepted criteria.

6. There is minimal experience of such coordinated action in the UK, although some areas are better than others. Recommend that Finland is referred to as a case study in primarily rural settings, and Freiburg, Germany, for a small city case study.

7. Recommend that note should be taken of NICE Public Health guidance in progress - Preventing obesity: a whole-system approach. EXPECTED 01 March 2012 http://guidance.nice.org.uk/PHG/Wave20/53

Leadership and advocacy
- inequalities and priority groups

**High priority (likely high population health impact and/or less cost)**

8. Recommend that current high-profile leadership and advocacy by local government and the local NHS to tackle overweight and obesity is maintained and further supported.

9. Local political leaders and senior council officers of all sectors, the local Director of Public Health in particular, and other senior local NHS executive and non-executive board members are vital for such leadership. The local third and private sectors also have an important role.

10. Recommend reorienting local government and NHS resources to further support existing leadership.

Building healthy public policy & creating supportive environments
- inequalities and priority groups

**High priority (likely high population health impact and/or less cost)**

11. Action is required across all social determinants of health. Recommend that the revised local Healthy Weight Strategy needs to include further action by the NHS, but more importantly it
needs to have renewed ownership and action outside the NHS, across all local partnerships, strategies, and the councils’ sectors, in further similar action already commenced.

12. Recommend that the existing high-level leadership and advocacy for the local Healthy Weight Strategy across all local multi-agency partnerships and council’s sectors is maintained and developed further.

13. Recommend the strengthening and reaffirmation of existing explicit links between the revised Healthy Weight Strategy and various local strategies for addressing climate change; the environment & pollution; sustainable (social, economic & environmental) development; health & well-being; local food production, distribution, marketing & procurement; education; spatial planning, urban design & building regulations; and sustainable integrated transport.

14. Recommend that all sectoral policies, strategies, plans and programmes within local government, the local NHS, and local partnerships should routinely undergo health impact assessment (HIA) as part of their development and consultation. Such HIAs should emphasise potential effects on physical activity, healthy eating, overweight and obesity, overall population health impact, geographic and social health inequalities, stages of the life-course and effects on key vulnerable groups.

15. Recommend that identified adverse health impacts and inequalities should be minimised, and health impact maximised, in final versions of policies, strategies, plans and programmes.

16. Recommend that local government, the NHS, and partnerships should consider reorienting resources to support developing local advocacy, policy, awareness, methods, training, and expert and non-expert capacity to implement routine HIA across all sectors.

17. Recommend that at the more operational level, multi-disciplinary and professional development, appraisal, training and recruitment policies are adapted to ensure adequate local skills and experience are available for more sustainable and healthy policy development and operational design for procurement; spatial & urban planning & building design; and transport, etc.

18. Recommend that when external expertise or consultancy is sought in such sectors, criteria are developed to ensure consultants and experts have adequate skills and experience in sustainable and healthy policy development and operational design.

19. Recommend that further advice is sought on including sustainability and health within non-health sectors at the strategic and operational levels. Such advice may be available from UK universities (e.g. the University of the West of England has expertise in designing healthy neighbourhoods), from UK localities with some experience (e.g. Exeter), but preferably from successful international case studies, as previously stated.

20. There is already evidence-based NICE guidance on the promotion and creation of physical environments that support increased levels of physical activity. Recommend that key stakeholders in the NHS and local government take further note of the advice. Further NICE guidance on spatial planning and health is expected in 2011.

21. Several relevant NICE public health guidance reports are currently in development. Recommend that note is taken of them by the NHS and local government:

- Transport policies that prioritise walking and cycling
- Preventing unintentional road injuries among under 15s: road design
- Preventing unintentional road injuries among young people
22. Existing patchy, but successful, local ‘settings-based’ (WHO Healthy Schools and Healthy Workplaces) health promotion programmes could be strategically expanded and intensified with re-oriented resources. Consideration should be given to developing a WHO Health Promoting Hospitals programme.

Strengthen community action and develop personal skills
- inequalities and priority groups

*Medium priority*
(likely low to moderate population health impact and/or moderate to high cost)

23. Consideration should be given to reorienting resources to develop a planned evidence-based, sustained multi-intervention campaign to strengthen community action and develop personal skills across the locality. The focus should be on addressing physical inactivity and unhealthy eating. It is recommended that components could include:

- Being a small part of wider interventions recommended in this report
- Linking to specific elements of the environment addressed elsewhere in these recommendations.
- Providing effective information to the population, in addition to tourists, on the availability of safe and accessible parks, walking paths & cycle lanes, playgrounds, swimming pools, etc.
- Being population-wide but with increased intensity as deprivation increases. Tailored to the stages of the life-course, an emphasis on family context and the following:
  - Healthy preconception and pregnancy
  - Healthy young children (0-5 years)
  - Healthy school years (5-16 years)
- NICE Guidelines for community engagement could be followed.
- Promoting moderate-intensity physical activity, particularly walking, and activities that are not dependent on particular facilities.
- Targeting community settings using theories of behaviour change to teach skills tailored to individual needs.
- Providing social support systems (walking groups, walk-to-school groups, etc.).
- Shift in emphasis from competitive or elite sports to physical activity for all. Health and sport/recreation sectors should develop accessible programmes that use physical activity and sport as a focus for community-wide activity. Participation rates in organised sport are currently lower in females, decline with age, and in lower socio-economic groups.
- Encourage sports, cultural and environmental associations as well as organisations for children, young people and older adults to engage many people in voluntary activities. I recommend that the campaign considers parts of the NICE Guidance Obesity: The prevention, identification, assessment and management of overweight and obesity in adults and children http://guidance.nice.org.uk/CG43 It covers:
  - how people can make sure they and their children stay at a healthy weight
  - how health professionals, local authorities and communities, childcare providers, schools and employers should make it easier for people to improve their diet and become more active.
• Using social marketing as one component to partly address some existing recognised barriers to physical activity and unhealthy eating.
• A mass-media campaign - only for reaching a large population for raising awareness and affecting knowledge, and as a useful component of other interventions.
• The campaign should be evaluated at appropriate intervals.
• Reference could be made to experience of a broader campaign used in rural Finland.


25. Recommend that note should be taken of NICE Public Health guidance in progress - Using the media to promote healthy eating. EXPECTED: TBC http://guidance.nice.org.uk/PHG/Wave20/56

Uncertain priority (no/uncertain/inadequate evidence of effectiveness or population impact)

26. The current initiatives of the local NHS Health Promotion Service and community development workers are recommended to be more strategically planned and evaluated, and to become part of the wider coordinated approach recommended here. The few effective interventions used should prioritise deprived areas and communities (but should also be more widely available); families, young mothers, children and young people; and older people.

27. The effectiveness and impact on inequalities and population health of certain current healthy weights health promotion initiatives should be reassessed in light of Chapter 7. Any that are ineffective should be stopped. Others of unknown effectiveness should only occur in a formal research evaluation context.

28. In particular, effective health promotion interventions should be part of interventions recommended under #29-39 and #42 & #43 below. Effective interventions should also be linked to the wider campaign proposed under this sub-section, and more within the proposed WHO settings approach.

Reorient (health care and other personal) services
- inequalities and priority groups

High priority (likely high population health impact and/or less cost)

29. Recommend that the key role for the NHS is providing local leadership and advocacy - which is already well developed - as well as technical expertise in assessing health need, effective interventions and facilitating health impact assessment.

30. The NHS should also lead by example by: by developing WHO Health Promoting Hospitals (health care settings) and WHO Healthy Workplaces programmes; ensuring health care facilities are accessible by public transport hubs, by safe active travel, and located to minimise car use; ensuring healthy building design; procuring, promoting and subsidising local healthy food and minimising choice and maximising price of unhealthy food available for patients, staff and visitors.

31. Recommend that all health care services implemented under this section are formally evaluated to pre-agreed criteria, as a matter of course.
Medium priority (likely moderate population health impact and/or moderate cost)

32. Proven effective preventive health care services, for individuals and small groups, for physical activity, healthy eating and overweight/obesity (as detailed in Chapter 7), should be available across the whole population. There should be increased availability and intensity as deprivation increases, tailored to the stages of the life-course, with an emphasis on the family context and the following:

- Healthy preconception and pregnancy
- Healthy young children (0-5 years)
- Healthy school years (5-16 years)

33. There is detailed NICE guidance for midwives, health visitors, pharmacists and other primary care services to improve the nutrition of pregnant and breastfeeding mothers as well as for children in low income households: http://guidance.nice.org.uk/PH11 Recommend that the existing local services that address features of the guidance are expanded further across the locality by reorienting resources. There should be an emphasis not only on breastfeeding, but also on nutrition and obesity in pregnancy. With further emphasis on training, effective health promotion, settings, the weeks after delivery, increased intensity with increasing deprivation, and on evaluation.

34. Recommend that note should be taken of NICE Public Health Guidance in progress: Weight management in pregnancy and after childbirth. EXPECTED 01 July 2010

35. Recommend that existing local efforts in recruiting schools to the NCMP are worthwhile, and should be further supported. Teachers’ and parents’ concerns should be addressed where possible. Every effort should be made to recruit schools from increasingly deprived areas.

36. In particular, NICE Guidance recommends that adults who are not physically active should be routinely advised to be moderately active by primary care health professionals for at least 30 minutes, 5 days of the week. They should be provided with details of local opportunities.

37. Recommend that a coordinated programme, building on existing action, is considered by the local NHS to widely implement relevant parts of NICE Guidance - Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children https://www.nice.org.uk/guidance/CG43 It covers

- how staff in GP surgeries and hospitals should assess whether people are overweight or obese
- what staff in GP surgeries and hospitals should do to help people lose weight
- care for people whose weight puts their health at risk.

38. Recommend that note should be taken of NICE Public Health Guidance in progress: Identification and weight management of overweight and obese children in primary care.

39. Recommend that children identified as overweight or obese from the local schools NCMP should be included in preventive and lifestyle interventions within NICE Guidance https://www.nice.org.uk/guidance/CG43

Lower priority (likely less population health impact and/or higher cost)

A healthy weight population health needs assessment- Volume I: Key points and summary report
40. Proven effective clinical treatment services for individuals with existing obesity (as detailed in Chapters 6 & 7) should be available across the whole population. Recognised evidence-based local (and regional where appropriate) clinical care pathways and guidelines should be developed with stakeholders across primary, secondary and tertiary care. There should be increased availability and intensity as deprivation increases, tailored to the stages of the life-course, with an emphasis on the family context and the following:

- Healthy young children (0-5 years)
- Healthy school years (5-16 years)

41. Recommend that children identified as obese from the local schools NCMP should be included in local care pathways for treatment.

**Uncertain priority (uncertain/inadequate effectiveness evidence or low population impact)**

42. NICE recommends that exercise referral schemes, pedometers and walking and cycling schemes should only be endorsed to promote physical activity from primary care if they are part of a formal research study. Exercise referral schemes are available in some practices in Cornwall. They should become part of more formal research evaluation in conjunction with a reputable university department. Any expansion should be within that context. It is already known that such interventions tend to have low population impact and tend not to have sustained effects.

It is recommended that short-term projects are considered under this sub-heading. They should be part of more formal research evaluation of effectiveness. If they are already known to be effective and have high population impact then they should be considered for wider implementation and longer-term funding.
Summary report

Chapter 1  Introduction and background

Overweight and obesity is a major and worsening public health problem affecting the majority of the population in Cornwall and the Isles of Scilly. It poses significant and rising costs to individuals, families and communities, as well as to the health and social care sectors and the economy in general.

In recent years there has been an epidemic rise in obesity. The rising level of obesity in children is particularly worrying.

The resulting NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year. These factors combine to make the prevention of obesity a major public health challenge.

On behalf of the multi-agency Cornwall and the Isles of Scilly Healthy Weights Group, NHS Cornwall and Isles of Scilly Department of Public Health commissioned this population health needs assessment as part of the process to inform the updating of the Cornwall and Isles of Scilly Healthy Weights Strategy 2009-2013. This summary report should be read in conjunction with its more detailed full technical report.
Chapter 2  Methods

The process is based on a social model of health determinants, and takes a population and life-course approach. It takes account of key stakeholders’ views.

This needs assessment aims to identify the current unmet need for addressing physical inactivity, high-energy unhealthy eating, overweight and obesity in Cornwall and Isles of Scilly taking account of health inequalities and the life course identified in the Cornwall and Isles of Scilly Healthy Weights Strategy 2009-2013:

- Healthy preconception and pregnancy
- Healthy young children (0-5 years)
- Healthy school years (5-16 years)
- Healthy young adults (16-19 years)
- Healthy adult years
- Healthy ageing

Full details of key definitions, concepts, references and the range of methods used are described in the accompanying full technical report.
Chapter 3 The health effects of overweight and obesity

Obesity has serious consequences for population health and life expectancy. People who are obese die on average nine years earlier than those of healthy weight. Obesity increases the risk of several already common chronic, disabling and often fatal diseases. The burden of obesity and its ill-effects has a social gradient and is increasingly worse from higher to lower socioeconomic groups, and in the least deprived areas to the most deprived.

