



Healthy Weight, Healthy Lives:

Tackling overweight and obesity in North Yorkshire 2016-2026

Signatories to the Healthy Weight and Healthy Lives strategy are



ageUK – representing the voluntary sector



Craven District Council - representing District Council members



Ryedale District Council - representing District Council officers



Harrogate and District NHS Foundation Trust - representing acute hospital providers

The organisations that are signatories to this strategy have made a commitment to work together to support local systems to achieve continuous improvements in the prevalence of overweight and obesity across the population of North Yorkshire.

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Foreword

It is not news that overweight and obesity is a global issue that is very much reflected at a national and local level here in North Yorkshire. Over 21% of four to five year olds, over 30% of 10-11 year olds and over 60% of adults in North Yorkshire are living with excess weight. This rate of excess weight is of concern because of its effects on physical and mental health, and reduced healthy life expectancy of those affected. Although the levels of excess weight for children in North Yorkshire are below the national average there are still 2,716 four to five year olds and 3,822 10-11 year olds who need support to maintain a healthy weight. Much more needs to be done to enable people to work towards an optimal weight and turn the tide on the prevalence of obesity across our County.

We recognise that many people find it hard to maintain a healthy weight and unfortunately there is no easy fix to losing excess weight and keeping it off. Our biology, the environment we live in, influences from our society and cultures, and the choices we make about the foods we eat and the activity we do all affect our weight. We all live in a world today that more readily promotes unhealthy rather than healthy eating, and fosters sedentary activities more than physical activities. We also recognise that over recent years, people's perception of what is a healthy weight has changed. It is often difficult to identify overweight and as a higher proportion of the population live with excess weight new norms are being accepted. Messages in the media about what is healthy and unhealthy are often confusing, and reading nutritional labels on the foods we buy is not always easy.

Health and Wellbeing Board
North Yorkshire



Readily available unhealthy products are difficult for us to ignore and in this context we welcome the Government's childhood obesity strategy that introduces a soft drinks industry levy and proposes to take out 20% of sugar in products we buy.

Obesity does not develop in isolation and the support we have from the people around us is essential to maintaining a healthy weight. It hardly needs saying that friends and families are one of the most important and lasting influences on the choices, health and otherwise, that we all make.

For children and young people, parents, grandparents and guardians have a fantastic potential to steer children in directions that lay the foundation for lifelong good health, providing children with the tools and experience they need to ignore the unhealthy cues and make healthy choices.

Our challenge in North Yorkshire is to create the environment that supports us in developing and sustaining healthy eating and physical activity habits; this is not simply a health issue, nor a matter of individual choice. This Strategy must align with other policy goals and aspirations such as climate change, transport, planning, rural issues, and education and employment, to name a few. We need to work in partnership, through the leadership of the North Yorkshire Health and Wellbeing Board, to inspire a healthy weight population and achieve our ambitions to reduce the number of people who are overweight at all ages. Together we can be successful in supporting more people to eat more healthily and be more active so they can live longer, happier lives.



County Councillor David Chance

Executive Member for Stronger Communities and Public Health



Dr Lincoln Sargeant

Director of Public Health for North Yorkshire

Summary of the Strategy

This Strategy details the issue of obesity in North Yorkshire, it describes why and where action is needed and explores how different stakeholders can contribute to tackling this agenda.

Obesity is widespread. Nationally, two thirds of adults, a quarter of two to ten year olds and one third of 11-15 year olds are overweight or obese. By 2050 obesity is predicted to affect 60% of adult men, 50% of adult women and 25% of children¹. The challenge in North Yorkshire is very real with over 66% of adults being overweight and obese. Over 21% of four to five year olds and over 30% of 10-11 year olds in our local communities are measured as having excess weight.

Obesity is associated with a range of health problems including type 2 diabetes, cardiovascular disease and cancer. 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 year¹. These factors combine to make the prevention of obesity a major public health challenge.

To optimise health it is recommended that individuals are encouraged to make changes to their diet and physical activity habits in a gradual way that falls within existing advice². Improvements in diet and physical activity, regardless of a weight loss, can result in significant health gains such as better mobility, prevention of some cancers, and improved mental health. Even small changes to physical activity and dietary habits will improve individual physical, mental and social health.

Tackling obesity however, is not straight forward. There are many complex behavioural and societal factors that combine to contribute to the causes of obesity. In recent years being overweight has become the norm for adults, which is something that requires attention.

The vision

'To inspire a healthy weight population'



The ambition

By 2026 we aim to have:

- Reduced the prevalence of overweight and obesity across the population.

The priorities

Six key priorities have been identified to tackle overweight and obesity in North Yorkshire, which include:

- supporting children's healthy growth and healthy weight
- promoting healthier food choices
- building physical activity into our daily lives
- providing the right personalised, accessible weight management services
- ensuring people have access to the right information and resources to make healthy choices that support weight loss
- building healthier workplaces that support employees to manage their weight.

The outcomes

The outcomes that are to be achieved over the lifetime of the Strategy are:

- reduction in health inequalities that arise from overweight and obesity
- reduction on demand on health and social care that arise from conditions/issues related to being overweight or obese
- fewer people with longer term conditions as a result of excess weight
- more employers with evidence based workplace health schemes
- improved offer of healthy food provision/ options in public sector settings
- improved provision of physical activity for children and young people across all sectors
- changes in the local activity and food related

environment such as changes in transport infrastructure or town planning which address the obesogenic environment

- wider use of technology to support healthy behaviours
- less discrimination and bullying associated with overweight and obesity
- more access and support for those wishing to take action to address their weight.

The indicators

We will measure the success of the Strategy through reviewing an established set of indicators:

- percentage of physically active and inactive adults – active
- percentage of physically active and inactive adults - inactive
- excess weight in adults
- excess weight in four to five year olds
- excess weight in 10-11 year olds
- proportion of the population meeting the recommended '5-a-day' on a 'usual day' - adults
- average number of portions of fruit consumed daily
- average number of portions of vegetables consumed daily
- utilisation of outdoor space for exercise/health reasons
- the percentage of working days lost due to sickness absence
- breastfeeding initiation
- breastfeeding prevalence at six to eight weeks after birth
- self-reported wellbeing – people with a low satisfaction score.

Work is currently being undertaken to compare local performance of these indicators against national baseline rates. Based on this analysis of current local performance, targets for each indicator will be set for the lifecycle of the Strategy. These targets will need to be agreed by members of the Strategy steering group and then reviewed and reported on annually.

Section 1:

Patterns and trends of obesity - children and adults



There is a wealth of information on rates of overweight and obesity at a national and local level. This section provides a high level summary of the data but further analyses can be accessed via the Joint Strategic Needs Assessment (JSNA) link <http://hub.datanorthyorkshire.org/dataset/jsna-data> and the Public Health England (PHE) website <https://www.noo.org.uk/>

To support the interpretation of the data presented in this Strategy it is useful to provide information on the measurement and terminology of obesity.

Measurement and terminology of obesity

Although body mass index (BMI) needs careful interpretation on an individual basis, it provides a meaningful picture at the population level for adults.

There are various ways in which to measure different aspects of obesity, these include Body Mass Index (BMI), skin fold thickness, waist circumference, and waist to hip ratio.

An adult BMI of between 25 and 29.9 is classified as overweight and a BMI of 30 or over is classified as obese. BMI is the most widely used approach in the UK, but it is important to note that it is not a direct measure of body fat mass or distribution, and BMI measures may be skewed by very high muscle mass. The relationship between BMI and health also varies with ethnicity. Figure 1 illustrates the BMI classifications.

Figure 1.

BM range (Kg/m ²)	Classification
< 18.5	Underweight
25 - 29.9	Overweight
30 - 34.9	Obesity I
35 - 39.9	Obesity II
= 40	Obesity III

Assessing the BMI of children is more complicated than for adults because a child's BMI changes as they mature. Also, these patterns of growth differ between boys and girls. Therefore, to work out whether a child's BMI is too high or too low, both the age and sex of the child need to be taken into account. In England, the British 1990 growth reference charts are used to classify the weight status of children according to their age and sex. BMI thresholds are frequently defined in terms of a specific centile, on a child growth reference. Child centile charts can be seen in Appendix 1.

Throughout this Strategy the terms 'excess weight', 'overweight' and 'obese' will be used. 'Excess weight' will be used when referring to both overweight and obese (BMI of 25 or above or above the 91st centile). The term obese is used for any adult with a BMI of 30 or above or any child on or above the 98th centile. This strategy is not focusing on those that are underweight.



The national picture

By 2050 obesity is predicted to affect 60% of adult men, 50% of adult women and 25% of children².

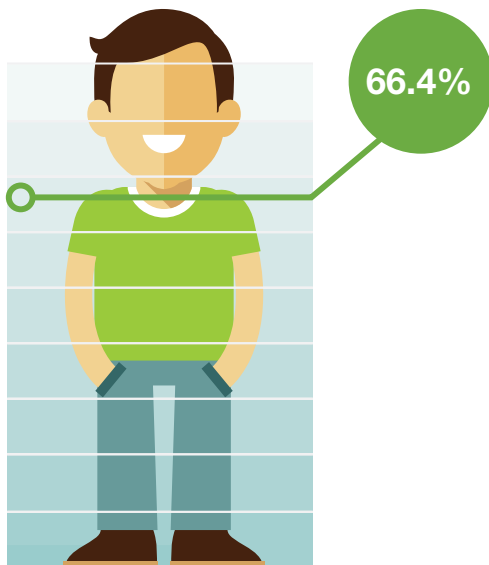
Adults

In England, the prevalence of obesity among adults rose from 14.9% to 25.6% between 1993 and 2014. The rate of increase has slowed down since 2001, although the trend is still upwards. The prevalence of overweight has remained broadly stable during this period at 36–39%.

The rapid increase in the prevalence of overweight and obesity has meant that the proportion of adults in England with a healthy BMI (18.5 - 24.9) decreased between 1993 and 2014 from 41.0% to 32.7% among men, and 49.5% to 40.4% among women. In England, currently 25.6% of adults (aged 16 years and over) are obese⁸.

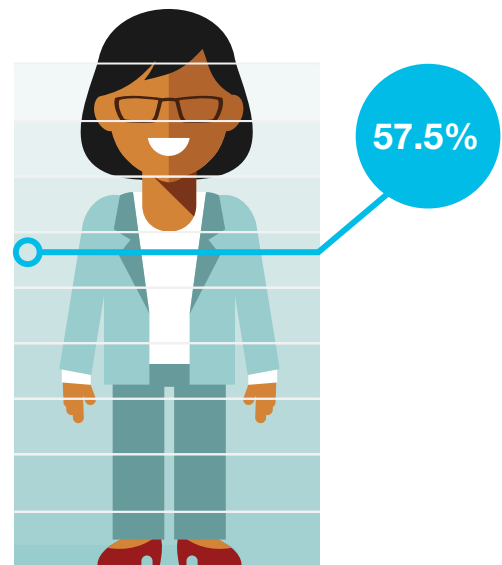
Most recent data highlights seven out of ten men (66.4%) and almost six out of ten women (57.5%) are overweight or obese (BMI 25 or above).

Almost seven out of ten men are overweight or obese (66.4%)



(Health Survey for England 2012 to 2014)

Almost six out of ten women are overweight or obese (57.5%)

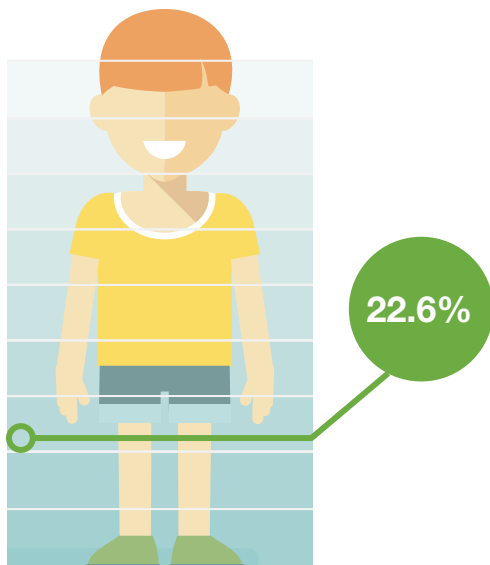


Children and young people

9.9% of boys and 9.0% of girls in Reception (aged four to five years) and 20.8% of boys and 17.3% of girls in Year 6 (aged 10-11 years) are also classified as obese according to the British 1990 population monitoring definition of obesity (above 98th centile)³.

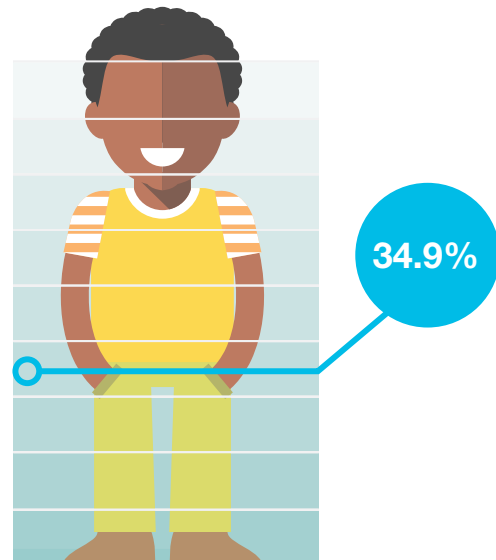
A trend of increasing child obesity has been seen between 1995 and 2004. There seems to be a slowing in the rate of increase of child obesity prevalence since 2004, particularly among older children.