The World Health Organization estimates that globally around 58% of type 2 diabetes, 21% of heart disease and between 8% and 42% of certain cancers are attributable to excess body fat.

There are many other widespread important health benefits of regular physical activity and regular healthy eating and drinking, apart from preventing overweight and obesity. Physical activity is particularly beneficial to older people.

One million fewer obese people in the population could lead to...

- **99,000** fewer cases
- **34,000** fewer cases
- **15,000** fewer cases


The average healthcare cost of physical inactivity alone for each PCT in England is estimated at £5 million per year.
Preconception and pregnancy
There is substantial evidence that obesity in pregnancy contributes to increased morbidity and mortality for both mother and baby. For example, the CEMACH Maternal Death Enquiry 2000-2003 found that approximately 35% of women who died were obese. The CEMACH Perinatal Mortality 2005 Report found that approximately 30% of the mothers who had a stillbirth or a neonatal death were obese. Increased rates of obesity related morbidity and mortality are reflected in increased social and financial costs:

- Obese women spend an average of 4.83 more days in hospital and the increased levels of complications in pregnancy and interventions in labour represent a 5 fold increase in cost of antenatal care
- The costs associated with newborns are also increased, as in babies born to obese mothers there is a 3.5 fold increase in admission to Neonatal Intensive Care Unit (NICU)
- The most deprived pregnant women have a risk of dying which is seven times higher than that of other pregnant women.
- Overweight and obesity in the pregnant woman also leads to a significant increase in the rate of elective and emergency Caesarean section delivery and contributes to a whole range of other fertility and reproductive disorders in women.

Children and School years
Overweight and obese children are highly likely to become overweight adults overweight and obese children are highly likely to become overweight adults. Some of the key areas affected by physical activity from early years through school years are summarised here:

- Communication
- Exploration
- Motor development
- Maintain healthy weight and prevent obesity
- Develop core skills (e.g. throwing and catching)
- Teamwork
- Bone mineralization
- Reduce risk of emotional, psychological and mental health problems
- Promote healthy habit for life, and reduce lifetime risk of six diseases

Particularly worrying are the first signs of children presenting with maturity-onset (or Type 2) diabetes.

Young adults
As for children, and physical activity can also:

- Limit weight gain and obesity in first place
- Modify cardiovascular risk factors
- Maintain healthy weight
- Reduce stress and enhances mental and social wellbeing and reduces adverse reactions to stress
- Reduce earlier cases of maturity-onset Type 2 diabetes

Adult years
Physical inactivity and/or obesity can lead to:

- Premature death
- Sleep apnoea
- Reduce flexibility
• Gall bladder diseases
• Lower back pain
• Complications in surgery
• Lead to increased stress and less mental and social wellbeing
• Higher cardiovascular risk - heart disease and stroke and hypertension
• Higher osteoporosis risk
• Maturity-onset Type 2 Diabetes - over 75% of newly diagnosed adults overweight or obese
• Osteoarthritis
• Some cancers such as breast cancer and colon cancer

Healthy ageing
Physical inactivity and/or obesity can lead to:

• All of the above but larger effect, and
• Risk of falls
• Impair social benefits
• Reduce activities of daily living and mobility
• Impaired cognition
Chapter 4  Underlying causes of overweight and obesity - physical inactivity, high-energy unhealthy eating, and their complex societal causes

Put simply, overweight and obesity in individuals results from an imbalance in

- physical activity and energy used up
- food and drink consumption and energy taken in

Complex societal factors contribute to physical inactivity and increased energy-rich food and drink consumption in society throughout the life-course.

Crucially, evidence suggests overweight children are highly likely to become overweight adults, with health problems getting worse as they get older. The life-course cannot therefore be ignored when considering the causes (or the prevention) of overweight and obesity.

Physical activity

The main influences on physical activity affect active travel in the macro-environment:

**Macro-environment**
- Socioeconomic environment (see figure 1, appendix 1 this summary report)
- Spatial planning and the built environment
- Transport policy and plans, and car use

**Micro-environment**
- Availability and access to local public space and local facilities
- Building design
- Culture and social attitudes and trends toward physical activity, active travel and sedentary activities
- Individual and family factors
  - Parental influence and activity levels
  - Team and peer influences
  - Knowledge of health benefits of physical activity, and amount/intensity to do
  - Social/enjoyment
  - Barriers: sedentary activity; motivation; facilities; time & prioritisation; perceived lack of skills and fitness; health concerns; physical environment (as above)

There is a notable difference in the weight of research evidence around physical activity compared to the lack assessing the influences on food consumption.

The regular diet of a population or sub-groups within it is determined by the *food environment* - both at macro and micro levels, and by more individual factors (in turn mainly influenced by the macro and micro food environment).

Healthy eating

**Macro food environment**
Societal influences such as the influence of the media, marketing, education, peer pressure or culture are strong influences on a population’s diet.

A decision to eat more fruit and vegetables may be influenced by the availability and quality of affordable fruit and vegetables near home. Therefore expendable income as well as spatial and urban planning can have an influence on diet.
There are large discrepancies amongst socioeconomic groups resulting in inequalities of unhealthy eating. Key influences include increasing (but differential) affluence, fashion, heavy marketing (often un-regulated, and often directly to children) and pressures on families to minimise food costs. Simultaneously, the number of shops selling high-quality nutritious food (such as fresh fruit and vegetables) within easy reach of homes is declining.

Reduced personal food growing (and community land availability), and decreased shopping and preparation time have raised the proportion of calories consumed outside the home.

Conversely, spending on dining out has risen. Such food eaten outside the home is often more energy-rich.

Along with the marketing, large-scale commercial control integration of food supply chains prevail. The main aim of for-profit corporations is profit, not health, and this is to be expected in the absence of any external market regulation to the contrary.

The WHO states that urbanisation creates conditions which promote poor eating habits. We are increasingly car (and desk) bound, and exposed to almost constant marketing temptations to buy and consume energy-dense foods available 24/7.

It is not clear from research to what extent the presence and use of food labelling is understood and translated into informed purchase choices of healthy food. In summary, regardless of consumer information on foods, a minority actually consider fat content or health claims, or recommended daily amounts, and regardless, this may not be translated into an informed healthy purchase.

Micro food environment
The family, parental and peer environment are critical in forming eating habits from a young age. Children learn to eat what they are served. The body’s own biological physiological satiety (fullness) signals to the brain may be overridden by other social and environmental cues.

Evidence shows that when served larger portions for an extended period of time, people consume more food. As mentioned earlier, parental restrictions may be weaker than advertising and peer pressure in determining the actual food and drink decisions of many children. The UK has already reached a situation of almost 24-hour fast processed food availability through supermarkets, kiosks, delivery/take away outlets, vending machines and sandwich shops, along with the heavily increased marketing and promotion that underlies the observed higher consumption of energy-dense foods.

Individual
Most children cannot correctly identify the correct fruit and vegetable guidelines.

Despite objective evidence of prevalent unhealthy diets, more than four in five children regarded their diet as healthy. Although the majority of children aged 11 to 15 agreed that ‘Healthy foods are enjoyable’.

A higher proportion of women (78%) than men (62%) correctly stated that five portions of fruit and vegetables should be consumed per day. And higher proportion of accuracy was found amongst younger age groups.

Despite objective evidence of prevalent unhealthy diets only a small proportion of adults perceived their diets as ‘not very healthy/ very unhealthy’.
A large minority of men did not think healthy foods were enjoyable, and said they did not ‘really care about what I eat’. More men than women stated ‘I get confused over what’s supposed to be healthy and what isn’t’ and a higher proportion of men than women agreed that ‘If you do enough exercise you can eat whatever you like’ and that ‘Healthy eating is just another fad’. An equal proportion of men and women chose the statement ‘The tastiest foods are the ones that are bad for you’.

The proportion agreeing with ‘I really care about what I eat’ increased with age, yet older adults were more likely to choose ‘I get confused over what’s supposed to be healthy and what isn’t’ and ‘Healthy eating is just another fad’.
Physical inactivity

Children
The South West is among the least-worst regions in England for the proportion of children meeting recommended physical activity levels. However, worse still, overall, physical activity levels are low in England in general compared to the best European countries.

Although active travel, rather than active play or sports, is the main form of activity, almost a quarter of England’s children walk for 20 minutes or more only less than once a year. Even less cycle regularly. Conversely, 38% of children in England walk 3 or more times per week and 25% cycle as frequently.

Adults
The map in figure 2 of appendix 1 at the end of this summary report shows the percentage of adults taking physical activity at least three times per week (including transport) by local authority area in the South West England, for 2007/8. Cornwall is in the group of South West local authority areas with the lowest percentage of adults, with 26.9%. In the best South West local authority areas their percentage lies between 31.2% and 46.6%.

Similarly, in Cornwall, only 17.6% of adults exercise adequately (including via transport) at least five times per week, whereas in the highest in the South West (Exeter) 36.3% do so. Cornwall’s position is slightly better if active travel is excluded.

Men report higher activity levels than women, but for both genders participation is generally low, and decreases with age. Overall, men are also generally more likely to participate in physical activity of higher intensity than women.

The majority of adults under 70 years make a 20 minute walk at least once a week, but this is not near enough to make an appreciable impact on health or population obesity prevalence.

Table 5.1 below shows the low level of regular cycling by adults in England. Low levels overall have persisted for many years. Levels in most of continental Europe tend to be much higher.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 or more times a week</td>
<td>5</td>
</tr>
<tr>
<td>Once to twice a week</td>
<td>4</td>
</tr>
<tr>
<td>Less than once a week, more than twice a month</td>
<td>2</td>
</tr>
<tr>
<td>Once or twice a month</td>
<td>4</td>
</tr>
<tr>
<td>Less than once a month, more than twice a year</td>
<td>4</td>
</tr>
<tr>
<td>Once or twice a year</td>
<td>5</td>
</tr>
<tr>
<td>Less than once a year or never</td>
<td>76</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

**Source:**
Inequalities
Adults in the lowest income quintile are more likely to be in the low physical activity participation group than those in the highest income quintile in England. Adults with no formal qualifications have the lowest active sport participation rates, although no group tend to have high participation rates in general.

In general, a lower proportion of adults from black and minority ethnic groups, adults with existing limiting disability, adults from lower socio-economic groups and women tend to participate in physical activity compared to the proportion for all adults.

Figure 5.1 demonstrates the large inequalities that exist between the former districts of Cornwall and the Isles of Scilly in the proportion of adults who participate in sport or active recreation for at least 30 minutes at least three times per week.

The Isles of Scilly, Caradon, Carrick and Penwith are in the 25% of English local authorities with the least worse percentage participation (although this is still low participation in terms of
population health impact). North Cornwall is in the quarter with middle-high participation. And Restormel and Kerrier are in the quarter of English local authorities with the lowest participation.

Physical activity levels tend to be very low amongst older women.

Healthy eating

Preconception and pregnancy
Breastfeeding rates upon discharge from hospital in Cornwall and the Isles of Scilly are relatively high. However, breastfeeding rates tend to decline in the first two weeks after discharge.

Young children
Publicly available and UK collected data on the consumption of food and drink among children is not as detailed as those for adults. This contrasts with the extensive ongoing private market research on children’s food consumption.

School years

School meals
Most of children’s food is consumed outside of school. However, most available information relates to school time consumption.

The School Meals in Primary Schools in England Study 2006 showed that schools tended to fail standards by serving starchy foods cooked in oil or fat more than three times a week, and by not serving fruit-based desserts at least twice a week.

By September 2008, all primary schools in England were required by law to meet new food-based and nutrient-based standards for food provided in schools. A sample survey in 2009 compared data from 2005 to assess the impact on catering provision and pupil food selection/consumption.

Compared with 2005, caterers provided healthier lunches, including more vegetables and salad, starchy foods not cooked in fat (like pasta and rice), fruit, fruit juice, and fruit-based desserts, and fewer desserts without fruit, chips and other starchy foods cooked in fat, and no crisps or confectionery. However, the study recommended that school caterers still needed to:

- Continue to reduce the number of times that starchy foods cooked in fat and meat products are provided
- Increase the range of ways in which fruit and fruit-based desserts are provided
- Encourage more pupils to take fruit and fruit-based desserts at lunchtime
- Find more ways to include vegetables in recipes
- Increase the iron and zinc content of recipes and meals
- Reduce the amount of salt used in cooking

As a result of limiting the range of foods to healthier options, pupils took healthier lunches in 2009 compared to 2005 (see fig 5.2). The study concluded however that somehow, pupils still needed to be encouraged to:

- Take more portions of fruit
- Eat more of the vegetables and fruit taken
- Choose alternatives to starchy foods cooked in oil and meat products even when they are on the menu
All meals and food intake
Among children aged 2 to 18 years from low income households, the Low Income Diet and Nutrition Surveys (LIDNS) shows that the main contributors to total energy intake were cereals and cereal products, meat and meat products and potatoes and savoury snacks.

For non-milk extrinsic sugars and saturated fats, both boys and girls from low income households exceeded the maximum of 11% of energy intake for both food macronutrients.

The main contributing food group to total fat intake among children from low income households was meat and meat products (22%), closely followed by cereals and potatoes (both contributing 19% to total fat intake).

Over 80% of children in low income families consumed white bread, chips (and other fried or roast potato products) and crisps and other savoury snacks during the survey periods. Boys were more likely to consume foods such as burgers, kebabs, meat pies and pastries than girls.

Confectionary, savoury snacks, sugary fizzy drinks and other processed foods (including meats) are large contributors to excessive total energy, extrinsic sugar, total fat and saturated fat for children from low income households.

Figure 5.3 shows that fruit and vegetable consumption in children aged 5-15 years in the South West of England is the third lowest of all English Regions for boys and girls, with only the North East and the West Midlands being lower. For the whole of England, the LIDNS showed that fruit...
and vegetable consumption among children in low income households was very low, with only 1% of boys and 4% of girls consuming five or more portions a day.

Figure 5.3

Young adults and adults
Nowadays although younger people are increasingly more likely to eat pasta and rice, they are also more likely to consume other miscellaneous cereals, savoury snacks and drink non-low calorie soft drinks. The proportion meeting the fruit and vegetable guidelines was lowest among younger adults aged 16-24 and was higher among the 25-54 age group.

Figure 5.4 shows that most energy intake in adults comes from cereals and cereal products and meat and meat products, a large proportion of which are in processed foods, ready meals or food eaten outside the home. Meat and meat products account for most total fat intake and saturated fat intake, although milk and milk products are the largest for the latter.

Figure 5.4 Main food group contributors to daily energy intake among adults

Great Britain

<table>
<thead>
<tr>
<th>Food Group</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cereals &amp; cereal products</td>
<td>31%</td>
</tr>
<tr>
<td>Meat &amp; meat products</td>
<td>15%</td>
</tr>
<tr>
<td>Milk &amp; milk products</td>
<td>10%</td>
</tr>
<tr>
<td>Drinks</td>
<td>10%</td>
</tr>
<tr>
<td>Potatoes &amp; savoury snacks</td>
<td>9%</td>
</tr>
<tr>
<td>Other food categories</td>
<td>25%</td>
</tr>
</tbody>
</table>
A range of foods are less likely to be eaten by adults who live in low income households including breakfast cereals, buns, cakes and pastries, skimmed and semi-skimmed milk, oily fish and tinned tuna, vegetables, fruit, nuts and seeds and fruit juice. But they were more likely to consume fat spreads, non-diet soft drinks, meat and meat dishes, pizza, processed meats, whole milk and table sugar. Amongst low income adults white bread and condiments were the most commonly consumed (over 70% of all adults reporting their consumption).

Men tend to consume more fats and oils, meat and meat dishes/products, sugars and preserves, non-low calorie soft drinks and alcoholic drinks than women.

There is an increase in the proportion of people who consume five or more portions of fruit and vegetables a day moving from lower to higher household income groups, especially for men.

Health Survey England 2007 showed that 7% of men in the South West consumed no fruit and vegetables at all (the worst region was 11% and the best was 6%). Only 29% of men in the South West ate 5 or more pieces daily (the worst was 13% and the best was 36%).

For women, 7% in the South West consumed no fruit and vegetables at all this was the worst region along with the East of England. The best was 3%). Only 36% of women in the South West ate 5 or more pieces daily but nevertheless this was the highest proportion of any region. The worst was the North East at 23%.

Healthy ageing
The oldest age group surveyed in Health Survey England, although more likely to consume breakfast cereals, yogurts, eggs, and fruit (excluding fruit juice), are also more likely to consume biscuits and cakes, puddings, compared to other age groups.

For vegetables (excluding potatoes), sugar and preserves the mean consumption by weight increased with age, but the proportion consuming these food types remained similar in each age group. That is, of those already eating these products they tended to eat more with age.

The proportion meeting the fruit and vegetable guidelines was lowest among younger adults but peaked among older adults, but then declined among the very oldest age group.
Preconception and pregnancy
It is difficult to obtain published data on obesity in pregnancy. However one Oxford study of pregnant women found there were 665 extremely obese women (BMI>50) among an estimated 764,387 maternities in the UK between September 2007 and August 2008, suggesting a prevalence of almost one in every 1,100 maternities.

Another study in north London found a prevalence of 24.3% for moderately obese pregnant women and 9.6% for very obese women (figure 6.1).

Figure 6.1 Frequency distribution of maternal body mass index at booking in 325 395 completed singleton pregnancies in North Thames (London).

Healthy young children (0-5 years)
In summary, the key findings of the National Child Measurement Programme (NCMP)\(^1\) for England as a whole for 2008/9 data show that in Reception (aged 4-5 years), more than one in five (22.8%) of the children measured were either overweight or obese

Data from NCMP during the 2008/09 academic year in Cornwall and the Isles of Scilly for participating children aged 4-5 years (table 6.1) shows that almost a quarter (24.3%) were either overweight or obese (higher than the national and South West average), with 14.4% overweight (higher than the national and South West average) and 9.9% obese.

---

\(^1\) The findings of the 2006/07 NCMP were compared to the 2006 HSE. It was shown that, apart from obese boys in Reception, the prevalence rates in the two studies are not statistically significantly different. The obesity prevalence estimate for boys in Reception was shown to be significantly higher in the HSE and warrants further investigation.
Table 6.1 2008/9 NCMP results for Cornwall and the Isles of Scilly - Reception Year

<table>
<thead>
<tr>
<th></th>
<th>Overweight</th>
<th>Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception</td>
<td>13.2%</td>
<td>9.6%</td>
</tr>
<tr>
<td>National</td>
<td>14.0%</td>
<td>8.9%</td>
</tr>
<tr>
<td>South West</td>
<td>14.4%</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

Healthy school years (5-16 years)

Nearly 50% of boys and over 40% of girls aged 6-10 years are at present forecast to be overweight or obese in England by 2050. Successive the Health Surveys for England have demonstrated the increasing trend. Despite the increasing trends in England, overweight and obesity in children is consistently higher in Wales for boys and girls. However, there are marked variations within England according to geography and deprivation especially.

In summary, the key findings of the National Child Measurement Programme (NCMP)\(^2\) for England as a whole for 2008/9 data are shown below:

- In Year 6 (aged 10-11 years), the prevalence of overweight or obesity was nearly one in three (32.6%)
- The percentage of obese children in Year 6 (18.3%) is nearly double than that in Reception (9.6%)
- The percentage of overweight children is higher in Year 6 (14.3%) than in Reception (13.2%)
- The prevalence of obesity is significantly higher in boys than in girls in both age groups

Obesity prevalence is statistically significantly higher in urban areas than in rural areas, as was the case in NCMP 2007/08. However differences are small.

As in the 2007/08 NCMP, a strong positive relationship exists between deprivation and obesity prevalence for children in Reception and Year 6. Obesity prevalence for children is well known to be closely linked to socioeconomic status, with higher obesity prevalence in more deprived areas. Nearly 60% of the variation in obesity prevalence between local authority areas can be explained by the proportion of children living in low income households.

According to measured Year 6 (aged 10-11 years) pupils in Cornwall and the Isles of Scilly 14.2% were overweight (similar to the national and South West average) and 17.9% obese (higher than the South West average, lower than the average), in 2008/9. In summary, almost one third were either overweight or obese (see table 6.2).

Table 6.2 2008/9 NCMP results for Cornwall and the Isles of Scilly - Year 6

<table>
<thead>
<tr>
<th></th>
<th>Overweight</th>
<th>Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 6</td>
<td>14.3%</td>
<td>18.3%</td>
</tr>
<tr>
<td>National</td>
<td>14.2%</td>
<td>16.2%</td>
</tr>
<tr>
<td>South West</td>
<td>14.2%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Cornwall and Isles of Scilly</td>
<td>14.2%</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

---

\(^2\) The findings of the 2006/07 NCMP were compared to the 2006 HSE. It was shown that, apart from obese boys in Reception, the prevalence rates in the two studies are not statistically significantly different. The obesity prevalence estimate for boys in Reception was shown to be significantly higher in the HSE and warrants further investigation.
The map in figure 6.3 (Appendix2) shows the variation in the prevalence of obesity 2008/9 in children aged 10-11 between PCT areas in England, with Cornwall and the Isles of Scilly lying above the England and average.

Obesity prevalence in the Year 6 age group varies by around 10% on average between the most deprived and least deprived local authorities in England, with Cornwall and the Isles of Scilly having above average obesity and deprivation compared to the average for PCTs in England.

The variation in the prevalence of overweight and obesity in Reception and Year 6 students in the NCMP between former districts of Cornwall in 2008/9 is shown in table 6.3 in Appendix 2. However the numbers in each are small, therefore the comparison is difficult to interpret. Nevertheless, Kerrier appears to have a significantly higher prevalence of Year 6 obesity compared to other districts.

**Young adults, adult years and healthy ageing**

By 2007 the majority of men and women in England were either overweight or obese. Statistical modelling of 2003-05 data in figure 6.4 suggests that just under a fifth (19%) of local authority areas had an obesity rate significantly higher than the national average, and 17% of LAs were estimated to have a significantly lower obesity rate than the national estimate.

For Cornwall and the Isles of Scilly 2007 estimates show a prevalence of adult obesity in Cornwall and the Isles of Scilly over 1.5 times worse than the best in England, but similar to the average for England.
Of the Cornwall commissioning localities adult obesity is highest in the East Cornwall and the West Cornwall locality groups.

In England, socioeconomic inequalities in obesity are apparent for women, but are not as clear in men, depending on the measure of inequality used. In 2007 among women, the proportions who were both overweight and obese were higher in the lowest three income quintiles (ranging from 33%-36% overweight and 27%-28% obese) than women in the highest quintile (average 29% overweight and 20% obese).

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Cornwall & IoS Prevalence of obese adults % 2007

<table>
<thead>
<tr>
<th></th>
<th>Cornwall and IoS</th>
<th>England average</th>
<th>England worst</th>
<th>England best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornwall and IoS</td>
<td>22.4</td>
<td>21.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England average</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England worst</td>
<td></td>
<td></td>
<td>31.0</td>
<td></td>
</tr>
<tr>
<td>England best</td>
<td></td>
<td></td>
<td>14.6</td>
<td></td>
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</tbody>
</table>

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Cornwall Health Profile 2007. APHO and Department of Health. © Crown Copyright 2007

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Burden of health effects of obesity in Cornwall and the Isles of Scilly

Department of Health estimates suggest that obesity-related disease cost the NHS Cornwall and the Isles of Scilly £200.7 million annually. Figure 6.5 shows how the burden is related to cancer and cardiovascular deaths in Cornwall (published data is not available for Isles of Scilly). For cancer deaths locally, 8.3% are estimated to be related to obesity. For cardiovascular disease 30.6% are estimated to be related to obesity.

Figure 6.5 Estimated number of annual obesity-related deaths from cancer and cardiovascular disease in Cornwall

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
</tr>
<tr>
<td>Number of deaths from cancer</td>
<td>2226</td>
</tr>
<tr>
<td>Estimated number of those deaths caused by obesity</td>
<td>185</td>
</tr>
<tr>
<td>Estimated number of deaths if obesity reduced by 5%</td>
<td>2217</td>
</tr>
<tr>
<td>Reduction in number of deaths</td>
<td>9</td>
</tr>
<tr>
<td><strong>Heart Disease and Stroke</strong></td>
<td></td>
</tr>
<tr>
<td>Number of deaths from Heart Disease and Stroke</td>
<td>1472</td>
</tr>
<tr>
<td>Estimated number of those deaths caused by obesity</td>
<td>450</td>
</tr>
<tr>
<td>Estimated number of deaths if obesity reduced by 5%</td>
<td>1449</td>
</tr>
<tr>
<td>Reduction in number of deaths</td>
<td>23</td>
</tr>
</tbody>
</table>

Source: DH
Chapter 7 Effective approaches to address overweight and obesity

The solution to preventing and reducing population overweight and obesity will have to be complex, coordinated and sustained, to deal effectively with the complex underlying influences on a whole population basis.