One in five children in Reception is overweight or obese (boys 22.6%, girls 21.2%)



(National Child Measurement Programme, 2014/15)

One in three children in Year 6 is overweight or obese (boys 34.9%, girls 31.5%)



The local picture

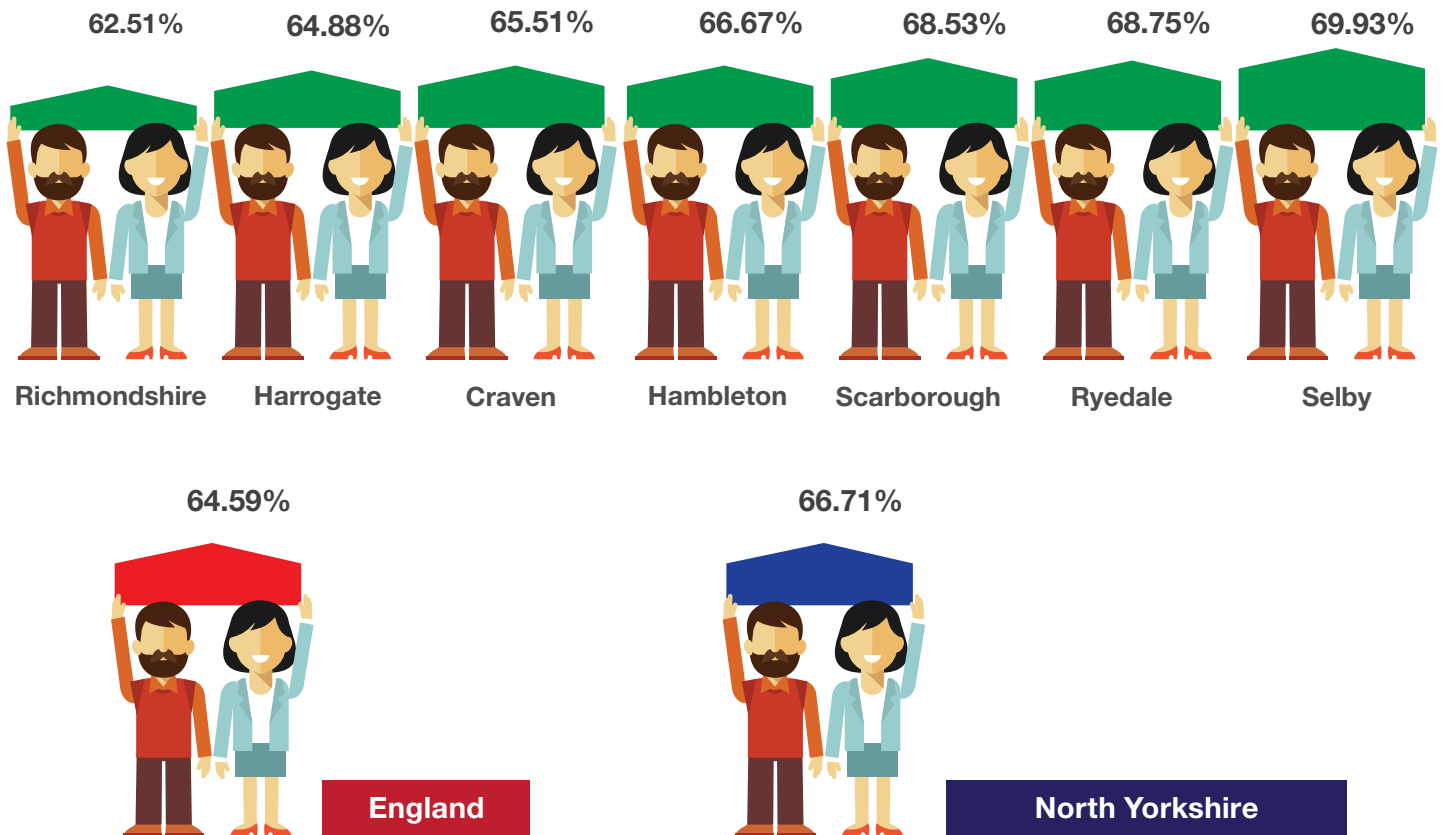
Adults

For 2012-2014 the prevalence of overweight and obese (BMI 25 or above) adults in North Yorkshire is 66.71%, which equates to 339,838 adults aged 16 and over. This is higher than the England prevalence of 64.59%. The diagram below illustrates the district level prevalence.

Richmondshire (62.51%) is significantly lower than the England average, and also lower than North Yorkshire (statistically similar). Harrogate (64.88%),

Craven (65.51%) and Hambleton (66.67%) are higher (statistically similar) than England, but lower (statistically similar) than North Yorkshire. Scarborough (68.53%) and Ryedale (68.75%) are both significantly higher than England, and also higher than North Yorkshire (statistically similar). Selby (69.93%) is significantly higher than both England and North Yorkshire.

Excess Weight in Adults (%) - 2012-14



Children and young people

Every year, as part of the National Child Measurement Programme (NCMP), children in Reception (aged four to five years) and Year 6 (aged 10-11 years) have their height and weight measured during the school year to inform local planning and delivery of services for children. The NCMP also allows population-level data to be gathered for analysis of trends in growth patterns and obesity.

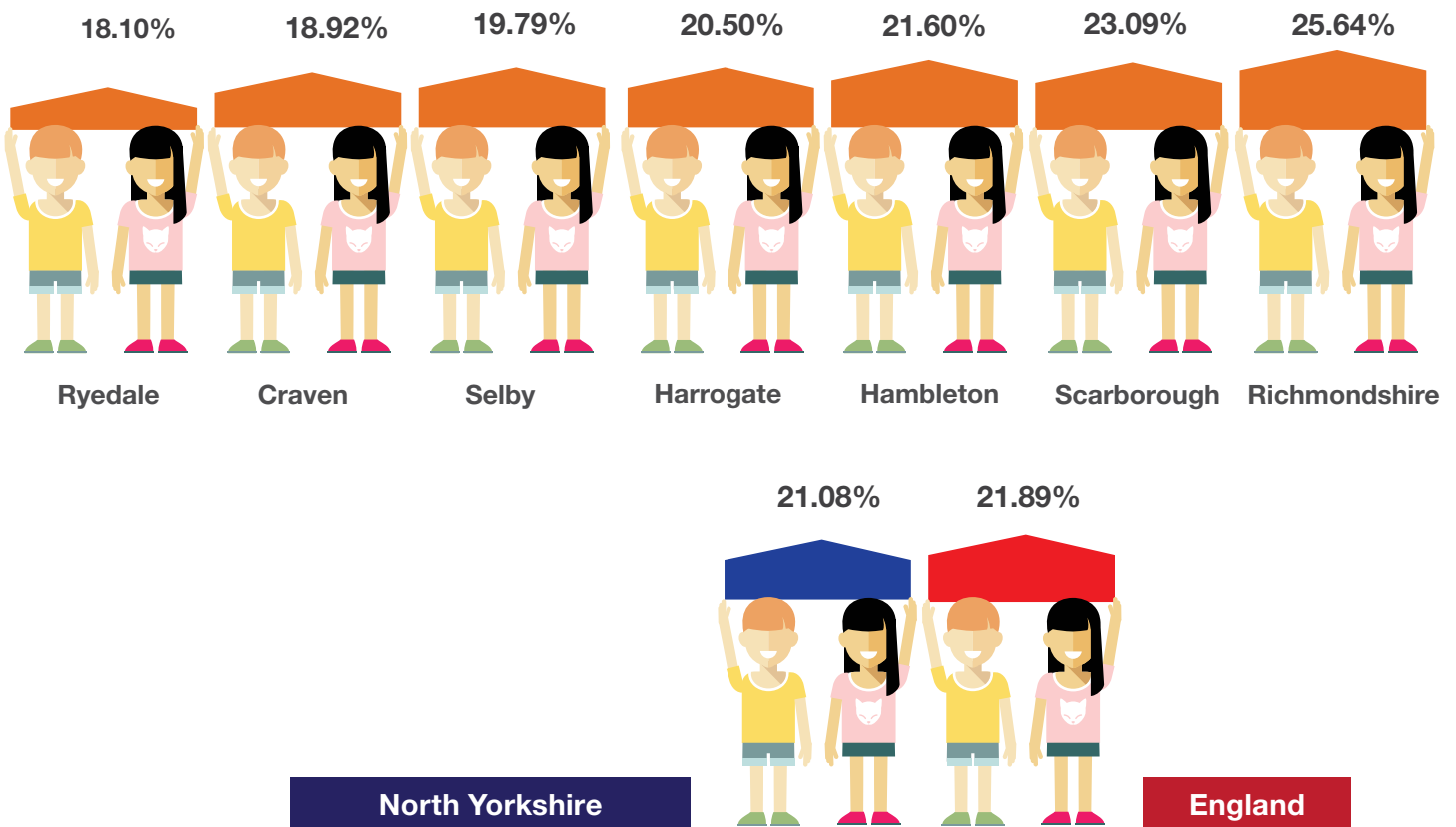
Four to five year olds

For 2012 - 2014 the prevalence of excess weight in four to five year olds in North Yorkshire is 21.08%, which equates to 2,716 four to five year

olds. This is lower than the national average of 21.89%. The diagram below illustrates the district level prevalence for four to five year olds.

Ryedale (18.10%), Craven (18.92%), Selby (19.79%) and Harrogate (20.50%) are lower (not statistically significant) than both the North Yorkshire and England average. Hambleton (21.60%) is higher than the North Yorkshire average (statistically similar), but lower than the England average (statistically similar). Scarborough (23.09%) is higher than both North Yorkshire and England averages (statistically similar). Richmondshire (25.64%) is higher than the North Yorkshire average (statistically significantly higher), but similar to the England average (statistically similar).

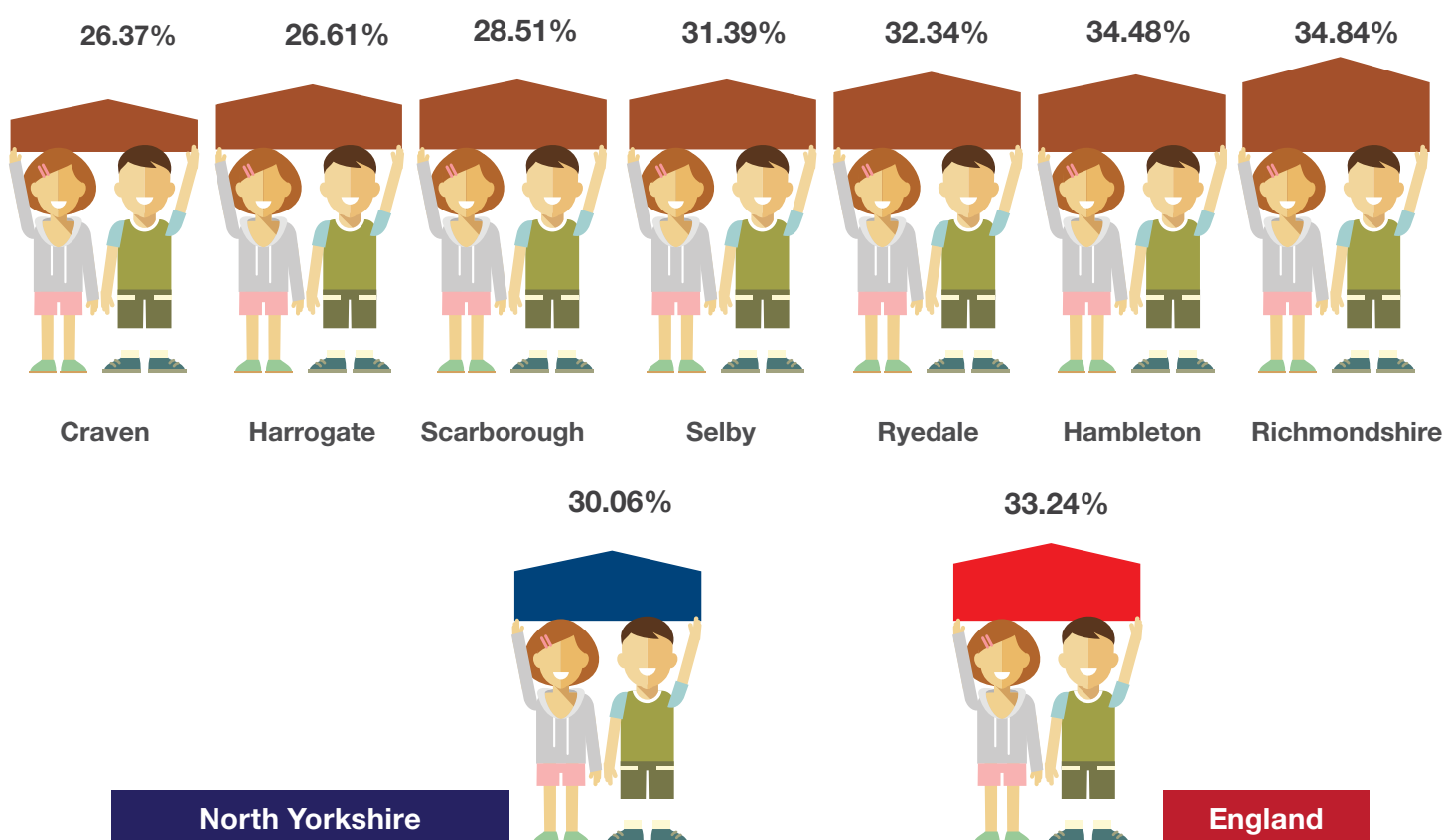
Child excess weight in 4-5 year olds (%) - 2014-15



10-11 year olds

The prevalence of excess weight in 10-11 year olds in North Yorkshire is 30.06%, which equates to 3,822 of 10-11 year olds. This is lower than the national average of 33.24%. The diagram below illustrates the district level prevalence for 10-11 year olds.