There is considerably more research into approaches and interventions that deal with physical inactivity than unhealthy eating at the population level.

The framework for action set out in the recent and influential *Marmot Strategic Review of Inequalities in England - Fair Society, Healthy Lives* is an appropriate starting point as an overarching framework for action on physical inactivity. Within this framework a whole range of known effective interventions can be coherently implemented for a more concerted and synergistic effect. The review took a life-course approach, mirroring the approach taken in this report. Key issues from the Review are:

“To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.”

“A central message of this Review, therefore, is that action is required across all these social determinants of health and needs to involve all central and local government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities.”

Physical activity

**Building healthy public policy and creating supportive environments for physical activity**

**General**
A local and national sustained and organised multi-sector, multi-agency approach within the framework of the Review is crucial for success. A key agency is local government.

**Regeneration, economic development and efficiency**
Policies that increase physical activity are more cost-effective. Employers benefit since having a physically active workforce can lead to reductions in absenteeism and increased productivity.

Local governments that spend the least on transport infrastructure are those with planning and transport policies that end up with medium- or high-density towns where trips can be easily made mainly using public transport, walking and cycling.

Neighbourhood renewal schemes that include adequate facilities and equipment for active living (such as basketball courts, skateboarding parks, playgrounds and football fields), small gardens, safe routes to school, public transport stations, and the establishment of safe neighbourhood parks reduce inequity in access and choices for physical activity.

**Spatial and land-use planning and the built environment**
The way the built environment and land-use are planned, designed and renewed is strongly associated with the resulting levels of physical activity and health.

Local government can protect the traditional design of older built-up areas and control further development of dispersed, segregated, suburban land-uses. Examples include business, retail and
leisure parks, isolated educational or hospital development and sporadic residential developments. These inherently rely on car access.

People are also more likely to walk or cycle when suburban sprawl is minimised, by improving public transport, restricting car use in towns and built-up areas, and when land use is mixed (locating shops, schools, health services, workplaces and other destinations are close to dwellings) so that their destinations are nearby. Density and a mix of shops, schools and workplaces encourage active transport. Local government and the health service can plan for this.

Opportunities for physical activity need to be created close to where people live and within built-up areas, together with creating cleaner, safer, greener and more activity-friendly local environments. Neighbourhood parks that are within walking or cycling distance of a person’s home or workplace can promote greater physical activity. Local government can work toward a green network in built-up areas accessible to all residents complemented by a network of squares and other outdoor places for active living.

Local government can ensure that children have safe places to play, and design streets and neighbourhoods to include safe areas for active play; ensure that housing developments incorporate shared play areas in common spaces; and provide interesting, safe, well-maintained playgrounds.

Beaches, green forests and hilly landscapes provide opportunities for hiking and active outdoor pursuits, but they have to be perceived as accessible by the local community, and perceived that they are not just for tourists or higher social groups. Such areas must be accessible by affordable transport and by safe high quality walking and cycling routes from local residential areas.

There is already evidence-based NICE guidance on the promotion and creation of physical environments that support increased levels of physical activity. Further guidance on spatial planning and health is expected in 2011. Key evidence so far includes:

<table>
<thead>
<tr>
<th>Strategies, policies and plans</th>
<th>Who should take action?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Those responsible for all strategies, policies and plans involving changes to the physical environment. This includes the development, modification and maintenance of towns, urban extensions, major regeneration projects and the transport infrastructure. It also includes the siting or closure of local services in both urban and rural areas.</td>
<td></td>
</tr>
<tr>
<td>What action should they take?</td>
<td></td>
</tr>
<tr>
<td>• Ensure planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life. Ensure local facilities and services are easily accessible on foot, by bicycle and by other modes of transport involving physical activity. Ensure children can participate in physically active play.</td>
<td></td>
</tr>
<tr>
<td>• Assess in advance what impact (both intended and unintended) the proposals are likely to have on physical activity levels. (For example, will local services be accessible on foot, by bicycle or by people whose mobility is impaired?) Make the results publicly available and accessible. Existing impact assessment tools could be used.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public open spaces</th>
<th>Who should take action?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Designers and managers of public open spaces, paths and rights of way (including coastal, forest and riverside paths and canal towpaths).</td>
<td></td>
</tr>
<tr>
<td>• Planning and transport agencies including regional and local authorities.</td>
<td></td>
</tr>
<tr>
<td>What action should they take?</td>
<td></td>
</tr>
<tr>
<td>• Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity. They should also be accessible by public transport.</td>
<td></td>
</tr>
<tr>
<td>• Ensure public open spaces and public paths are maintained to a high standard. They should be safe, attractive and welcoming to everyone.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Buildings</th>
</tr>
</thead>
</table>
Who should take action?
• Architects, designers, developers, employers and planners.

What action should they take?
• Those involved with campus sites, including hospitals and universities, should ensure different parts of the site are linked by appropriate walking and cycling routes. (Campuses comprise two or more related buildings set together in the grounds of a defined site.)
• Ensure new workplaces are linked to walking and cycling networks. Where possible, these links should improve the existing walking and cycling infrastructure by creating new, through routes (and not just links to the new facility).

Who should take action?
• Architects, designers and facility managers who are responsible for public buildings (including workplaces and schools).

What action should they take?
• During building design or refurbishment, ensure staircases are designed and positioned to encourage people to use them.
• Ensure staircases are clearly signposted and are attractive to use. For example they should be well-lit and well-decorated.

Schools
Who should take action?
• Children’s services, School Sport Partnerships, school governing bodies and head teachers.

What action should they take?
• Ensure school playgrounds are designed to encourage varied, physically active play.
• Primary schools should create areas (for instance, by using different colours) to promote individual and group physical activities such as hopscotch and other games.

Further detail is available in the full report.

Transport and active travel
The transport system can strongly influence opportunities to be physically active, both by facilitating walking and cycling, by reducing sedentary car use, and by enabling people to get to places to be active in other ways.

Local government can integrate strategic land-use and transport planning for active travel.

Local government can create a comprehensive plan for cycling and walking in existing and future development and integrate the plan into broader transport planning.

Actual traffic injury and fatality risk (and a perceived risk resulting from high motor vehicle speed, heavy traffic flow and a lack of separate lanes, tracks and paths on busy routes are major reasons why people do not walk or cycle in built-up areas. This is especially true for children and older people.

Lack of pavements and protected areas for walking and cycling to school can contribute to increasing collisions involving children or a fear of collisions.

Brief traffic signals and wide streets with inadequate lane markings on roadways also compromise the safety of older pedestrians.

High vehicular speed, the number of kilometres of major arterial streets in a neighbourhood, poorly located bus stops and crossings and poor lighting are associated with higher risks to the safety of pedestrians of all ages. Other sources of danger for pedestrians and cyclists include poorly maintained pavements.

Local government can support cycling with appropriate traffic policies and legislation. Expanded high-quality on- and off-road segregated cycling networks within and between built-up areas are crucial. They can build adequate continuous separate lanes and tracks for pedestrians, cyclists and cars on busy streets and re-prioritise junctions to favour pedestrians, cyclists and public transport. Adequate bicycle storage in public places is important.
Public and private organisations can provide bicycles and changing rooms for staff. There are tax incentives for this.

Several relevant NICE public health guidance reports are currently in development:
- Transport policies that prioritise walking and cycling
- Preventing unintentional road injuries among under 15s: road design
- Preventing unintentional road injuries among young people

There is existing NICE guidance on the promotion and creation of physical environments that support increased levels of physical activity that contains a section on active transport, summarised as:

<table>
<thead>
<tr>
<th>Who should take action?</th>
<th>Who should take action?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those responsible for all strategies, policies and plans involving changes to the physical environment, including local transport authorities, transport planners and local authorities.</td>
<td>Planning and transport agencies, including regional and local authorities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What action should they take?</th>
<th>What action should they take?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads. (This includes people whose mobility is impaired.) Use one or more of the following methods:</td>
<td>Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity. These routes should offer everyone (including people whose mobility is impaired) convenient, safe and attractive access to workplaces, homes, schools and other public facilities. (The latter includes shops, play and green areas and social destinations.) They should be built and maintained to a high standard.</td>
</tr>
<tr>
<td>- re-allocate road space to support physically active modes of transport (as an example, this could be achieved by widening pavements and introducing cycle lanes)</td>
<td>- restrict motor vehicle access (for example, by closing or narrowing roads to reduce capacity)</td>
</tr>
<tr>
<td>- restrict motor vehicle access (for example, by closing or narrowing roads to reduce capacity)</td>
<td>- introduce road-user charging schemes</td>
</tr>
<tr>
<td>- introduce traffic-calming schemes to restrict vehicle speeds (using signage and changes to highway design)</td>
<td>- create safe routes to schools (for example, by using traffic-calming measures near schools and by creating or improving walking and cycle routes to schools).</td>
</tr>
</tbody>
</table>

Further detail is available in the full report.

**Community action for physical activity**

Comprehensive and sustained community-wide campaigns that involve many sectors and the public in highly visible, broad-based, multiple interventions in combination (such as media promotion, support and self-help groups, community fairs and events, programmes in the schools and workplaces, and the creation of walking paths and trails) can be highly effective in increasing physical activity.

In any given neighbourhood, policies that improve walkability and land-use mix are likely to increase overall community cohesion. This is partly due to urban design that helps increase personal security and encourages neighbours to socialise, watch out for and help each other.

Social support systems (such as walking groups, outdoor tai-chi groups and walk-to-school groups) also help people become more active.

Finland provides a strong example of a shift in emphasis from competitive and elite sports to health-enhancing physical activity for all. The health and sport/recreation sectors should develop
accessible programmes that use physical activity and sport as a focus for community-wide activity.

Sports, cultural and environmental associations as well as organisations for children, young people and older adults engage many people in voluntary activities. They play an important part in building social cohesion.

Although the sport sector is viewed as a priority area for increasing rates of physical activity, participation rates in organised sport are lower in females, decline with age, and are less in lower socio-economic and minority groups. High quality research that assesses the effects of interventions to increase participation in sport does not currently exist.

**Develop personal skills for physical activity**

Approaches focusing solely on changing individual behaviour or small groups have limited success in terms of population health impact as they will not reach the majority of the population (most of whom are inactive). Neither do they tend to have lasting effects. Increasingly, the evidence suggests that policies and programmes to enable people to be physically active are more effective and have more impact if they primarily modify the physical and social environments (see above).

It is important to provide effective information on the availability of safe and accessible parks, walking paths and cycle lanes, playgrounds, swimming pools and other facilities.

The following factors are parts of effective programmes:

- targeting individuals in community settings using theories of behaviour change to teach skills and tailor interventions to individual needs
- promoting moderate-intensity physical activity, particularly walking, and activities that are not dependent on particular facilities
- incorporating regular follow-up and contact with an exercise specialist

While mass-media campaigns can reach large populations at relatively low cost, they can rarely demonstrate a population-level effect on behaviour on their own. Campaigns are, however, usually effective in raising awareness of an issue and affecting knowledge, and so can be a useful component of a comprehensive package of interventions.

Health promotion programmes should link to specific elements of the environment. For example, programmes such as TravelSmart link to key cycling or walking routes, or promote use of the stairs in key buildings where this is a viable option.

**Social marketing** is about understanding people’s starting point in relation to an issue, in this case unhealthy weight gain. The key questions are:

- What in their behaviours places them at risk?
- What drives their current behaviours?
- How might they be motivated to change?
- Who might be able to influence them?
- What might act as barriers to change?

In relation to social marketing, evidence from diverse sources points to a number of issues that act as barriers to lifestyle change within families:

- limited parental awareness of weight status and associated health risks
- parental beliefs that healthy lifestyles are too challenging

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- pressure on parents that undermines healthy food choices
- pressure on parents that reduces the opportunities for active lifestyles

There has been much less work on physical activity and social marketing, compared with healthy eating. However, the following are clear:

- Public perception of the link between obesity and ill-health is poor
- Concerns about diet and activity may not be a priority, especially in communities with low socio-economic status
- The impact of individual interventions to increase physical activity through counselling or exercise referral schemes, has usually been small and the sustainability of these interventions is relatively low
- Parents commonly identify safety, park facilities and urban design as important in creating opportunities for, or conversely as barriers to, active transport or free-play

- Parental support for activity in all its forms is crucial, but may be constrained by ‘time-poor’ lifestyles and real or perceived issues of cost and access.

- ‘Perceived barriers’ was the most consistent negative correlate. In adolescents, gender (boys only), ethnicity, perceived competence, intention and previous physical activity, sensation seeking, participation in community sports, parental and other adult support, sibling physical activity, and physical environment including opportunities to exercise were all consistently positively associated with physical activity. Sedentary behaviour after school and at weekends and depression were consistently negatively associated with physical activity.

- Barriers to healthier lifestyles, in terms of diet and activity, relate to physical and emotional issues. The barriers may be real or perceived but the net impact is to foster the parental belief that healthy lifestyles are too challenging, which reduces motivation to change.

- Parents are important role models for attitudes to, and participation in, physical activity.

- Active play is an undervalued component of physical activity.

- Computer games and videos are among the most highly valued and preferred activities for children. But decreases in television viewing are associated with decreased weight gain.

Adequate and sustained social marketing as an integral part of wider population measures, and addressing identified barriers, may help address low population physical activity, but needs to be implemented in the context of high quality research evaluation.

**Reorient health and other personal services to promote physical activity**

**Role of the health sector**

The key for the health sector is providing local leadership, advocacy and stewardship for increasing physical activity.

The health sector should join forces with town planners, transport officials and architects to help create places where physical activity is easier and safer.

Health promotion programmes should link to specific elements of the environment. For example, programmes such as TravelSmart link to key cycling or walking routes, or promote use of the stairs in key buildings where this is a viable option.
Physical activity should have a stronger role in primary prevention, for example, by ensuring that all GPs and other primary care professionals offer counselling and advice on physical activity, and are well trained to do so. This occurs as a matter of course in countries such as Sweden and has been part of NICE’s evidence-based guidance since 2006.

The health sector should set the example by promoting physical activity among employees and users of health systems, by such means as providing facilities for employees to walk and cycle to work, or to be active in their lunch breaks, and by ensuring that there are appropriate disincentives to unnecessary car use.

NICE guidance recommends that GP exercise referral schemes should be considered experimental. They should only occur in the context of formal research.

**Settings for physical activity**

WHO has pioneered the settings approach to health improvement. Key settings include:

- Schools (e.g. WHO Health Promoting Schools Programme)
- Workplaces - further details on effective interventions on physical activity in the workplace have been published in May 2008 by NICE.
- Healthcare settings (e.g. WHO Health Promoting Hospitals)

**Population groups**

Reference is made to the life-course approach as set out earlier in this report.

**Healthy eating, overweight and obesity**

There is considerably more research into approaches and interventions that deal with physical inactivity than unhealthy eating at the population level. More of the interventions for healthy eating lie in regulating the private sector.

A similar approach to the effective physical activity approach is advocated by WHO which complements the Marmot framework.

**Building healthy public policy and creating supportive environments for healthy eating**

A similar approach to the effective physical activity approach is advocated by WHO which complements the Marmot framework. Details are available from:

- [http://www.euro.who.int/document/e89858.pdf](http://www.euro.who.int/document/e89858.pdf)
- [http://www.euro.who.int/document/e78578.pdf](http://www.euro.who.int/document/e78578.pdf)

**Community action for healthy eating**

A healthy weight population health needs assessment- Volume I: Key points and summary report
Approach as for physical activity.

**Personal skills for healthy eating**
Approach as for physical activity.

| NICE Public Health guidance in progress - Using the media to promote healthy eating. EXPECTED: |
| TBC |

**Reorient health and other personal services to promote healthy eating**

**Preconception and pregnancy & healthy young children**
There is detailed NICE guidance for midwives, health visitors, pharmacists and other primary care services to improve the nutrition of pregnant and breastfeeding mothers as well as for children in low income households. [http://guidance.nice.org.uk/PH11](http://guidance.nice.org.uk/PH11)

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**Maternal and child nutrition: Guidance for midwives, health visitors, pharmacists and other primary care services to improve the nutrition of pregnant and breastfeeding mothers and children in low income households.**


**Description**
This guidance is for health professionals, commissioners and managers, pharmacists, those providing pre-school childcare and other relevant public, community, voluntary and private sector organisations.

It relates to pregnant women (and those who are planning to become pregnant), mothers and other carers of children aged under 5 and their children. It is particularly aimed at those on a low income or from a disadvantaged group.

**Recommendations for health professionals include:**

- **Breastfeeding - Recommendation 7**
  - Who is the target population?
    - Pregnant women and breastfeeding mothers.
  - Who should take action?
    - Commissioners and managers of maternity and children’s services.
  - What action should they take?
    - Adopt a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include:
      - activities to raise awareness of the benefits of – and how to overcome the barriers to – breastfeeding
      - training for health professionals
      - breastfeeding peer-support programmes
      - joint working between health professionals and peer supporters
      - education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period (the support may be provided by a volunteer).
      - Implement a structured programme that encourages breastfeeding, using BFI as a minimum standard ([www.babyfriendly.org.uk](http://www.babyfriendly.org.uk)). The programme should be subject to external evaluation.
      - Ensure there is a written, audited and well-publicised breastfeeding policy that includes training for staff and support for those staff who may be breastfeeding. Identify a health professional responsible for implementing this policy.
      (See also NICE clinical guideline 37 on postnatal care at [www.nice.org.uk/guidance/CG37](http://www.nice.org.uk/guidance/CG37))
  - **Recommendation 11**
    - Who is the target population?
      - Pregnant women and new mothers, particularly those who are least likely to start and continue to breastfeed. For example, young women, those who have low educational achievement and those from disadvantaged groups.
    - Who should take action?
      - Commissioners and managers of maternity and children’s services.
    - What action should they take?
• Provide local, easily accessible breastfeeding peer support programmes and ensure peer supporters are part of a multidisciplinary team.
• Ensure peer supporters:
  - attend a recognised, externally accredited training course in breastfeeding peer support
  - contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth)
  - offer mothers ongoing support according to their individual needs. This could be delivered face-to-face, via telephone or through local groups can consult a health professional and are provided with ongoing support
  - gain appropriate child protection clearance.
• Consider training peer supporters and link workers to help mothers, parents and carers follow professional advice on feeding infants aged 6 months and over. The advice should promote an increasingly varied diet using food of different textures in appropriate amounts (in addition to milk), in response to the baby’s needs.

Infant formula
Recommendation 14
Who is the target population?
Pregnant women and mothers.

Who should take action?
Commissioners and managers responsible for maternity, children’s and primary care services. GPs, midwives, health visitors and pharmacists.

What action should they take?
- Commissioners and managers should ensure mothers have access to independent advice from a qualified health professional on the use of infant formula. This should include information on the potential risks associated with formula-feeding and how to obtain ongoing advice at home.
- Midwives should ensure mothers who choose to use infant formula are shown how to make up a feed before leaving hospital or the birth centre (or before the mother is left after a home birth). This advice should follow the most recent guidance from the DH ("Bottle feeding" 2006).
- Avoid promoting or advertising infant or follow-on formula. Do not display, distribute or use product samples, leaflets, posters, charts, educational or other materials and equipment produced or donated by infant formula, bottle and teat manufacturers.
  (See also NICE clinical guideline 37 on postnatal care at www.nice.org.uk/CG037)

Child health promotion
Recommendation 16
Who is the target population?
Parents and carers of infants and pre-school children.

Who should take action?
NHS trust and PCT commissioners and managers. Health visitors, community nursery nurses, the child health promotion programme (CHPP) team and children’s centre teams.

What action should they take?
- Commissioners and managers should work with local partners to ensure mothers can feed their babies in public areas without fear of interruption or criticism.
- Health visitors should assess the needs of all mothers, parents and carers with young children. They should provide relevant, early and ongoing support at home for those with the greatest needs, including any that may be the result of a physical or learning disability or communication difficulties.
- Health visitors and the CHPP team should:
  * provide mothers and other family members with support to introduce a variety of nutritious foods (in addition to milk) to ensure the child is offered a progressively varied diet from 6 months
  * encourage and support parents and carers to make home-prepared foods for infants and young children, without adding salt, sugar or honey
  * encourage families to eat together and encourage parents and carers to set a good example by the food choices they make for themselves
  * advise parents and carers not to leave infants alone when they are eating or drinking.

Recommendation 17
Who is the target population?
Infants and pre-school children.

Who should take action?
NHS trust and PCT commissioners and managers. GPs, pediatricians, midwives, health visitors and community nursery nurses.

What action should they take?
- As a minimum, ensure babies are weighed (naked) at birth and at 5 and 10 days, as part of an overall assessment of feeding. Thereafter, healthy babies should be weighed (naked) no more than fortnightly and then at 2, 3, 4 and 8–10 months in their first year.
- Ensure infants are weighed using digital scales which are maintained and calibrated annually, in line with medical devices standards (spring scales are inaccurate and should not be used).
- Commissioners and managers should ensure health professionals receive training on weighing and measuring infants. This should include: how to use equipment, how to document and interpret the data, and how to help parents and carers understand the results and implications.
- Ensure support staff are trained to weigh infants and young children and to record the data accurately in the child health record held by the parents.

**Pre-school settings**

**Recommendation 20**

**Who is the target population?**

Parents and carers of infants and pre-school children.

**Who should take action?**

Nursery nurses, home-based child carers and others working in pre-school day care settings such as nurseries, crèches and playgroups.

**What action should they take?**

- Support breastfeeding mothers by:
  * offering them the opportunity to breastfeed when they wish
  * ensuring expressed breast milk is labeled with the date and name of the infant and stored in the main body of the fridge
  * implementing DH guidance (‘Bottle feeding’ 2006) on the preparation and use of powdered infant formula to reduce the risk of infection to infants in care settings.

**Recommendation 21**

**Who is the target population?**

Infants and pre-school children up to the age of 5 years.

**Who should take action?**

Teachers, teaching assistants, nursery nurses, home-based child carers and those working in pre-school day care settings such as nurseries, crèches and playgroups.

**What action should they take?**

- Implement a food policy which takes a ‘whole settings’ approach to healthy eating, so that foods and drinks made available during the day reinforce teaching about healthy eating.
  - Take every opportunity to encourage children to handle and taste a wide range of foods that make up a healthy diet by:
    * providing practical classroom-based activities
    * ensuring a variety of healthier choices are offered at mealtimes, and snacks offered between meals are low in added sugar and salt (for example, vegetables, fruit, milk, bread and sandwiches with savoury fillings)
    * ensuring carers eat with children whenever possible.

**Family nutrition**

**Recommendation 22**

**Who is the target population?**

Families with children aged up to 5 years.

**Who should take action?**

Commissioning agencies, local authorities, local strategic partnerships, voluntary agencies and local businesses that fund or provide community projects. Public health nutritionists and dietitians.

**What action should they take?**

- Public health nutritionists and dietitians should offer parents in receipt of Healthy Start benefit practical support and advice on how to use the Healthy Start vouchers to increase their intake of fruit and vegetables.
- Provide support (both practical and financial) to develop and maintain community-based initiatives which aim to make a balanced diet more accessible to people on a low income. Examples include: food cooperatives, ‘cook and eat’ clubs, ‘weaning parties’ and ‘baby cafes’.
- Work with local retailers to improve the way fresh fruit and vegetables are displayed and promoted.

**Diet in pregnancy**

**Recommendation 5**

**Who is the target population?**

Pregnant women and those who may become pregnant.

**Who should take action?**

Midwives, obstetricians, GPs, health visitors and dietitians.

**What action should they take?**

- Early in pregnancy, discuss the woman’s diet and eating habits and find out and address any concerns she may have about her diet.
- Provide information on the benefits of a healthy diet and practical advice on how to eat healthily throughout pregnancy. This should be tailored to the woman’s circumstances. The advice should include: eat five portions of fruit and vegetables a day and one portion of oily fish (for example, mackerel, sardines, pilchards, herring, trout or salmon) a week.
### Obesity

**Recommendation 6**

**Who is the target audience?**

Pregnant women who have a pre-pregnancy body mass index (BMI) over 30, and those with a BMI over 30 who have a baby or who may become pregnant.

**Who should take action?**

Obstetricians, gynaecologists, GPs, midwives, health visitors, nurses, dietitians, those working in contraceptive services or on weight management programmes (commercial or voluntary).

**What action should they take?**

- Inform women who have a BMI over 30 about the increased risks this poses to themselves and their babies and encourage them to lose weight before becoming pregnant or after pregnancy. Provide a structured programme that:
  - addresses the reasons why women may find it difficult to lose weight, particularly after pregnancy
  - is tailored to the needs of an individual or group
  - combines advice on healthy eating and physical exercise (advising them to take a brisk walk or other moderate exercise for at least 30 minutes on at least 5 days of the week)
  - identifies and addresses individual barriers to change
- Health professionals should refer pregnant women with a BMI over 30 to a dietitian for assessment and advice on healthy eating and exercise. Do not recommend weight-loss during pregnancy.
- Advise breastfeeding women that losing weight by eating healthily and taking regular exercise will not affect the quantity or quality of their milk.