Child excess weight in 10-11 year olds (%) - 2014/15



Craven (26.37%) is significantly lower than the England average, and lower (statistically similar) than North Yorkshire. Harrogate (26.61%) is significantly lower than both England and North Yorkshire. This is due to a much greater sample size taken for Harrogate, equating to a smaller confidence interval. Scarborough (28.51%) is significantly lower than the England average, and lower (statistically similar)

than North Yorkshire. Selby (31.39%) and Ryedale (32.34%) are both higher than the North Yorkshire average (statistically similar), but are also both lower than the England average (statistically similar). Hambleton (34.48%) and Richmondshire (34.84%) are both significantly higher than North Yorkshire, and are also higher than England (statistically similar).

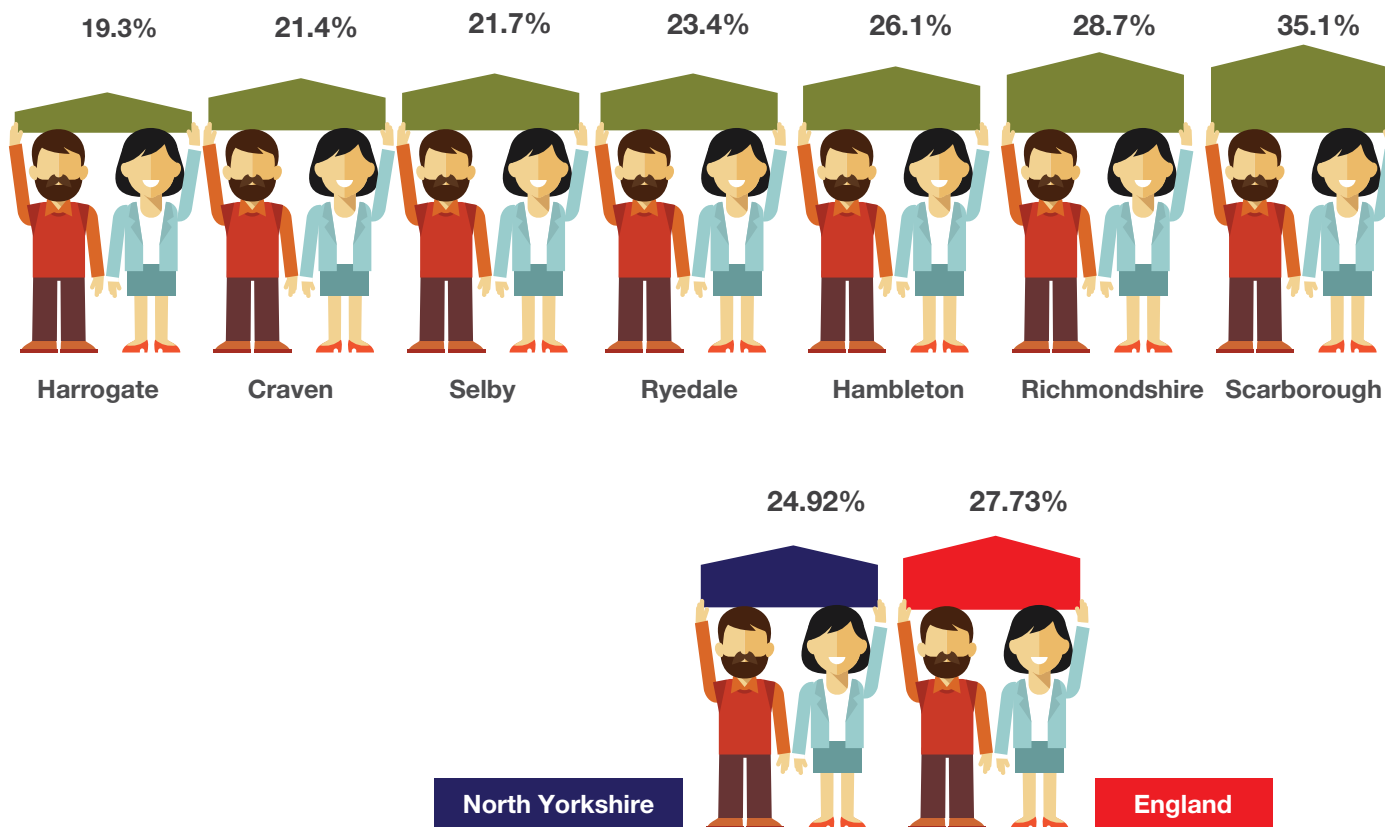
Physical activity - adults

Most recent estimates suggest that approximately 124,313 North Yorkshire residents aged 16 years and over are inactive. Overall, North Yorkshire has a comparatively lower proportion of inactive adults aged 16 years and above, at 24.92%, compared to the England average of 27.73%.

Harrogate has the lowest proportion of inactive adults in North Yorkshire at 19.3%, which is significantly lower than both the England (27.73%) and North Yorkshire (24.92%) averages.

Scarborough has the highest proportion of inactive adults in North Yorkshire at 35.1%, which is significantly higher than both the England and North Yorkshire averages.

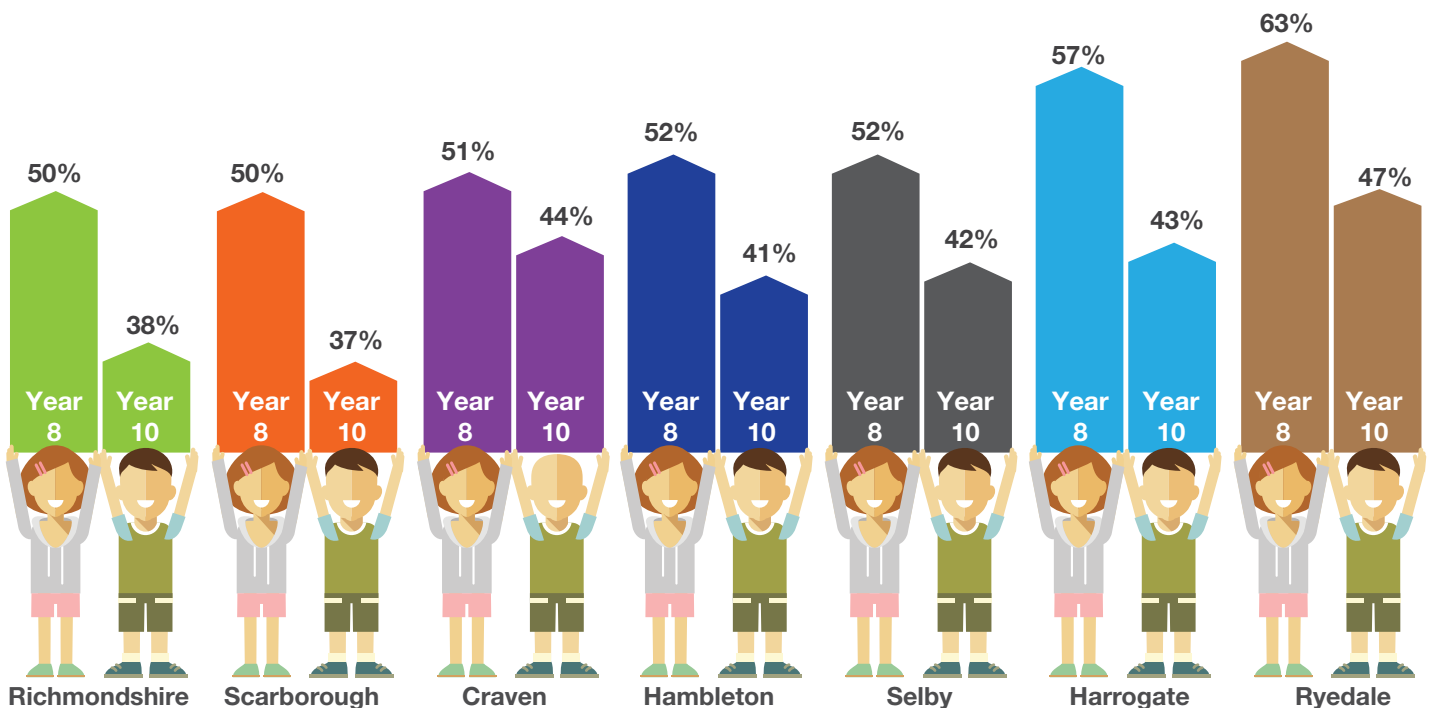
Percentage of physical active and inactive adults - inactive adults



Physical activity – children and young people

North Yorkshire County Council Children and Young People's Service (CYPS) commission a survey of children and young people covering aspects of learning and wellbeing on a biannual basis called Growing Up in North Yorkshire. The survey provides key information about the learning and wellbeing of children and young people across Years 2, 6, 8, and 10. As part of the survey pupils are asked about their levels of physical activity.

% Year 8 and 10 Children who spent time participating in sport after school - GUNY 2015



The health inequalities

Health inequalities arise because of inequalities in society and in the conditions in which people are born, grow, live, work, and age. In the UK, socioeconomic inequalities have increased since the 1960s and this has led to wider inequalities in both child and adult obesity, with rates increasing most among those from poorer backgrounds⁵.

There are major health challenges relating to specific 'equality groups' based on age, sex, ethnicity, sexuality, and disability⁵.

Age and gender

The prevalence of obesity and overweight changes with age. Prevalence of obesity is lowest in the 16-24 year age group, and generally higher in the older age groups among both men and women. There is a decline in prevalence in the oldest age group, which is particularly apparent in men. This pattern has remained consistent over time (Figure 2).

Prevalence of obesity

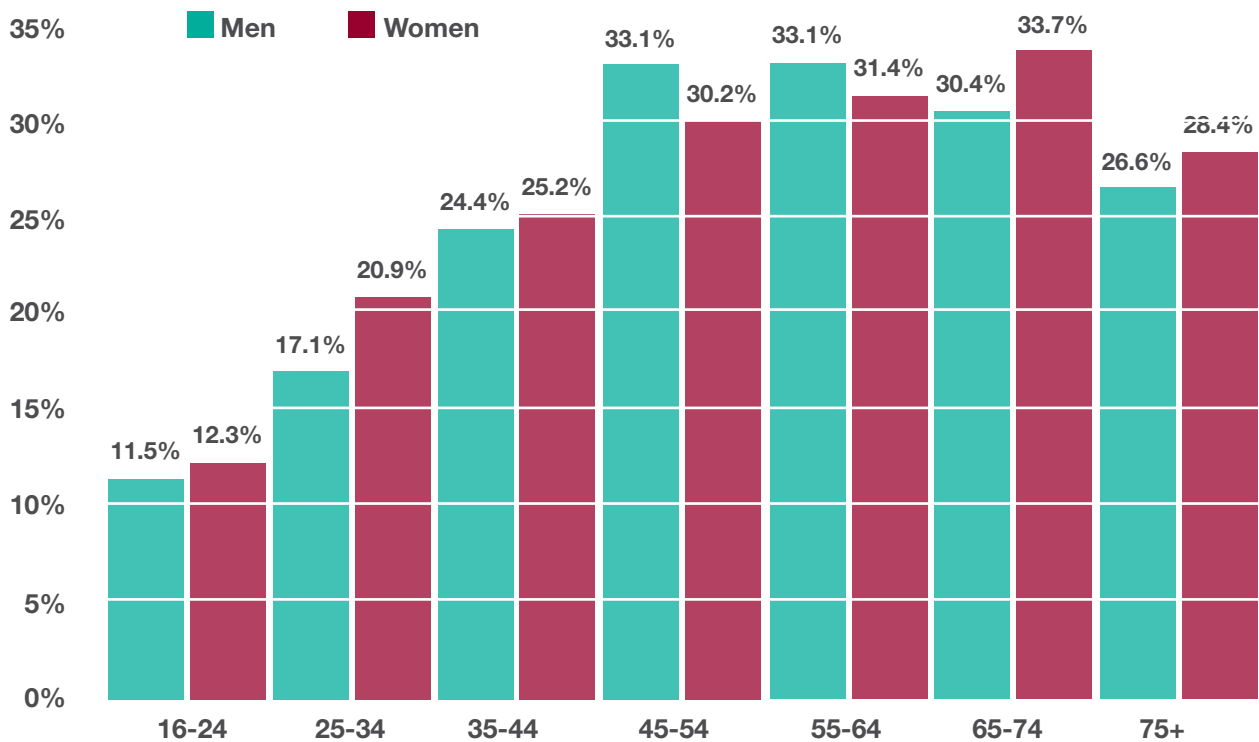


Figure 2 Obesity prevalence by age and gender (Health Survey for England 2008-2012)



Our population is ageing, and obesity is increasing in the elderly bringing massive and rapidly changing burdens of ill health related to increased body weights and fat as well as the main drivers of poor diet and inactivity. Increasing inactivity and illness in elderly people commonly results in substantial loss of muscle mass while body fat is relatively preserved or increased⁶.