(See also NICE clinical guideline 62 on antenatal care at [www.nice.org.uk/guidance/CG62](http://www.nice.org.uk/guidance/CG62) and NICE clinical guideline 43 on obesity at: [www.nice.org.uk/guidance/CG43](http://www.nice.org.uk/guidance/CG43))

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**NICE Public Health Guidance in progress: Weight management in pregnancy and after childbirth. EXPECTED 01 July 2010**

[http://guidance.nice.org.uk/PHG/Wave18/3](http://guidance.nice.org.uk/PHG/Wave18/3)

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**Healthy school years (5-16 years)**

Identification and weight management of overweight and obese children in primary care


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**Healthy school years (5-16 years), young adults (16-19 years), adult years and Healthy ageing**

**NICE: December 2006**

**Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children**

[http://guidance.nice.org.uk/CG43](http://guidance.nice.org.uk/CG43)

The NICE clinical guideline on the prevention, identification, assessment and management of overweight and obesity in adults and children covers:

- how staff in GP surgeries and hospitals should assess whether people are overweight or obese
- what staff in GP surgeries and hospitals should do to help people lose weight
- Care for people whose weight puts their health at risk.
- how people can make sure they and their children stay at a healthy weight
- how health professionals, local authorities and communities, childcare providers, schools and employers should make it easier for people to improve their diet and become more active.

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**A healthy weight population health needs assessment- Volume I: Key points and summary report**
Chapter 8 Policies, strategies, plans and services in relation to physical activity and healthy eating in Cornwall and the Isles of Scilly

Group 1: Reorient services, developing personal skills and strengthen community actions

Here the map of local clinical and personal services, and policies, strategies, plans and programmes directly addressing the treatment or prevention of physical inactivity, unhealthy eating, overweight and obesity from health, leisure and sports sectors is summarised. Local NHS health promotion and sports and leisure interventions directed at individuals or small groups are also included in Group 1.

Group 1 services and policy documents were identified from local NHS and councils’ websites, and through stakeholder consultation. Relevant service information and content was then analysed for their effectiveness and potential population and health inequalities impact. Results are summarised here.

There is evidence that effectiveness, population health impact and health inequalities are being considered in the following NHS policy documents:

- Cornwall and IoS Healthy Weight Strategy 2009-13
- Looking Ahead - A Healthy Future for All
- Helping people to stay healthy and live independently
- Stretching our ambition for a healthy future - The Strategic Framework for Healthcare in Cornwall and the Isles of Scilly 2008 - 2011

In particular healthy weights features highly, and significant high-level leadership and advocacy for health and healthy weights is already occurring, especially in the context of the Health and Wellbeing Partnership and its Healthy Weight Group.

There is evidence of considerable health and healthy weight prevention activity and initiatives across Cornwall and the Isles of Scilly. Services are mainly from the NHS in general, NHS health promotion services, and from sports and leisure sectors. Details of the analysis are given in Volume II: The Full Technical Report.

In general, whilst there are good examples, services tend not to be fully linked to clear research evidence of effectiveness. In addition, they tend not to take a whole population approach and, generally, they are not based on addressing the underlying determinants of and barriers to health and healthy weight, even though overweight and obesity is a major whole population public health problem. There is a large variation in geographic and population group coverage. Sometimes the more deprived groups or areas are targeted, but this is not consistent.

Current services and initiatives do not appear to be coordinated, and part of a strategic approach to tackling overweight and obesity, based on the whole population, with increasing intensity of service with as the gradient of deprivation increases, and in combination with coordinated other approaches. Where services are available, a very small number of the whole Cornwall and Isles of Scilly overweight and obese population are reached annually. Consequently, even if thought to be effective, the maximum potential for the population health impact of the services, on their own, is small. Finally, as many services and initiatives are of uncertain effectiveness and impact, they should ideally be part of formal academic research of their effectiveness. However, at best, it appears that many undergo process or output evaluation only.

Tier 1 Prevention and self-management
Current best practice suggests that for Tier 2 clinical services there should be a local care pathway arrangement for a paediatric specialist multi-disciplinary team dealing with children identified with obesity. This care pathway should link Tier 2 services with Tier 1 and Tier 3 services. The Tier 2 team should ideally comprise a community paediatrician, a paediatric dietician and there should be a weight management course available from a specialist exercise advisor in liaison with a child psychologist. A similar service for adults is also advocated.

In relation to local Tier 2 services a whole family community based approach to childhood healthy weights supported by medical advice is taken. Out-patient appointments are available to see a Consultant Community Paediatrician to ensure there are no underlying medical conditions. From 2010 a Paediatric Dietician will be available with a specific focus upon healthy weights in childhood. However, there is currently no recurrent funding identified for the community based whole family approach.

Current best practice suggests that for Tier 3 clinical services there should be a local care pathway arrangement for a paediatric endocrinologist and access to specialist medication and bariatric surgery service. Services may be available to the local population but be part of a more regional tertiary service. There is a gap in this service at present.

Other PCTs during 2009 invested the following for the Tier approach, although it is not clear whether investments have been assessed for evidence of effectiveness and population health impact:

- Brighton & Hove £250k with acknowledgement from Board that more resource may be required. (Total population: 253,500)
- NHS Hammersmith & Fulham £350-400K (Total population: 172,500)
- Croydon £300k 0-13 years (Total population: 339,500)
- Sheffield PCT £250-300k 7-14 years (Total population: 530,300)

### Tier 1 Early intervention and prevention

<table>
<thead>
<tr>
<th>Service name</th>
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<tbody>
<tr>
<td>Weight Matters</td>
<td>Healthy Living Initiative Programme &amp; health trainers.</td>
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<td>'Weight Management on Referral' as part of Weight Matters</td>
<td>Leap Active</td>
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<tr>
<td>Brief Interventions</td>
<td>Eatsome</td>
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GROUP 2: Create supportive environments and build healthy public policy

The content analysis of identified documents and information consisted of several steps. Firstly, the documents were screened to exclude those not developed or published by the councils of Cornwall or the Isles of Scilly or by NHS Cornwall.

After screening, the second group of documents contained only those from sectors other than health, leisure or sport that could potentially affect physical activity or healthy eating, perhaps indirectly. The relevant sections searched in council websites were:

- Business
- Community and living
- Council and democracy
- Education and learning
- Environment and planning
- Health and social care
- Housing
- Jobs and careers
- Leisure and culture
- Transport and streets

Secondly, an analysis grid covering the key features of interest was developed. Based on the grid, the analysis of the content of the retained policy documents was carried out. The content of each group two document was analysed to record and consider in the grid to what extent, if at all, it considered in a health impact assessment, the likely effect of its proposed sectoral approaches and interventions on health, and on obesity, overweight, physical activity or healthy eating in particular. Details of the analysis are given in Volume II: The Full Technical Report.

Many relevant policy and other types of documents were identified from the Cornwall Council and The Council of the Isles of Scilly websites. The sectors involved had the potential of significantly affecting physical activity across the two jurisdictions. However, as expected, there was less relevant policy that could potentially affect healthy eating, given that many of the relevant leavers lie with central government and the private sector. In general, despite the potential links to health, and healthy weights in particular, almost no document had undergone a formal health impact assessment in its consultation process. Consequently no policy document thoroughly considered its potentially large impact on population healthy weight or on health inequalities. A small minority of documents made short statements in relation to health, but there were not comprehensive and following systematic assessment.

Group 2 - Cornwall

<table>
<thead>
<tr>
<th>Policy name</th>
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<tr>
<td>Local Transport Plan 2</td>
<td>Young People’s Organised Activities, Cornwall Council Education and Learning Young people’s organised activities</td>
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<td>Cornwall Transport Engineering Manuals</td>
<td>Cornwall Council Sure Start Children’s Centres</td>
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<td>Cornwall Accessible Walks</td>
<td>Cornwall Council School Transport Policy</td>
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<td>Cornwall Cycle Routes &amp; Trails</td>
<td>Cornwall Council Learning Curriculum Advice &amp; Support</td>
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<tr>
<td>Cornwall Council Cycling - Information and advice</td>
<td>‘Travelling to School Initiative’</td>
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<td>Cornwall Road Safety</td>
<td>Cornwall Council Learning - School meals</td>
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<td>Cornwall Road Safety Traffic Schemes</td>
<td>Cornwall Council - Youth Cornwall</td>
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<tr>
<td>Cornwall Council Speed Management Strategy</td>
<td>Older People’s Partnership Board</td>
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<tr>
<td>Cornwall Council Traffic calming</td>
<td>Cornwall &amp; IoS Community Safety Partnership Plan 2008-2011</td>
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<tr>
<td>Cornwall Traffic Signals and crossings</td>
<td>Cornwall Council Sustainability</td>
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<tr>
<td>Cornwall Affordable Housing Policy</td>
<td>Cornwall Sustainable Energy Partnership</td>
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<td>Cornwall Interim Planning Policy</td>
<td>Cornwall Council Footsteps Towards a Better Climate</td>
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<td>Cornwall Local Development Framework</td>
<td>Sustainable Community Strategy</td>
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<td>Cornwall Council A Design Statement for Cornwall</td>
<td>Cornwall Council Sustainable Procurement Strategy</td>
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<tr>
<td>Camborne Pool Illogan Redruth Area Action Plan</td>
<td>Cornwall county farm service</td>
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<tr>
<td>Cornwall Common Land &amp; Town and Village Greens</td>
<td>Cornwall farmers’ markets</td>
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<tr>
<td>Cornwall Countryside Access Land</td>
<td>Cornwall’s Green Paper - Economic Priorities and Strategic Intent</td>
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<tr>
<td>Supplementary planning guidance that covers active travel and physical activity provision</td>
<td>Economy and Europe Strategic Plan</td>
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<td>Cornwall Council Education and Learning Extended Services</td>
<td>Local Area Agreement</td>
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### Group 2 - Isles of Scilly

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<th>Policy name</th>
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<tr>
<td>Vision statement</td>
<td>Economic Development &amp; Objective One - The Isles of Scilly Integrated Area Plan</td>
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<tr>
<td>The key Corporate priorities for 2006-2020:</td>
<td>Environmental Health Service</td>
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<tr>
<td>Children and Young People’s Plan 2008 - 2011</td>
<td>Planning - Core strategy</td>
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<td>Early Years Service</td>
<td>Planning - Local Plan</td>
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<td>Extended Schools Service - Extended Schools Strategic Delivery Plan</td>
<td>Leisure &amp; culture facilities</td>
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<tr>
<td>Out of School Clubs</td>
<td>Sustainable Community Strategy</td>
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<td>Services for Young People</td>
<td>Procurement Strategy</td>
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<tr>
<td>Youth Services</td>
<td>Transport and streets</td>
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<tr>
<td>Building control</td>
<td>Local Area Agreement</td>
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Chapter 9  Stakeholder views

The views of a range of stakeholders on current and future efforts to address overweight and obesity were sought from the members of the Cornwall and Isles of Scilly Healthy Weight Group. Members were sent questionnaires and a focus group was held at scheduled Healthy Weight Group meeting in Truro. Full details of the methods and questionnaire used are given in Volume II of this report.

In summary, the recurring themes and issues that emerged as dominant included:

Overall approach and framework (and general issues)

- The need for further strategic thinking in the approach to address overweight and obesity.
- The need for a more whole population approach, rather than patchy targeted areas or groups, and short-term projects.
- No strong sense of leadership for the entirety of the agenda, only from public health,
- More evidence-based interventions needed - “Too much emphasis on non-evidence-based short term initiatives to do with marketing themselves rather than substance of intervention”
- Partner agencies need to be delivering agenda this with the PCT - not just a health responsibility to fund interventions
- The subject seems to be too big and complex - what can I really do about it?
- Poor levels of understanding about the problem and about what can be done to improve the situation
- Funding - Obesity is at a disadvantage because it is categorised as “preventative” and therefore lower on the list of priorities
- A lack of real priority for the issue e.g. overweight/obesity is a top public health issue yet no additional resources have been made available through the LAA to help tackle the issue.
- Need shared targets and/or vision across health, LAs and third sector
- Problems around integration of current initiatives.

Building healthy public policy and creating supportive environments

- Taxation, subsidies and legislation could achieve the desired more quickly.
- Poor economic status contributes.
- Time and cost are key reasons why people don’t address their health and weight - low wages is a problem for Cornwall.
- High debt - huge house prices and fickle industries other than the public sector and the developing third sector result in low paid seasonal work.
- Current unhealthy planning and transport planning are very major contributors to obesity locally - “Highly obesegenic built environment at total odds with natural environment….opportunity for active travel is poor due to lack of infrastructure development...” and ...."Planning policy which to date has failed to provide adequate accessible, attractive and usable open space, or to encourage active travel or plan in such a way as to encourage activity.”
- New roads don’t have cycle routes.
- Children playing less and less outside.
• New housing developments with low priority for open space.
• Congregation of fast food outlets near to most educational establishments a problem.
• Concern for litigation and limited public funds for the maintenance of play equipment and landscaped sites means items are removed. Concerns over child protection result in ‘fear’ that can reduce a child’s world and ability to take risks.
• “Superb” natural resources, but Green Gym and Blue Gym initiatives low profile, but very appealing, although difficult to find out information about it.
• Access to natural environment and built environment a problem - especially in terms of walking and cycling infrastructure and poor public transport.
• Reduced cost entry to leisure facilities for children in need in north Cornwall is helpful
• Fun play areas that engage children for longer i.e. in St Austell is beneficial.