Deprivation

In adults, the highest level of educational attainment can be used as an indicator of socioeconomic status. For both men and women obesity prevalence decreases with increasing levels of educational attainment.

There is a strong relationship between deprivation and childhood obesity. Analysis of data from the National Child Measurement Programme (NCMP) shows that obesity prevalence among children in both Reception and Year 6 increases with increased socioeconomic deprivation (Figure 3). Obesity prevalence of the most deprived 10% of the population is approximately twice that of the least deprived 10%⁷.

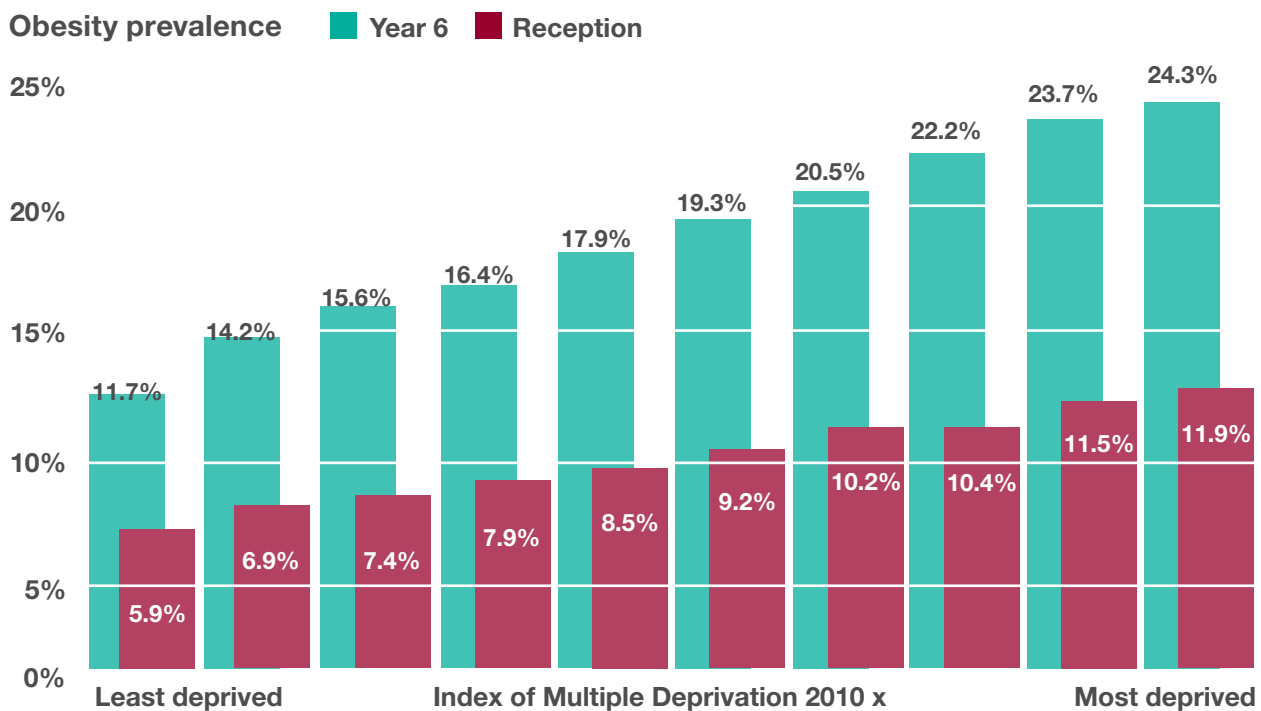
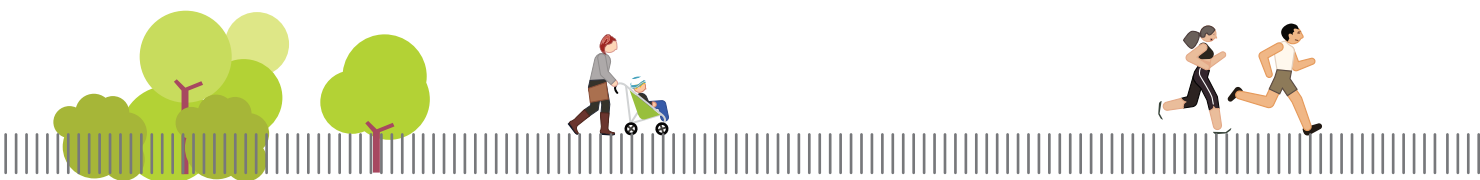


Figure 3 Prevalence of obesity by deprivation decile (National Child Measurement Programme 2012/13).



Ethnicity

There is no straightforward relationship between obesity and ethnicity, with a complex interplay of factors affecting health in minority ethnic communities in the UK. Whilst many people from minority ethnic groups have healthier eating patterns than the White population, unhealthy diets and low levels of physical activity are known to be of concern in some minority ethnic groups, in particular those of South Asian origin. Members of minority ethnic groups in the UK often have lower socioeconomic status, which is in turn, associated with a greater risk of obesity in women and children. People from minority ethnic groups may also experience elevated levels of obesity-related stigma⁷.

Disability

33% of obese adults have a limiting long-term illness or disability⁸. Obesity may lead to disability as a consequence of increased body weight, associated co-morbidities, environmental factors, or a combination of these. Obesity places mechanical stress on joints, increasing risk of back pain and osteoporosis, which may in turn limit mobility⁹. Some obese people may face difficulties in performing tasks such as walking, climbing steps, driving or dressing¹⁰. This in turn can lead to physical inactivity, pain and discomfort, functional limitations and mental distress¹¹.

Physical inactivity and muscle atrophy, as well as secondary conditions such as depression, chronic pain, mobility problems, and arthritis, have been found to contribute to the development of obesity among people with physical disability¹².

For those with learning disabilities, obesity is linked to lower levels of physical activity, poor diet, and the side effects of medication¹³. People with learning disabilities are more likely to be either underweight or obese than the general population¹⁴. A report by the Sainsbury's Centre for Mental Health in 2005 found that the rate of obesity among people with a learning disability was significantly different to those without such a disability (28.3% compared to 20.4%)¹⁵.

The reasons for this higher prevalence of obesity in people with learning disabilities are a complex mix of behavioural, environmental and biological factors. Genetic disorders such as Prader-Willi syndrome carry a high risk of severe obesity and it has been estimated that 24–48% of adults with Down's syndrome are obese¹⁶. Psychotropic medication, used by 30–50% of adults with learning disabilities can also lead to weight gain.

Children who have a limiting illness are likely to be obese or overweight particularly if they also have a learning disability.



Section 2:

Overweight and obesity – the complexities, the impact, and the opportunities

The complexities – causes of excess weight

Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the build up of excess body fat. Tackling obesity however, is not straightforward. As highlighted in the Foresight Report¹, the common perception is that if only people ate less and did more, the problem would be solved. However, there are many complex behavioural and societal factors that combine to contribute to the causes of obesity. They differ between population groups and across the life course, which is why a range of solutions is required.

The approach for the prevention and management of obesity should be modelled on tackling this issue across the life course, targeting groups where there

are periods of metabolic change, which are linked to spontaneous changes in behaviour, or periods of significant shifts in attitudes, for example:

- pregnancy and first year of life
- early years (one to four years)
- childhood (five to ten years & 11-16 years)
- adulthood (17-59 years) – including key life changes such as leaving home, becoming a parent, ill health
- older people (60+ years).

The Foresight Report¹ presents an obesity system map (Figure 4) that puts energy balance at its centre with over 108 variables that directly or indirectly affect energy balance.



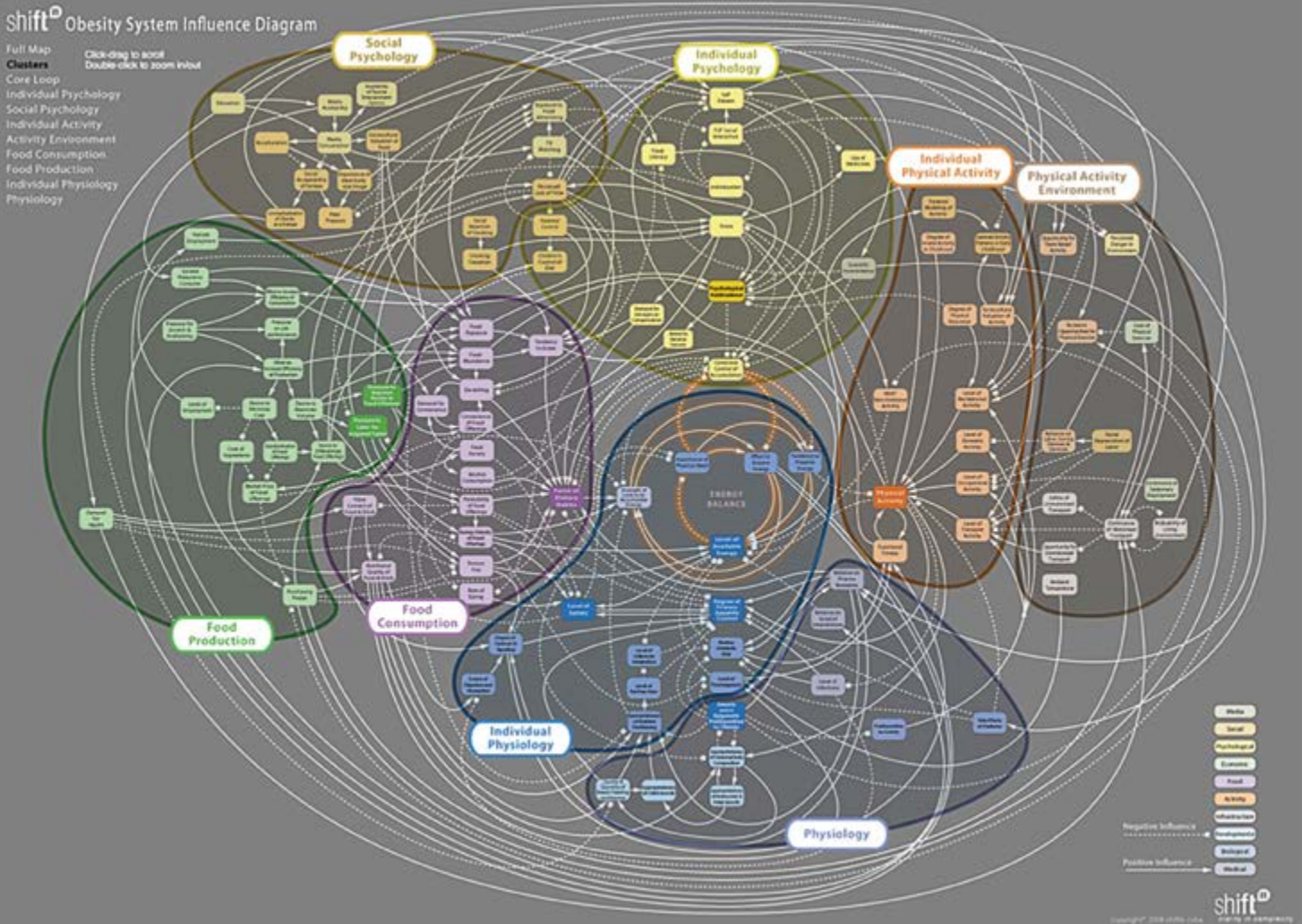


Figure 4 Foresight Obesity Systems Map

A link to the full systems map can be accessed via <http://www.shiftn.com/obesity/Full-Map.html>

The Foresight map can be usefully divided into seven cross-cutting predominant themes which, in recent decades, have resulted in the increasing numbers of people who are overweight or obese. Factors affecting weight include:

Biology (physiology): an individual’s starting point - the influence of genetics and ill health.

At the heart of obesity lies biological system that struggles to maintain energy balance to keep the body at a constant weight. This system is not well adapted to a fast-changing world, where the pace of technological progress has outstripped human evolution. Some constitutionally lean individuals may have a finely tuned appetite control system that precisely matches energy intake to meet energy needs. Other individuals may have a poorly tuned control system in which food intake is persistently

above energy needs, making them more susceptible to obesity. Until relatively recently, food scarcity ensured that this predisposition was not as apparent. However, in the modern world, especially in developed countries, where there is a surplus of energy-dense, low-cost food, this hidden metabolic sensitivity is exposed and will lead to weight gain unless conscious control overrides this^{17 18 19}.

Activity environment: the influence of the environment on an individual’s activity behaviour, for example a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and showers.

How people perceive their environment can be grouped into seven categories – safety, availability and access, convenience, local knowledge and satisfaction, urban form, aesthetics, and

supportiveness of neighbourhoods. Recent research suggests that, in general, our perceptions of the environment have significant but uncertain associations with physical activity.

Physical activity: the type, frequency and intensity of activities an individual carries out, such as cycling vigorously to work every day.

It is generally accepted, at least for adults, that, as society has changed, there have been systematic reductions in energy expenditure, as a consequence of fewer manual jobs, increases in car ownership and the rise of labour-saving devices for use at home and work²⁰. Despite evidence of reductions in walking and cycling to school, the impact of similar changes on physical activity in children is less clear. Other factors may also be relevant, such as the increased fears of parents about unsupervised outdoor play for children²⁰.

Clearly, given the general increase in sedentary employment and the longer hours worked in the UK over the past decades, there are limited opportunities for other forms of activity during the working day. Attention has therefore focused on the importance of energy expended during routine daily activities as a contributor to overall energy.

Societal influences: the impact of society, for example the influence of the media, education, peer pressure or culture.

It is critical to consider the wider cultural and social context to individual's behaviours such as the influence of organisational cultures, social processes and the media. Indeed, while society focuses on individual behaviours as a cause of obesity, organisational behaviours play a substantial but often unconsidered role in cuing the behaviour of individuals. For example it is organisations that make the decisions about the range of snacks in a workplace, the availability and contents of vending

machines, and whether employees receive incentives to use cars but no incentives to use bicycles.

Individual psychology: for example a person's individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences.

What motivates and determines health-related behaviour is complex but in modern societies, there is a psychological conflict between what people want (e.g. fatty, sweet foods) and their desire to be healthy and/or slim. Mixed feelings and beliefs about healthy lifestyle choices complicate individual choices. For instance, most people know that eating fatty foods in excess is generally bad for them while taking exercise is generally beneficial. Yet they tend to enjoy eating foods that are high in calories or excessive salt and find it difficult to find the time to exercise. Other important dimensions to behaviour that serve to further complicate this issue include overcoming existing habits, the role of different types of beliefs, the degree of control or perceived control an individual has over their environment and their perceived vulnerability to risk.

Food environment: the influence of the food environment on an individual's food choices, for example a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables near home.

Environmental influences on diet often involve physical ease of access to food and drink, for example, from supermarkets for home consumption, from takeaways and from restaurants. As eating habits become more unstructured, the availability of and access to 'food on the go' is an important consideration.



Although it is impossible to say consumers buy their food on price alone, price does frame the context in which consumer responses are made. Cheaper food sources tend to be more energy-dense and nutrient-poor, that is, they provide plentiful calories, especially in the form of fats and sugars, but relatively low levels of vitamins and minerals.

Food consumption: the quality, quantity (portion sizes) and frequency (snacking patterns) of an individual's diet.

Eating behaviour is shaped by the drive and opportunities to eat. As a result, energy intake may vary from zero to several thousand calories a day. Food and drink access, availability and price plus individual psychology can all affect the foods we consume.

The impact of excess weight

Obesity is widespread. Nationally, two thirds of adults, a quarter of two to ten year olds and one third of 11-15 year olds are overweight or obese. Excess weight in adults is predicted to reach 70% by 2034. This rate of overweight and obesity affects the physical and mental state, and impacts on the life expectancy, of those affected. An increase in the prevalence of long term conditions associated with overweight and obesity is contributing to the increased demand on health and social care services.

The impact - on physical health

There is now a considerable body of evidence linking obesity with a wide range of physical health issues.

Being overweight or obese in childhood has consequences for physical health in both the short term and the longer term. Once established, obesity is notoriously difficult to treat, so prevention and early intervention are very important.

Obese children are more likely to be ill, be absent from school due to illness, experience health-related limitations and require more medical care than children who are a healthy weight ²¹.

Potential physical health related consequences of overweight and obesity in children and young people include type 2 diabetes, asthma, obstructive sleep apnoea and cardiovascular disease. Physical health risks factors include high blood pressure, high cholesterol and musculoskeletal problems.

The physical health risks for adults are just as concerning. Compared with a non-obese man, an obese man is:

- five times more likely to develop type 2 diabetes
- three times more likely to develop cancer of the colon
- more than two and a half times more likely to develop high blood pressure – a major risk factor for stroke and heart disease.

An obese woman, compared with a non-obese woman, is:

- almost thirteen times more likely to develop type 2 diabetes
- more than four times more likely to develop high blood pressure
- more than three times more likely to have a heart attack²².

Risks of other diseases, including angina, gall bladder disease, liver disease, ovarian cancer, osteoarthritis and stroke, are also increased for those who are obese compared with those who are not.



The impact - on diabetes prevalence

Being overweight or obese is the main modifiable risk factor for type 2 diabetes. Currently 90% of adults with type 2 diabetes are overweight or obese. In England, the rising prevalence of obesity in adults has led, and will continue to lead, to a rise in the prevalence of type 2 diabetes. This is likely to result in increased associated health complications and premature mortality, with people from deprived areas and some minority ethnic groups at particularly high risk.

In England, obese adults are five times more likely to be diagnosed with diabetes than adults of a healthy weight. People with severe obesity are at greater risk of type 2 diabetes than obese people with a lower BMI²³.

People with diabetes are at a greater risk of a range of chronic health conditions including cardiovascular disease, blindness, amputation, kidney disease and depression than people without diabetes. Diabetes leads to a two-fold excess risk for cardiovascular disease. Nearly one in five people with diabetes have clinical depression²⁴, rates of depression being nearly twice as high in people with type 2 diabetes compared to those without the condition (19.1% compared to 10.7%), with higher rates among women than men²⁵.

Type 2 diabetes usually appears in adults, but recently more children in the UK are being diagnosed with the condition, some as young as seven²⁶. 95% of children under 17 years old that are diagnosed with type 2 diabetes are overweight and 83% are obese²⁷.

To tackle the rising trend of type 2 diabetes NHS England, Public Health England and Diabetes UK have completed an initial roll out of a Diabetes Prevention Programme. The Programme is established to identify those at high risk and refer them onto an evidence-based behaviour change programme to help reduce their risk. By

2020 the roll out across the whole country will be completed. There is a huge opportunity in North Yorkshire to increase the identification of those who are at risk of diabetes and increase the access to evidence-based behaviour change programmes when the national roll out commences.

The impact - on mental health

The connection between obesity and common mental health disorders is an important public health issue. Both these conditions have major implications for health care systems and account for a significant proportion of disease²⁸. Individuals who suffer from both obesity and common mental health disorders may also face particular risks to health and wellbeing, as it is likely that the conditions may perpetuate each other²⁹.

Being overweight as a child or adolescent has been found to have an adverse effect on a young person's self-esteem, self-image, and self-concept,³⁰ with physical appearance and athletic/physical competence being most affected^{31 32}. Obesity has also been associated with depression in adolescents. A lack of physical activity, low self-esteem, body dissatisfaction, eating disorders and weight-based teasing are all obesity related factors that cause mental health disorders in children and adolescents. Factors linked to mental health disorders including lack of energy, medication, family breakdown or poverty are thought to contribute to obesity in children and young people. The impact of obesity on mental wellbeing increases with age and is stronger in girls than boys.

In adults the relationship between obesity and common mental health disorders is complex. Some researchers suggest that obesity can lead to common mental health disorders, whilst others have found that people with such disorders are more prone to obesity. Some evidence suggests an obese person has a 55% increased risk of developing depression over time, and a depressed person has a 58% increased risk of becoming obese³⁴.



Low self-esteem, stigma, dieting and weight cycling, medication, and hormonal and functional impairment are all thought to be factors associated with obesity that impact on mental health. Unhealthy lifestyles, medication and reduced support are factors associated with poor mental health that are thought to contribute to the increased prevalence of obesity in adults.

Whilst both obesity and common mental health disorders share similar symptoms such as sleep problems, sedentary behaviour and poorly controlled food intake, for the most part they are treated as separate health problems, often leading to poor treatment outcomes²⁸. There is a real opportunity for partners who have responsibility for commissioning and providing obesity interventions and services to work with mental health professionals to address obesity and mental health more cohesively.

Local action – North Yorkshire’s Mental Health Strategy: Hope, Control and Choice (2015 – 2020)

North Yorkshire’s Mental Health Strategy (2015-2020) highlights the importance of working in new ways to take into account the physical health of those suffering from poor mental health. There is real opportunity for a co-ordinated action across the two strategies.

Access to the strategy is via <http://www.nypartnerships.org.uk/mentalhealthstrategy>

The impact - on maternal health

Maternal obesity (defined as obesity during pregnancy) increases health risks for both the mother

and child during and after pregnancy. Statistics on the prevalence of maternal obesity are not collected routinely in the UK, but trend data from the Health Survey for England show that the prevalence of obesity among women of childbearing age increased during the period 1997-2010. Women who are obese are significantly more likely to be older in pregnancy, to have a higher parity (number of pregnancies), and live in areas of high deprivation, compared with women who are not obese⁷.

There is a large body of evidence which links maternal obesity to adverse pregnancy outcomes. In the UK, the Centre for Maternal and Child Enquiries (CMACE) summarises these risks as follows;

- severe morbidity
- miscarriage
- cardiac disease
- spontaneous first trimester and recurrent miscarriage
- pre-eclampsia
- gestational diabetes
- thromboembolism
- post-caesarean wound infection
- infection from other causes, postpartum haemorrhage
- low breastfeeding rates.

Maternal obesity rates are influenced by social, economic and demographic changes in the population, which is important to consider when planning public health strategies and interventions. This Strategy provides the chance for partners commissioning and providing maternity services to monitor and review service provision to reduce the risks associated with maternal obesity. Key stakeholders also have the opportunity to work together to effectively commission and deliver weight loss interventions that support women of child bearing age to manage their weight prior to conception.



The impact - on life expectancy

Obesity reduces life expectancy by an average of three years, or eight to ten years in the case of severe obesity (BMI over 40). This eight to ten year loss of life is equivalent to the effects of lifelong smoking³⁵.

The impact - on social care

There is an important link between obesity and social care: both through the association between obesity and the development of long term conditions, and the physical and social difficulties that may result from the development of severe obesity. Increasing obesity prevalence along with the growing needs of an ageing population, the rise in non-communicable diseases associated with obesity, and rising public expectations for service intervention and treatment³⁶ present significant challenges and cost implications to both the health and social care systems.

Adults with severe obesity may have physical difficulties which inhibit activities of daily living. People are more likely to require housing adaptations such as specialist mattresses, doors, toilet frames, hoists and stair lifts, specialist carers and provision of appropriate transport and facilities (such as bariatric patient transport and specialist leisure services).

Long term conditions account for 70% of the total health and social care spend. While life expectancy has improved over time, the length of time people spend in ill health towards the end of life has increased. In England more than 15 million people have a long term condition and the care of people with long term conditions accounts for 70% of total health and social care spend³⁸.

The impact - on housing

The type of housing and the communities in which people live has an impact on their opportunities to live a healthy and active life. Housing is closely linked to the provision of accessible, safe green space, which in turn can influence obesity. In addition, obese people, particularly those with severe obesity may require specialist home adaptations and support services to enable them to be more independent and improve their quality of life.

The impact - on the economy

Estimates of the direct costs to the NHS for treating overweight and obesity, and related morbidity in England, have ranged from £479.3 million in 1998 to £4.2 billion in 2007. Estimates of the indirect costs (those costs arising from the impact of obesity on the wider economy such as unemployment, early retirement and associated welfare benefits) over the same time period ranged between £2.6 billion³⁹ and £15.8 billion⁴⁰.

Obese employees take increased amounts of short and long term sickness absence than workers of a healthy weight. There are significant workplace costs associated with obesity. For an organisation employing 1,000 people, this could equate to more than £126,000 a year in lost productivity due to a range of issues including back problems and sleep apnoea. There may be jobs which obese people find more difficult to do or which are more dangerous due to the associated conditions linked to obesity, for example sleep problems may impact on alertness and may pose a potential danger for employees who drive or operate machinery.

The opportunities – changing individual lifestyle and behaviour

For those that are overweight or obese, losing weight can reduce the risk of some potentially serious health problems. Most people who need to lose weight can get health benefits from losing even a small amount – about 5% - of weight if they keep it off. Even a moderate weight loss of 3% that is kept off may improve or prevent health problems⁴¹.

Eating and physical activity are two critical behaviours with the potential to influence energy balance in the body. Eating behaviour is shaped by the drive and the opportunities to eat. Physical activity is the behavioural component of energy expenditure. Research in social psychology tells us a great deal about how people make their decisions⁴². What motivates and determines health related behaviour is complex, but in modern societies, there is a psychological conflict between what people want (e.g. fatty, sugary foods) and their desire to be healthy and/or slim¹.