Community engagement
• The current frequency of apparent “pet” projects is problematic.
• Issues around health promotion initiatives’ integration, effectiveness, evaluation and population coverage.
• Lack of overall population impact of range of current approaches.
• Issues around role, effect, patchiness and short-term funding of community projects, and nature of role of links of statutory bodies with them.
• Use of the community sector (local people providing local solutions and unlocking more national funding through charity / community interest status) is positive.
• SETTINGS - This approach is important - the workplace, school, campuses, NHS environment. To involve adults, families, children.
• Making good progress with settings. But some issues are: employers tend to see obstacles rather opportunities; a focus on Work Place Health is required particularly within the public sector (biggest employers - Cornwall Council, NHS and Devon and Cornwall constabulary); schools need more intense intervention and especially in schools more reluctant to participate, rather than the schools which are already working very well. Role of schools in active travel and sport. The continued presence of vending machines in leisure centres, hospitals etc is a problem.

Developing personal skills
• Low levels of health literacy
• The current frequency of apparent “pet” projects.
• Issues around health promotion initiatives’ integration, effectiveness, evaluation and population coverage.
• Lack of overall population impact of range of current approaches.
• Unclear population impact of current sport facilities and initiatives.
• Eating of fast food (pre-prepared rather than take-aways), people being in a rush - families with both parents working and time stressed meal times.
• The acceptance of overweight/ obesity and inactivity as normal
• Better coordination of all initiatives needed. This seems to work best in W Cornwall with the W Cornwall Healthy living site.
• Many initiatives are thought to be useful, despite patchiness and short term funding, lack of integration, although little reference to effectiveness and inequalities is made by stakeholders:
  o Keep It in the Family, which is a family based Weight Management programme based on MEND delivery with a community based enhancement.
This is in early stages of development but seems to be a good model. The negative is that it is expensive.
- Interventions such as Eatsome project, ‘Keep it in the family using MEND’ with links to natural environment, extended services investment in means tested voucher systems for access to heavily subsidised or free activity programmes, MOBILISE, why weight?, play ranger programmes and recent investment in improving play infrastructure in County.
- Family based work has had positive results. ‘Change for Life’ social marketing campaign is also positive along with developing ‘Blue Gym’ concept.

Reorienting services
- Issues around health promotion initiatives’ integration, effectiveness, evaluation and population coverage.
- Lack of overall population impact of range of current approaches.
- Breastfeeding peer mentoring for certain women is positive. But peer mentoring for breastfeeding, services and facilities not consistent across the county
- A greater focus is required on maternal obesity and being healthy for pre-conception.
- Medicalising overweight/obesity - takes the responsibility away from the individual and places emphasis on medical interventions
- “Get schools 100% behind the weighing and measuring programme.”
- GP exercise referral lack mentioned (but no reference to its evaluation, effectiveness, population health impact.)
- Health Promotion offer training in a great 8 week course called Shape up but they struggle to involve many practices. “.....low levels of interest within General Practice.”
- GP’s would engage better with the whole concept of obesity if there was an easy to use structured referral pathway.
- An unstructured obesity service at present- “no paediatrician with an interest in obesity and the adult physician with an interest is leaving Cornwall.....” and “We don’t have a comprehensive service in place for children identified as obese / overweight at all age groups.” Two paediatric dieticians for the county (1 may not be full time) but significant activity already. Having to consider not taking “simple obesity” referrals.
- Another endocrinologist will take over the clinic after the current adult physician with an interest leaves. For many patients referral to this clinic represents the 1st time they have seen a dietician or even had involvement with LEAP (Local exercise action plan - Health promotion). Currently have no “talking therapies” involved in weight management apart from the occasional prebariatric patient who is referred for psychological assessment. There is a local bariatric surgeon. He offers gastric banding. Any patient who requires gastric bypass is referred to Exeter.
- Lifestyle Consultations delivered by Health Promotion as a brief intervention in partnership with the Barriatric Assessment team at RCHT seem to work well. This is a model that could be looked at for other areas.
Approach and framework for action

High priority (likely high population health impact and/or less cost)

Effective action - occurring
The overall strategic approach to healthy weight in Cornwall and the Isles of Scilly is effective. It reflects that highlighted in Chapter 7. It is a local partnership multi-agency approach with public health at its heart. It has a multi-agency strategy which will be revised in the light of this report.

Health inequalities and the life-course are prominent within the framework.

Gaps - effective action not occurring or inadequate intensity
Health inequalities are currently strongly highlighted in the local strategic approach. However, there is a tendency to focus on, or target, only the most deprived areas or groups, as is common in other localities in England. But the Marmot Report reiterates that focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.

Similarly, the current focus of the local strategic approach appears to be on discrete and sometimes patchy, programmatic clinical or health promotion service (and also including the tiered care pathway clinical services) specifically for physical activity and healthy eating, especially in those already overweight or obese. Similarly for the related sport or leisure services (see Reorienting Services below). Whilst such services are important components of any strategy (if implemented according to the health gradient), they will not achieve the most population health impact on their own.

Whilst action in non-health sectors is included, this does not appear to be the focus of the local strategic approach. Especially important are non-health local authority sectors, where the most population health impact could be achieved.

Furthermore, the Healthy Weight Strategy appears to be primarily embedded within the Health and Wellbeing Partnership and its Healthy Weight Group, although maximum inclusion of local authority sectors is probably achievable by extending its reach to local vision, goals, strategies and partnerships that overarch most if not all sectors.

Ineffective action or of uncertain effectiveness
Nil of note.

Leadership and advocacy

High priority (likely high population health impact and/or less cost)

Effective action - occurring
Significant senior and professional public health leadership and advocacy for population health, the life-course, health inequalities and healthy weight is already occurring locally within the health, partnership and local authority arenas.

Gaps - effective not occurring
Important senior professional local NHS public health leadership and advocacy of the healthy weight issue appears to be occurring with limited public health resource support at present.
Parallel leadership and advocacy of the healthy weight issue by senior council officers and leading local elected members, across all local authority sectors, is not as extensive as it could be in order to achieve maximum effectiveness and population health impact.

Ineffective action or of uncertain effectiveness
Nil of note.

**Building healthy public policy & Creating supportive environments**

*High priority (likely high population health impact and/or less cost)*

**Effective action - occurring**
Considerable proposed action is already occurring within the NHS, sports and leisure sectors and partnerships in terms of high-level strategy and facilities in the health and wellbeing and healthy weight agendas.

There are occasional brief links between health policy, strategy and plans, and those of other sectors.

Action to create settings with healthier environments in schools and workplaces is occurring. National school meals initiatives, the local Healthy Schools programme (which is based on a WHO model) and local healthy workplace initiatives are important examples.

**Gaps - effective not occurring**
Links between local overarching and non-health sector policies, strategies and plans and health (and healthy weight) are not explicit or extensive at present.

Assessment and maximisation of population health impact, addressing the social health determinants and health inequalities across the life-course (in terms of healthy weight, physical activity and healthy eating), in non-health sectors’ policies, strategies and plans, is not occurring routinely and to any great extent at present.

Formal and structured Health Impact Assessment of non-health sectors’ policies, strategies and plans, with professional public health input and support, and community and stakeholder involvement, is not occurring routinely to any great extent at present.

Awareness of knowledge and skills in public health issues in disciplines and professions within non-health sectors may be currently inadequate to effectively address healthy weight in Cornwall and the Isles of Scilly.

It is not apparent that regular formal advice is sought by non-health sectors from evidence-based guidance, from external consultants and academics, and from national and international case studies with experience in successfully tackling healthy weights in non-health sectors.

The (WHO) Healthy Schools programme and healthy workplace initiatives, whilst successful and expanding, are not always explicit in terms of emphasising physical activity, healthy eating and tackling healthy weight, using evidence-based coordinated approaches, addressing related infrastructure issues and barriers, and strategically implementing according to the health gradient.

Ineffective action or of uncertain effectiveness
Nil of note.

**Strengthen community action and develop personal skills**

*Medium priority*
Effective action - occurring
A few health promotion and sport and leisure initiatives are occurring that have some evidence of effectiveness, but small population health impact (see Chapter 8 for details).

A social marketing initiative to address barriers to healthy lifestyles is being developed and implemented.

There is evidence of some patchy community initiatives developed from local grass roots action.

Gaps - effective not occurring
It is not clear whether the few effective initiatives that are occurring are implemented with a presence and intensity according the health gradient. Some appear to be targeted at the most deprived areas only, others do not appear to follow any such pattern, but are nevertheless patchy.

Community initiatives are patchy.

The few effective initiatives that are occurring in this category seem historic, and do not appear to yet form part of a coordinated and sustained programme of evidence-based and needs-based action, within the Healthy Weight Strategy, and with other types of interventions.

Ineffective action or of uncertain effectiveness
Chapter 7 and 8 point to several initiatives that fall into this category, which are known to be ineffective, or are of uncertain effectiveness. Some are occurring, and this suggests that they should either be stopped, or should form part of a more formal research of effectiveness framework, before being continued or extended geographically.

Reorient (health care and other personal) services
Medium priority (likely moderate population health impact and/or moderate cost)
Lower priority (likely less population health impact and/or higher cost)

Effective action - occurring
Effective action according to NICE guidance is already occurring to increase breastfeeding rates.

The number of schools taking part in the NCMP is increasing.

A few health promotion and sport and leisure initiatives are occurring that have some evidence of effectiveness, but small population health impact (see Chapter 8 and previous category for details).

Although of low population health impact, clinical services to treat obesity in adults are available.

Gaps - effective not occurring
Whilst important action is taking place in school and workplace settings, the NHS should also lead by example. For example, to date, there is no local WHO Health Promoting Hospital (or any health care settings) programme.

It is not apparent whether antenatal health promotion includes significant emphasis on current NICE (and forthcoming) guidance on nutrition and obesity in pregnancy, not only on breastfeeding post-natally. It is not clear whether further effective measures, according to NICE guidance, are

(likely low to moderate population health impact and/or moderate to high cost)
in place to improve breastfeeding continuation in the weeks after delivery, and based on the health gradient.

Local efforts to recruit schools to the NCMP are worthwhile. However there remain gaps, especially in deprived areas and according to the health gradient. Teachers’ and parents’ raise perceive concerns about the programme.

Neither the NCMP, nor primary care in general, currently appear to be linked to a well developed local tiered care pathway that would allow identified children to be further assessed and managed in terms of effective health promotion and clinical treatment.

It is not currently clear whether all local primary and secondary care clinical staff follow existing NICE guidelines on how to routinely assess, opportunistically and systematically, most of their patients for the presence of overweight or obesity. It is not clear whether all staff are aware of what they should subsequently do to help people lose weight. This includes that all clinical staff should routinely advise all physically inactive adults to be moderately active for at least 30 minutes, 5 days of the week.

As for children, primary care in general does not currently appear to be fully linked to a well developed local tiered care pathway that would allow identified adults to be further assessed and managed in terms of effective health promotion and clinical treatment.

**Ineffective action or of uncertain effectiveness**

Chapter 7 and 8 point to several initiatives that fall into this category, which are known to be ineffective, or are of uncertain effectiveness. This suggests that they should either be stopped, or should form part of a more formal research of effectiveness framework, before being continued or extended geographically. In particular NICE recommends that exercise referral schemes fall into this category as it is already known that such interventions tend to have low population impact and tend not to have sustained effects. Currently 14 practices are taking part in Cornwall. Although they are part of a process service evaluation, it is not apparent that the programme forms part of an academic research of effectiveness study.
Recommendations

Approach and framework for action - inequalities and priority groups

High priority (likely high population health impact and/or less cost)

43. The Marmot Strategic Review of Inequalities in England - Fair Society, Healthy Lives is an appropriate starting point as an over-arching framework for action on physical inactivity, unhealthy eating, overweight and obesity. This should be adopted as the overall approach of the revised local Healthy Weight Strategy.

44. The existing local Healthy Weight Strategy’s life-course approach should be re-emphasised in the revised version, as in the Marmot Review.