Mixed feelings and beliefs about health and lifestyle choices complicate individual choices. Important dimensions that further complicate behaviour change include overcoming existing habits, the role of different types of beliefs i.e. consequences, expectations of others, social norms and the motivation to comply.

Improving nutrition

Over the last 30 - 40 years there have been profound changes in our relationship with food – how we shop and where we eat, as well as the foods available and how they are produced. Food is now more readily available, more heavily marketed, promoted and advertised and, in real terms, is much cheaper than ever before⁴³.

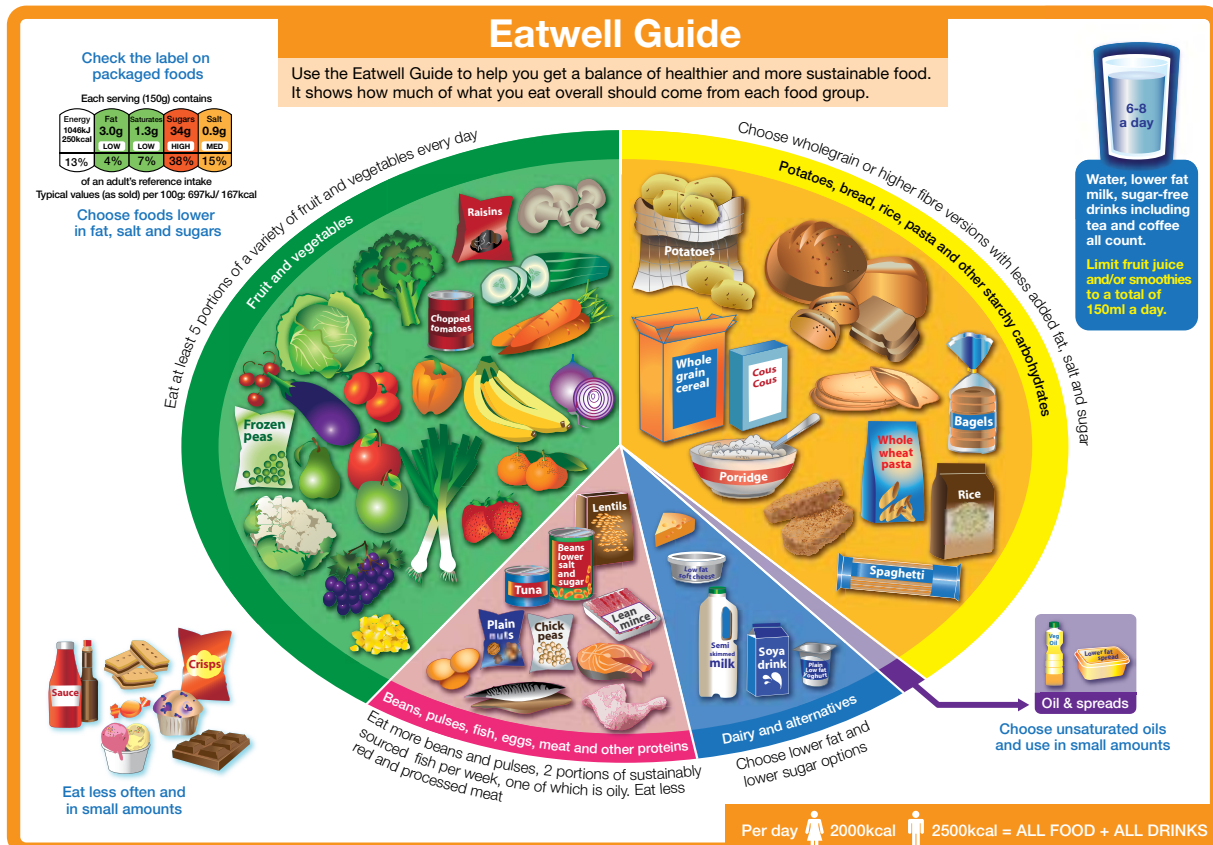
Consumption of excess calories is often due to over consumption of high energy foods and drinks such as processed or fast food, sweetened and alcoholic drinks, or large portion sizes. Eating healthily is about eating the right amount of food

for individual energy needs. Overweight and obesity prevalence indicates that many of us are eating more than we need, and we should eat and drink fewer calories to lose weight⁴⁴.

Adults are more likely to maintain a healthy weight if they reduce consumption of high energy-dense foods and drinks and consume a lower-fat, high fibre diet, consisting of fruit, wholegrains, vegetables, lean meat and fish. Public Health England’s (PHE) new Eatwell Guide illustrates a healthy diet being one that includes more fruit, vegetables and starchy carbohydrates and fewer sugary foods and drinks. PHE have now put foods high in fat, salt and sugar outside of the main image (Figure 5) and these are described as ‘foods to eat less often and in small amounts’. This reflects the advice that they are not an essential part of a healthy and balanced diet.

The diagram below is also available online here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/528193/Eatwell_guide_colour.pdf

Figure 5 Public Health England’s new Eatwell Guide (March 2016).



Source: Public Health England in association with the Welsh Government, Food Standards Scotland and the Food Standards Agency in Northern Ireland

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Reducing sugar intake

Consuming too many foods and drinks high in sugar can lead to weight gain and related health problems, as well as tooth decay. Sugar intakes of all population groups are above the recommendations, contributing between 12 - 15% of energy. Consumption of sugar and sugar sweetened drinks is particularly high in school age children. It also tends to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequence. In general, the main sources of sugar in the UK diet are similar for both children and adults. These include soft drinks; table sugar; confectionery; fruit juice; biscuits; buns; cakes; pastries and puddings; breakfast cereals; and alcoholic drinks (for adults) with some foods making a larger contribution in different age groups.

The review, 'Sugar reduction: the evidence for action'⁴³ determines that a range of factors, including marketing, promotions, advertising and the amount of sugar in manufactured food, is contributing to an increase in sugar consumption. The evidence review shows that action to reduce sugar consumption levels could include, but is not limited to, reducing:

- the volume and number of price promotions in retail and restaurants
- the marketing and advertising of high sugar products to children
- the sugar content in, and portion size of everyday food and drink products.



National action – Introducing a soft drinks industry levy and taking out 20% of sugar in products

In August 2016 the Department of Health announced in the 'Childhood Obesity Strategy: A Plan for Action' that they will be introducing a soft drinks industry levy across the UK. The revenue from the levy on producers and importers will be invested in programmes to reduce obesity, which includes doubling the Primary PE and Sport Premium. In the same Strategy, the Department of Health have committed to launching a broad, structured sugar reduction programme to remove sugar from the products children eat most. All sectors of the food and drinks industry will be challenged to reduce overall sugar across a range of products that contribute to children's sugar intakes by at least 20% by 2020, including a 5% reduction in year one. This will be achieved through reduction of sugar levels in products, reducing portion size or shifting purchasing towards lower sugar alternatives.

Access to the strategy is via <https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action>

Reducing fat intake

Fat is a rich source of energy; one gram provides 37 kJ (nine kcal). Fat is made up of building blocks called fatty acids and these are classified as saturated, monounsaturated or polyunsaturated depending on their chemical structure. Some of these are essential components of the diet but others can be detrimental to our health if too much is consumed. All types of fat provide the same number of calories (nine kcal/g) regardless of where they come from. This means that too much of any type of fat can encourage weight gain. Foods that contain a lot of fat provide a lot of energy and are called energy-dense foods. Consuming too many energy-dense foods can lead to excess energy intake. This energy will be stored as body fat and, over time, promote the development of obesity,

which increases the risk of developing conditions such as heart disease, type 2 diabetes and cancer. Foods high in saturated fat, such as butter, fried foods, and some cakes, biscuits and pastries, should only be eaten in small amounts, as this type of fat can increase blood cholesterol levels.

The recommended amount of total daily fat intake for males is 95g, of which 30g should only be saturated fats. For females the total daily fat intake is 70g, of which 20g should only be from saturated fats⁴⁵.

Local action – Food for Life

The Soil Association’s Food for Life (FFL) programme aims to transform food culture in schools and their communities through a whole school approach to embed change by using a well-established framework for schools to follow, leading to an award based accreditation of their success. FFL uses food as a way to improve the whole school experience by making lunchtimes a positive feature of the day and enriching classroom learning with farm visits and practical cooking and growing. FFL is about bringing people together – teachers, pupils, families, cooks, caterers, farmers and the wider community – to enjoy good, wholesome food and change food culture throughout their community.

North Yorkshire County Council’s Public Health Team have commissioned a two year FFL programme that will offer hands on tailored support to schools where there are high rates of overweight and obesity (identified through the National Child Measurement Programme data) to enable them to gain national FFL accreditation. The programme will be delivered by the Energy Traded Service working within the Council.

Young people spend a considerable amount of time at school making this an effective environment for change and a setting where building skills and knowledge and demonstrating good lifestyle can have a lasting impact.

<http://www.foodforlife.org.uk/>

Reducing alcohol consumption

The relationship between obesity and alcohol consumption is complex. Associations between the two are heavily influenced by a number of factors including: patterns and levels of drinking; types of alcoholic drinks consumed; gender; body weight; diet; genes; physical activity levels; and other lifestyle factors⁴⁶.

Alcohol accounts for nearly 10% of the calorie intake amongst adults who drink⁴⁷. A recent survey by Alcohol Concern found that many people are unaware how many calories they are consuming in the form of alcoholic drinks⁴⁸, and they often fail to include them in their assessment of daily calorie consumption⁴⁹.

Much of the research regarding alcohol to date focuses on alcohol dependency, binge drinking and associated crime and disorder⁵⁰. The relationship with obesity does not appear to have been a research priority. Further research to help clarify this complex relationship is required to understand this relationship better.

Local action – North Yorkshire’s Alcohol Strategy (2014-2019)

The North Yorkshire Joint Alcohol Strategy aims to reduce the health, social and economic harms from alcohol. There is a real opportunity locally to build on the progress of the Alcohol Strategy action and work to address obesity and alcohol more cohesively.

Access to the strategy is via <http://www.nypartnerships.org.uk/index.aspx?articleid=28432>

Increasing physical activity

Being inactive is an issue at any age across all communities. If we spend too much time in positions that do not use energy, for example sitting at our desks for long periods and sitting in front of the television for long periods of time, our health can be affected. This is because of the way it affects our circulation and failure to use our muscles and bones.

How much physical activity should you do?

Adults (19 to 64) should aim for at least **150 minutes** of moderate intensity activity, in bouts of 10 minutes or more, each week

All adults should undertake muscle strengthening activity, such as

- exercising with weights
- yoga
- or carrying heavy shopping

at least 2 days a week

This can also be achieved by 75 minutes of vigorous activity across the week or a mixture of moderate and vigorous.

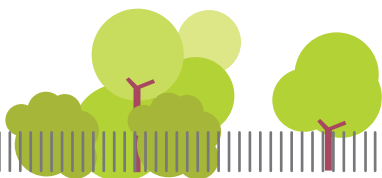
Minimise the amount of time spent sedentary (sitting) for extended periods

Source: Public Health England, 2016

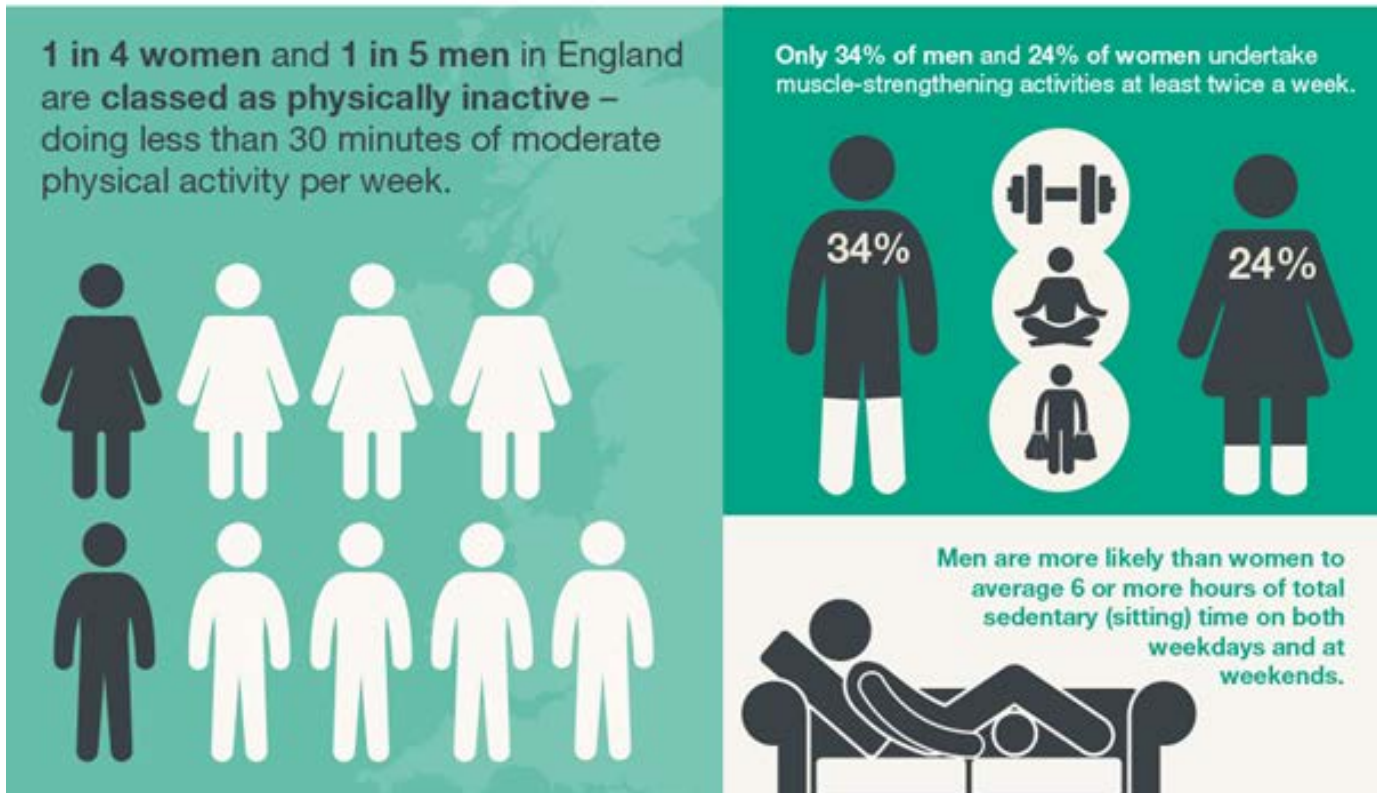
To stay healthy adults aged 19 and over need a mixture of aerobic and strength exercise. Adults should aim for:

- At least 150 minutes of moderate intensity aerobic activity, per week. Examples of moderate intensity aerobic activity include, brisk walking, riding a bike and pushing a lawn mower
- Strength exercises on a minimum of two days per week such as yoga, heavy gardening and lifting weights.

National guidelines stipulate different levels and amounts of physical activity for children and young people depending on their age. Children and young people should reduce the time they spend sitting watching TV, playing computer games and travelling by car when they could walk or cycle instead.



How active are we?



Source: Public Health England, 2016

Nationally, only 19% of men and 26% of women are physically active. Only 23% of girls aged five to seven meet the recommended levels of daily activity, by ages 13-15 only 8% meet the recommendations⁵¹.

There are several reasons that contribute to people being inactive and having sedentary lifestyles:

- Physical activity has slowly been removed from our daily lives as a result of social, cultural and economic change.
- Employment type has changed over time; less people have manual jobs and more people sit in offices for long periods of time. More than 40% of women and 35% of men spend more than six hours a day desk bound or sitting still.
- Increased use of technology at home and at work has resulted in more sedentary behaviours such as watching the television, using the computer, using mobile phones or tablets for long periods of time.
- The design of towns and cities does not always support people to be active.
- Speed and convenience are prioritised over walking or cycling.
- Public spaces are not designed appropriately or do not have the facilities people require to be physically active⁵².



Local action – North Yorkshire Sport

North Yorkshire Sport is a charity that exists to use the power of sport and physical activity to drive positive change in people's lives. This work includes delivering aspects of the Government Strategy 'Sporting Future: Strategy for an Active Nation' which focuses on reducing inactivity and using sport to tackle wider outcomes such as obesity and crime reduction. North Yorkshire Sport is a charity that exists to use the power of sport and physical activity to drive positive change in people's lives. The work of the charity includes supporting primary schools in the effective use of the PE and Sport premium, and providing new and alternative clubs for young people. North Yorkshire Sport also work to create a strong infrastructure for sport and physical activity through the development of the workforce i.e. coaches and provision of facilities, and working with targeted population groups to reduce inactivity. For more information visit www.northyorkshiresport.co.uk

Access to the Sporting Future: Strategy for an Active Nation is via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/486622/Sporting_Future_ACCESSIBLE.pdf

Improved access to evidence based treatment services

For those that are overweight or obese, losing weight can reduce the risk of some potentially serious health problems. Most people who need to lose weight can get health benefits from losing even a small amount – about 5% - of weight if they keep it off. Even a moderate weight loss of 3% that is kept off may improve or prevent health problems⁵³.

The provision of weight management services is crucial in supporting people make positive behaviour changes associated with food and physical activity. The main strategies for treating obesity are provision of lifestyle advice, referral for weight management, prescription of anti-obesity drugs and, in severe cases, referral for bariatric surgery. Clinical guidelines recommend a stepped approach to weight management depending on the severity of a patient's obesity and whether they have weight-related comorbidities, with more intensive interventions offered as appropriate. Interventions should be agreed between the clinician and patient, and offered in conjunction with long-term follow-up and continuing care. Weight management interventions, as part of a wider approach to the development of local care pathways for obesity, should address all the relevant stages from screening patients to identify those who would benefit from an intervention, by offering brief interventions in primary care before referring to a specific weight management service.

All weight management interventions should focus on diet and physical activity together, rather than attempting to modify either diet or physical activity alone. Weight management interventions should also include behaviour change strategies to increase people's physical activity levels and/or decrease inactivity, improve eating behaviour and the quality of the person's diet and reduce energy intake.

The National Institute for Health and Care Excellence (NICE) recommends that weight management services are provided for adults with a body mass index¹ (BMI) of >25, and for children >91st centile⁵⁴, as part of a tiered approach to weight management services^{55 56}. The obesity care pathway generally consists of four tiers. Typically, tier 1 covers universal services, tier 2 covers lifestyle weight management services, tier 3 covers specialist multi-disciplinary team weight management services, and tier 4 covers bariatric surgery^{57 58}. Figure 6 illustrates the different 'tiers' within the obesity pathway as set out in NICE guidance.



Local authorities are responsible for commissioning public health services, including approaches typically described as tiers 1 and 2. The responsibility for commissioning tier 3 services continues to be debated, though a systems working group convened by PHE and NHS England identified clinical commissioning groups (CCG) as the preferred commissioner. Commissioning of tier 4 services has recently changed to now reside with CCGs. NYCC currently commissions tier 2 weight management services within all District Council areas.

Tier 3 services represent an important (and sometimes final) intervention as part of the wider obesity pathway. A tier 3 obesity service is for obese individuals (usually with a body mass index ≥ 35 with co-morbidities or 40+ with or without co-morbidities) who have not responded to previous tier interventions. A tier 3 service is comprised of a multi-disciplinary team of specialists, led by a clinician and typically including: a physician (consultant or GP with a special interest); specialist nurse; specialist dietician; psychologist or psychiatrist; and physiotherapist/physical activity specialist/

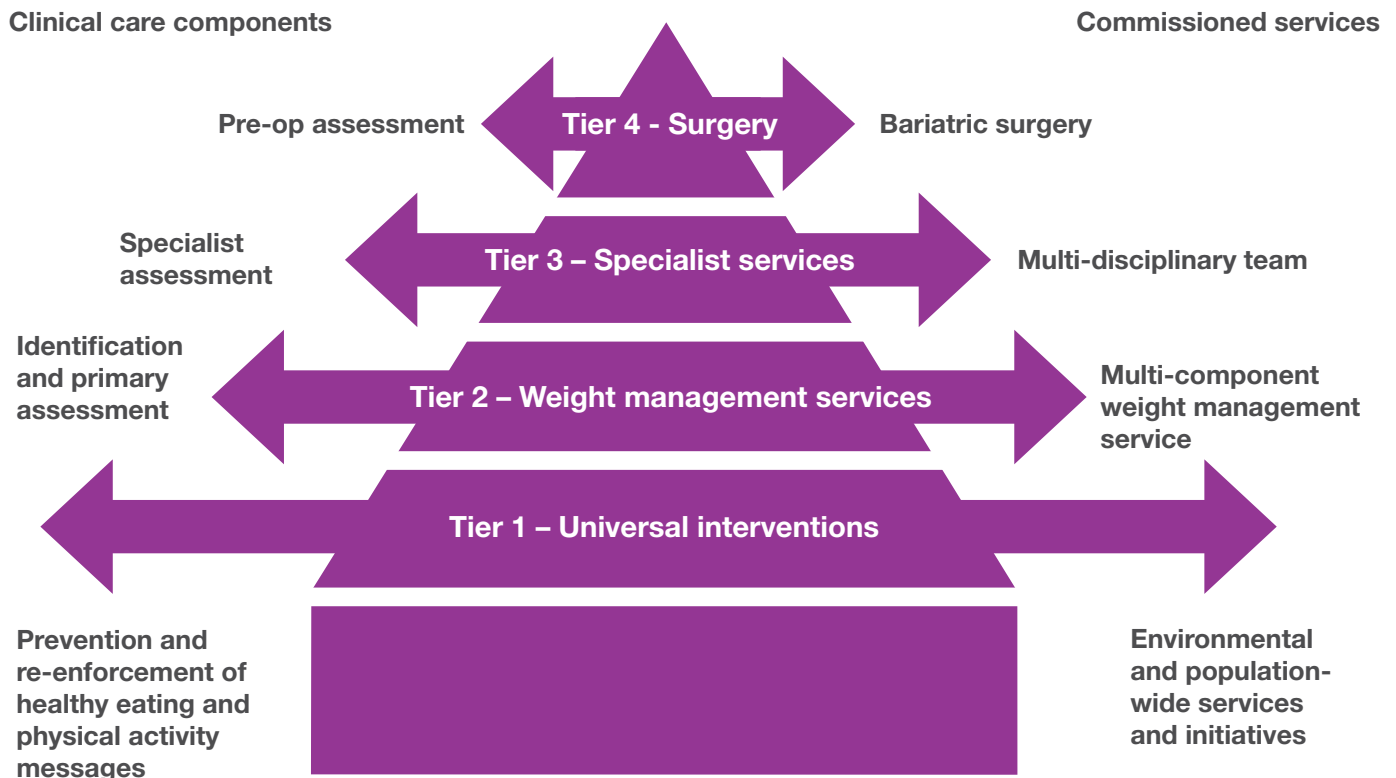
physiology. In the absence of tier 3 services patients cannot ordinarily access bariatric surgery. There is currently only tier 3 provision in two Districts within North Yorkshire. Where progress to tier 4 bariatric surgery is required patients should undergo a service based weight loss programme (non-surgical tier 3/4), for a duration of 12 – 24 months, the minimum acceptable period being six months. Patients completing tier 3 support who pro-actively manage their diet and exercise are more likely to subsequently succeed in the dietary control required post-surgery, and therefore maximise the outcomes of their surgery. It is therefore really important to have a range of services across all tiers in North Yorkshire, which meet NICE guidance.

Access to NICE guidance associated with diet, nutrition and obesity is via this link

<https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/diet--nutrition-and-obesity>

A list of all the relevant NICE guidance can be seen in Appendix 2.

Figure 6 Obesity pathway



The obesity pathway is significant in supporting wider care pathways such as type 2 diabetes prevention and management, cardiac rehabilitation, and stroke rehabilitation and for supporting patients to be in optimum health for improved surgical outcomes. It is vital that partners work together to ensure these are joined up and clinically effective.

The opportunities – changing the environment we live in

Changes to our environment (including both the activity and food-related environment) are a necessary part of any response to support behaviour change and appropriate behaviour patterns. Solutions to address the obesogenic environment such as changes in transport infrastructure and urban design can be more difficult and costly than targeting intervention at the group, family or individual. However, they are more likely to affect multiple pathways within the obesity system in a sustainable way^{59, 60, 58}.

The Foresight report (2007)¹ highlights that humans adapt readily to environments that promote sedentary behaviour; poor-quality food choices and cultures exist where being active or eating 'healthy' foods are not high priorities or where there may be resistance to change. Environmental factors such as access to healthy food options, access to safe open spaces for play and physical activity, an infrastructure that supports active travel, and walking and cycling are all key in enabling the local population to make positive lifestyle changes and change the shift in priority.

Key settings such as early years, schools and workplaces are crucial to addressing overweight and obesity within the environments that we live.

Obesity can impact on the workplace in a number of ways. Obese employees take increased amounts of short and long term sickness absence than workers of a healthy weight. In addition to the impact on individual health and increased business costs due to time off work through associated illnesses, obese people frequently suffer other issues in the workplace including prejudice and discrimination⁶¹. There is a real opportunity to support local employers develop workplace health policy and interventions that support improved diet and physical activity levels of their workforce. Sign up to the national Workplace Health Charter is also recommended so that good practice can be recognised and shared with others.

Early years settings and schools are hugely important in supporting children and young people to improve their diet and physical activity levels. A whole-school approach should be used to develop life-long healthy eating and physical activity practices⁶². Departments and services involved in education and learning have a significant role in tackling overweight and obesity in North Yorkshire. Supporting schools to implement the School Food Plan, further develop Healthy Schools Programmes, and participate in the Eat Better, Start Better programme are some of the actions that can be taken locally within schools and early years settings. Full participation in the National Child Measurement Programme is key in the identification of overweight and obese children and provides the opportunity to enhance the information and guidance families and carers receive to support weight management.