45. The two core themes of the Marmot Review should be wholeheartedly embraced within the revised local Healthy Weight Strategy, namely:

- “To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.

- “A central message of this Review, therefore, is that action is required across all these social determinants of health and needs to involve all central and local government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities.”

46. Recommend that the framework of the World Health Organizations’ Ottawa Charter for Health Promotion is used within the overarching Marmot framework. It forms the next level of practical scaffolding within which to position interventions. It comprises:

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient (health care and other personal) services

47. Recommend that any intervention considered must be based on research evidence of effectiveness and where possible cost-effectiveness. New or unproven interventions should be considered experimental. They should only occur within a time-limited formal research context. Effective interventions with low population impact should be given lower priority for investment. Interventions proven to be ineffective should be stopped. Any intervention implemented should be evaluated against pre-agreed and accepted criteria.

48. There is minimal experience of such coordinated action in the UK, although some areas are better than others. Recommend that Finland is referred to as a case study in primarily rural settings, and Freiburg, Germany, for a small city case study.

49. Recommend that note should be taken of NICE Public Health guidance in progress - Preventing obesity: a whole-system approach. EXPECTED 01 March 2012 http://guidance.nice.org.uk/PHG/Wave20/53
Leadership and advocacy
- inequalities and priority groups

*High priority (likely high population health impact and/or less cost)*

50. Recommend that current high-profile leadership and advocacy by local government and the local NHS to tackle overweight and obesity is maintained and further supported.

51. Local political leaders and senior council officers of all sectors, the local Director of Public Health in particular, and other senior local NHS executive and non-executive board members are vital for such leadership. The local third and private sectors also have an important role.

52. Recommend reorienting local government and NHS resources to further support existing leadership.

Building healthy public policy & creating supportive environments
- inequalities and priority groups

*High priority (likely high population health impact and/or less cost)*

53. Action is required across all social determinants of health. Recommend that the revised local Healthy Weight Strategy needs to include further action by the NHS, but more importantly it needs to have renewed ownership and action outside the NHS, across all local partnerships, strategies, and the councils’ sectors, in further similar action already commenced.

54. Recommend that the existing high-level leadership and advocacy for the local Healthy Weight Strategy across all local multi-agency partnerships and council’s sectors is maintained and developed further.

55. Recommend the strengthening and reaffirmation of existing explicit links between the revised Healthy Weight Strategy and various local strategies for addressing climate change; the environment & pollution; sustainable (social, economic & environmental) development; health & well-being; local food production, distribution, marketing & procurement; education; spatial planning, urban design & building regulations; and sustainable integrated transport.

56. Recommend that all sectoral policies, strategies, plans and programmes within local government, the local NHS, and local partnerships should routinely undergo health impact assessment (HIA) as part of their development and consultation. Such HIAs should emphasise potential effects on physical activity, healthy eating, overweight and obesity, overall population health impact, geographic and social health inequalities, stages of the life-course and effects on key vulnerable groups.

57. Recommend that identified adverse health impacts and inequalities should be minimised, and health impact maximised, in final versions of policies, strategies, plans and programmes.

58. Recommend that local government, the NHS, and partnerships should consider reorienting resources to support developing local advocacy, policy, awareness, methods, training, and expert and non-expert capacity to implement routine HIA across all sectors.

59. Recommend that at the more operational level, multi-disciplinary and professional development, appraisal, training and recruitment policies are adapted to ensure adequate
local skills and experience are available for more sustainable and healthy policy development and operational design for procurement; spatial & urban planning & building design; and transport, etc.

60. Recommend that when external expertise or consultancy is sought in such sectors, criteria are developed to ensure consultants and experts have adequate skills and experience in sustainable and healthy policy development and operational design.

61. Recommend that further advice is sought on including sustainability and health within non-health sectors at the strategic and operational levels. Such advice may be available from UK universities (e.g. the University of the West of England has expertise in designing healthy neighbourhoods), from UK localities with some experience (e.g. Exeter), but preferably from successful international case studies, as previously stated.

62. There is already evidence-based NICE guidance on the promotion and creation of physical environments that support increased levels of physical activity. Recommend that key stakeholders in the NHS and local government take further note of the advice. Further NICE guidance on spatial planning and health is expected in 2011.

63. Several relevant NICE public health guidance reports are currently in development. Recommend that note is taken of them by the NHS and local government:

- Transport policies that prioritise walking and cycling
- Preventing unintentional road injuries among under 15s: road design
- Preventing unintentional road injuries among young people

64. Existing patchy, but successful, local ‘settings-based’ (WHO Healthy Schools and Healthy Workplaces) health promotion programmes could be strategically expanded and intensified with re-oriented resources. Consideration should be given to developing a WHO Health Promoting Hospitals programme.

**Strengthen community action and develop personal skills - inequalities and priority groups**

*Medium priority*  
*(likely low to moderate population health impact and/or moderate to high cost)*

65. Consideration should be given to reorienting resources to develop a planned evidence-based, sustained multi-intervention campaign to strengthen community action and develop personal skills across the locality. The focus should be on addressing physical inactivity and unhealthy eating. It is recommended that components could include:

- Being a small part of wider interventions recommended in this report
- Linking to specific elements of the environment addressed elsewhere in these recommendations.
- Providing effective information to the population, in addition to tourists, on the availability of safe and accessible parks, walking paths & cycle lanes, playgrounds, swimming pools, etc.
- Being population-wide but with increased intensity as deprivation increases. Tailored to the stages of the life-course, an emphasis on family context and the following:
Healthy preconception and pregnancy
Healthy young children (0-5 years)
Healthy school years (5-16 years)

NICE Guidelines for community engagement could be followed.
Promoting moderate-intensity physical activity, particularly walking, and activities that are not dependent on particular facilities.
Targeting community settings using theories of behaviour change to teach skills tailored to individual needs.
Providing social support systems (walking groups, walk-to-school groups, etc.).
Shift in emphasis from competitive or elite sports to physical activity for all. Health and sport/recreation sectors should develop accessible programmes that use physical activity and sport as a focus for community-wide activity. Participation rates in organised sport are currently lower in females, decline with age, and in lower socio-economic groups.
Encourage sports, cultural and environmental associations as well as organisations for children, young people and older adults to engage many people in voluntary activities. I recommend that the campaign considers parts of the NICE Guidance Obesity: The prevention, identification, assessment and management of overweight and obesity in adults and children http://guidance.nice.org.uk/CG43 It covers:
  o how people can make sure they and their children stay at a healthy weight
  o how health professionals, local authorities and communities, childcare providers, schools and employers should make it easier for people to improve their diet and become more active.

Using social marketing as one component to partly address some existing recognised barriers to physical activity and unhealthy eating.
A mass-media campaign - only for reaching a large population for raising awareness and affecting knowledge, and as a useful component of other interventions.
The campaign should be evaluated at appropriate intervals.
Reference could be made to experience of a broader campaign used in rural Finland.

http://guidance.nice.org.uk/PHG/Wave20/54

67. Recommend that note should be taken of NICE Public Health guidance in progress - Using the media to promote healthy eating. EXPECTED: TBC
http://guidance.nice.org.uk/PHG/Wave20/56

Uncertain priority (no/uncertain/inadequate evidence of effectiveness or population impact)

68. The current initiatives of the local NHS Health Promotion Service and community development workers are recommended to be more strategically planned and evaluated, and to become part of the wider coordinated approach recommended here. The few effective interventions used should prioritise deprived areas and communities (but should also be more widely available); families, young mothers, children and young people; and older people.

69. The effectiveness and impact on inequalities and population health of certain current healthy weights health promotion initiatives should be reassessed in light of Chapter 7. Any that are ineffective should be stopped. Others of unknown effectiveness should only occur in a formal research evaluation context.
70. In particular, effective health promotion interventions should be part of interventions recommended under #29-39 and #42 & #43 below. Effective interventions should also be linked to the wider campaign proposed under this sub-section, and more within the proposed WHO settings approach.

Reorient (health care and other personal) services - inequalities and priority groups

High priority (likely high population health impact and/or less cost)

71. Recommend that the key role for the NHS is providing local leadership and advocacy - which is already well developed - as well as technical expertise in assessing health need, effective interventions and facilitating health impact assessment.

72. The NHS should also lead by example by: by developing WHO Health Promoting Hospitals (health care settings) and WHO Healthy Workplaces programmes; ensuring health care facilities are accessible by public transport hubs, by safe active travel, and located to minimise car use; ensuring healthy building design; procuring, promoting and subsidising local healthy food and minimising choice and maximising price of unhealthy food available for patients, staff and visitors.

73. Recommend that all health care services implemented under this section are formally evaluated to pre-agreed criteria, as a matter of course.

Medium priority (likely moderate population health impact and/or moderate cost)

74. Proven effective preventive health care services, for individuals and small groups, for physical activity, healthy eating and overweight/obesity (as detailed in Chapter 7), should be available across the whole population. There should be increased availability and intensity as deprivation increases, tailored to the stages of the life-course, with an emphasis on the family context and the following:
   - Healthy preconception and pregnancy
   - Healthy young children (0-5 years)
   - Healthy school years (5-16 years)

75. There is detailed NICE guidance for midwives, health visitors, pharmacists and other primary care services to improve the nutrition of pregnant and breastfeeding mothers as well as for children in low income households: http://guidance.nice.org.uk/PH11 Recommend that the existing local services that address features of the guidance are expanded further across the locality by reorienting resources. There should be an emphasis not only on breastfeeding, but also on nutrition and obesity in pregnancy. With further emphasis on training, effective health promotion, settings, the weeks after delivery, increased intensity with increasing deprivation, and on evaluation.

76. Recommend that note should be taken of NICE Public Health Guidance in progress: Weight management in pregnancy and after childbirth. EXPECTED 01 July 2010 http://guidance.nice.org.uk/PHG/Wave18/3
77. Recommend that existing local efforts in recruiting schools to the NCMP are worthwhile, and should be further supported. Teachers’ and parents’ concerns should be addressed where possible. Every effort should be made to recruit schools from increasingly deprived areas.

78. In particular, NICE Guidance recommends that adults who are not physically active should be **routinely advised** to be moderately active by primary care health professionals for at least 30 minutes, 5 days of the week. They should be provided with details of local opportunities.

79. Recommend that a coordinated programme, building on existing action, is considered by the local NHS to widely implement relevant parts of NICE Guidance - *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children* [http://guidance.nice.org.uk/CG43](http://guidance.nice.org.uk/CG43). It covers:
   - how staff in GP surgeries and hospitals should assess whether people are overweight or obese
   - what staff in GP surgeries and hospitals should do to help people lose weight
   - care for people whose weight puts their health at risk.


81. Recommend that children identified as overweight or obese from the local schools NCMP should be included in preventive and lifestyle interventions within NICE Guidance [http://guidance.nice.org.uk/CG43](http://guidance.nice.org.uk/CG43)

**Lower priority (likely less population health impact and/or higher cost)**

82. Proven effective clinical treatment services for individuals with existing obesity (as detailed in Chapters 6 & 7) should be available across the whole population. Recognised evidence-based local (and regional where appropriate) clinical care pathways and guidelines should be developed with stakeholders across primary, secondary and tertiary care. There should be increased availability and intensity as deprivation increases, tailored to the stages of the life-course, with an emphasis on the family context and the following:
   - Healthy young children (0-5 years)
   - Healthy school years (5-16 years)

83. Recommend that children identified as obese from the local schools NCMP should be included in local care pathways for treatment.

**Uncertain priority (uncertain/inadequate effectiveness evidence or low population impact)**

84. NICE recommends that exercise referral schemes, pedometers and walking and cycling schemes should only be endorsed to promote physical activity from primary care if they are part of a formal research study. Exercise referral schemes are available in some practices in Cornwall. They should become part of more formal research evaluation in conjunction with a reputable university department. Any expansion should be within that context. It is already known that such interventions tend to have low population impact and tend not to have sustained effects.

It is recommended that short-term projects are considered under this sub-heading. They should be part of more formal research evaluation of effectiveness. If they are already known to be...
effective and have high population impact then they should be considered for wider implementation and longer-term funding.
Appendix 1

Figure 1 Local authority deprivation scores in the South West of England, 2007, with graph showing relatively high deprivation in Cornwall (orange bar) and Isles of Scilly compared with other SW areas.

A healthy weight population health needs assessment- Volume I: Key points and summary report
Figure 2 Percentage of adults taking physical activity at least three times per week (including transport) by local authority area in South West England, 2007/8
Appendix 2

Figure 6.3

NOO Primary Care Trust e-Atlas: Child obesity and its determinants

Appendix 2

A healthy weight population health needs assessment- Volume I: Key points and summary report
Table 6.3 Comparison of overweight and obesity prevalence between former districts of Cornwall, NCMP 2008/9

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