Schools have opportunities to support healthier eating, physical activity and to shape healthy habits. Schools also have unique contact with parents and can signpost them to information and advice on keeping their children healthy⁶³. From September 2017, the Department of Health have introduced a new voluntary healthy rating scheme for primary schools to recognise and encourage the contribution to preventing obesity by helping children eat better and move more. The scheme is taken into account during Ofsted inspections. Locally, there is a real opportunity to support primary schools to sign up to the healthy rating scheme and pioneer change within the school setting.





Source: Public Health England, 2016

The activity environment – creating a more active society

In recent years, there has been increased interest in how the environment influences physical activity. Early physical activity research tended to focus on determinants of physical activity at the individual or group level and, as a result, early interventions operated predominantly at the individual level. More recently, research has begun to investigate the role of environmental factors in shaping an individual's decisions about their behaviour²⁹.

Increased reliance on the car over the last fifty years and the focus on the car in planning and transport practice over the past two generations has resulted in a suppression of walking and cycling across all sectors of society. Current data suggests that 64% of trips are made by car, 22% are made on foot and 2% of trips are made by bike⁶⁴. Living in rural areas also has an impact on the amount of walking, cycling and active travel undertaken. Narrow rural roads that often have no pavement or crossing facilities, the lack of lighting, fewer cycle facilities

to keep cyclists out of the flow of traffic, amenities, schools and workplaces being further distances from home than in urban areas, and national speed limits for cars on rural roads can all be contributing factors that increase the use of cars, reduce walking and the use of bikes for recreational or active travel options. This decline in active travel has mirrored the increase in the proportion of overweight, obese and inactive people in the population.

The Government's ambition is to make cycling and walking the norm for a short journey or as part of a longer journey⁶⁵. Promotion of 'active transport' (e.g. walking and cycling) is one way of increasing activity. But without complementary broader environmental changes to tackle the wider environment, including the distance to frequent destinations such as shops, workplaces and schools, along with the diversity of land uses in a neighbourhood (residential, commercial, industrial), changing individual behaviour is limiting.



High connectivity and land-use mix have been used to indicate the walkability of the environment. There is also evidence of a relationship between the perceived and actual safety, greenery, aesthetics and upkeep of neighbourhoods and physical activity⁶⁶. As well as the space between buildings, the design and layout of buildings themselves can support physical activity with, for example, prominent and appealing staircases rather than escalators or lifts.

Creating a more active society, in which it is easier and more natural for people to be active than inactive, will require action by a huge range of bodies over a significant period of time. This will mean offering people ways to be physically active that they enjoy, at times and places that suit them, and encouraging people to create opportunities to engage in activity for themselves. NICE guidance (PH41 and PH8) recommends multi-agency action to:

- ensure walking and cycling programmes form a core part of local transport investment planning
- support individuals to make personalised travel plans
- implement town-wide programmes to promote cycling for both transport and recreational purposes
- implement local walking and cycling programmes
- 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
- plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity
- ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity
- ensure public open spaces and public paths are maintained to a high standard and are safe, attractive and welcoming to everyone

- ensure school playgrounds are designed to encourage varied, physically active play.

Local action – North Yorkshire’s Local Transport Plan (LTP 4) (2016-2045)

The North Yorkshire Local Transport Plan prioritises healthier travel and promoting healthier travel opportunities, focusing on fully operational street lighting, maintaining and promoting public right of way, continuing to prioritise the maintenance of our existing infrastructure for walking and cycling (including footways, roads, and cycle tracks) over the provision of new facilities, and improving road safety.

<http://www.northyorks.gov.uk/article/30583/Local-transport-plan-four-LTP4>

Active play

Children seem to be born with an instinctive love of physical activity⁶⁷ but play, an important element of physical activity from early childhood, has become ever more restricted. At home, sedentary activities increasingly dominate while more formal play facilities tend to be at a distance from the home and often accessed by car. From across the developed world there is strong evidence that compared with previous generations, children spend less time playing outdoors and that they walk and cycle less⁶⁷.

Research suggests that over recent decades parents have increasingly tried to avoid risks to their children from outside the home by creating barriers to their children’s independent mobility⁶⁸. This ‘retreat from the street’ removes a crucial initial step for children’s active independence. Moreover, in this environment where perceived traffic danger is a major concern,



adults often want to segregate children from risk, to 'park them' in safe places and to set controls on where they can play or go and how they get there⁶⁹. Letting children roam or play outside unaccompanied is now sometimes judged as an indication of neglectful and irresponsible parenthood⁷⁰.

NICE guidance on 'Promoting physical activity and the environment' and 'Promoting physical activity for children and young people' highlights some key recommendations that can contribute to increases in active play:

- ensure open spaces and outdoor facilities encourage physical activity
- ensure public open spaces can be reached on foot [and] by bicycle
- identify transport policy which discourages children and young people from walking and cycling e.g. policies to keep traffic moving may make it difficult to cross the road. Consider how these policies can be improved to encourage active travel
- re-allocate road space to support physically active travel e.g. by widening pavements
- introduce traffic-calming schemes.

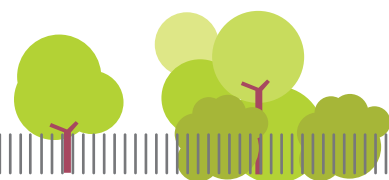
Local action – York and North Yorkshire's Safer Roads, Healthier Places Strategy (2016-2020)

York and North Yorkshire's Safer Roads, Healthier Places Strategy aims to strengthen the local partnership approach and brings together resources and expertise in order to achieve its ambition of meeting the long term road safety targets and improving the health and wellbeing of the population through the recognised co-benefits of road safety activity, such as increased physical activity.

Safer roads are an important part of a healthy environment and overall wellbeing. It is widely acknowledged that roads where people are safe and feel safe can encourage more active travel and active play, therefore road safety activity can have a direct

effect on increasing more active modes of transport and active play. The Strategy also recognises that well designed and maintained roads that are attractive, accessible and appropriate are also key in enabling people to make safer and healthier travel choices.

The Safer Roads, Healthier Places Strategy captures the coordinated actions that The York and North Yorkshire 95 Alive Road Safety Partnerships will deliver in order to support the development of safer road environments that enable people to walk, cycle and ride, and encourage sustainable modes of transport while protecting our local communities.



The food environment – increasing access to healthy and competitively priced food

Environmental influences on diet often involve physical ease of access to food and drink, for example, from supermarkets for home consumption, from takeaways and from restaurants. As eating habits become more unstructured, the availability of, and access to, ‘food on the go’ is an important consideration.

Community food provision

Neighbourhood food environments (‘foodscapes’) have been labelled ‘obesogenic’ when they facilitate the overconsumption of energy dense, nutrient poor foods, and increased levels of overweight and obesity⁷¹. Understanding the influence of such foodscapes on diet and health has become more urgent with recent changes in society. During the past decade in the United Kingdom, consumption of food away from the home has increased by 29%⁷², while the number of takeaway (or fast food) outlets has increased dramatically⁷³. Food eaten outside the home is more likely to be high in calories⁷⁴. Of particular concern are hot food takeaways, which tend to sell food that is high in fat and salt, and low in fibre, fruit and vegetables⁷⁵.

The density of outlets across England varies between 15 and 172 per 100,000 population²³.

The data shows a strong association between deprivation and the density of fast food outlets, with more deprived areas having a higher proportion of fast food outlets per head of population than others.

Foods consumed away from the home are typically less healthy than those consumed at home^{76 77}. Therefore, the environments around workplaces and commuting routes, for example, are important areas of study and potential targets for government policy intervention⁷³. Using local planning laws, policy initiatives have developed with the intention to limit neighbourhood access to sources of ‘unhealthy’ food. These restrictions have historically been based on concerns over noise, litter, and neighbourhood aesthetics, but more recently have come to acknowledge the potential adverse effects of these food outlets on diet and health^{78 79}.



Local action – 'Healthier Choices for a Healthier You' Business Award

North Yorkshire County Council's Trading Standards team have established a free to join certification scheme aimed at supporting and promoting businesses selling food and drink who provide 'healthier options' to their customers. The aim of the Scheme is to reduce the levels of saturated fat, sugar and salt in food provided by retailers, takeaways and manufacturers of food in North Yorkshire.



Sustainable food

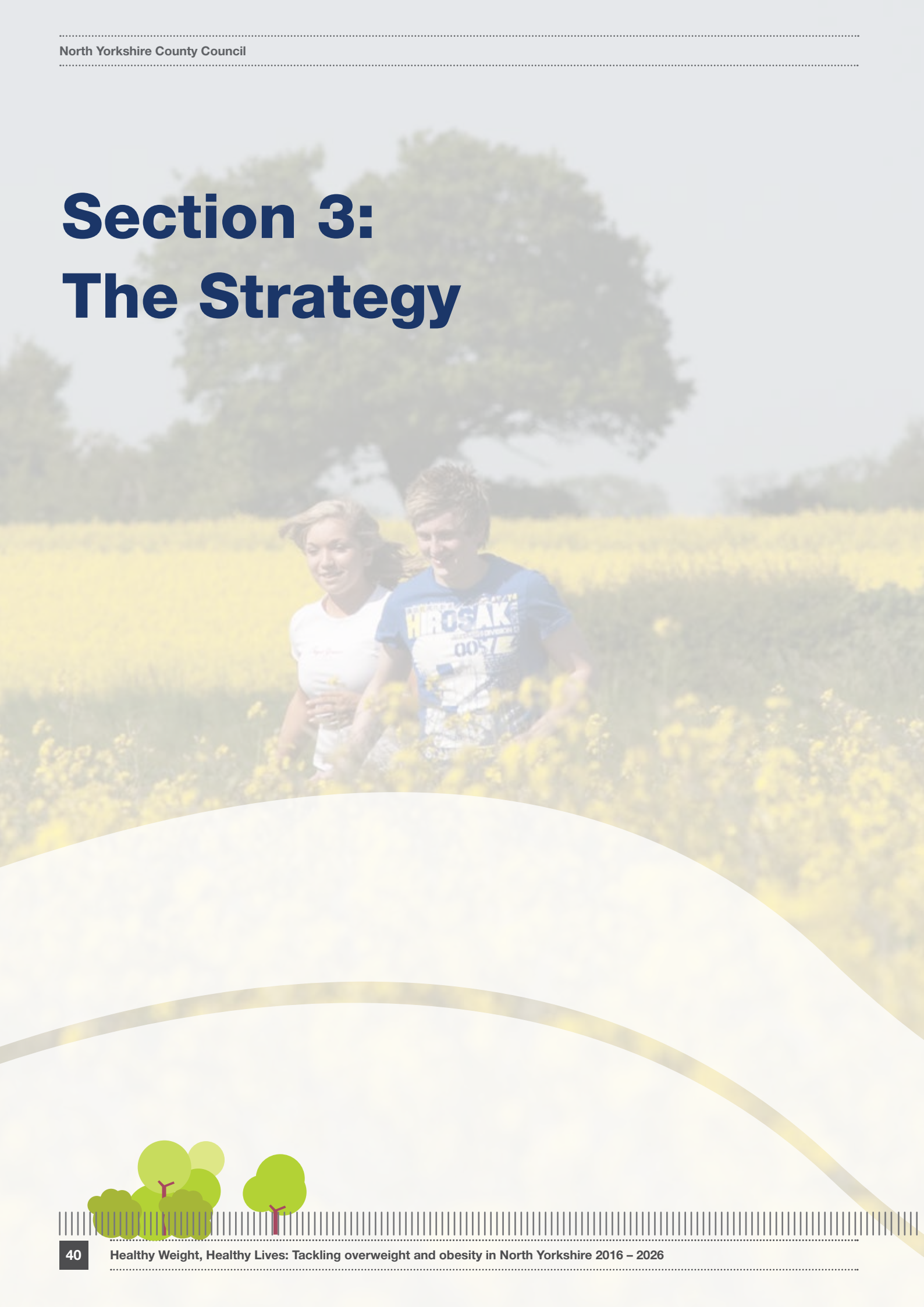
Sustainability is a very broad concept and is about direction of travel rather than reaching a specific destination⁸⁰. In developing sustainable food programmes, it is useful to think about food across six areas:

- Promoting healthy and sustainable food to the public
- Tackling food poverty, diet-related ill health and access to affordable healthy food
- Building community food knowledge, skills, resources and projects
- Promoting a vibrant and diverse sustainable food economy
- Transforming catering and food procurement
- Reducing waste and the ecological footprint of the food system

These six 'key issues' have been used to structure the Sustainable Food Cities Award. There is opportunity to work with local businesses and key stakeholders to develop a North Yorkshire food partnership and join the Sustainable Food City Network to further develop local action on the six key issues relation to sustainable food.



Section 3: The Strategy



The vision

The vision of North Yorkshire's 'Healthy Weight, Healthy Lives: Tackling overweight and obesity in North Yorkshire' Strategy is

'To inspire a healthy weight population'

The ambition

By 2026 we aim to have:

- Reduced the prevalence of overweight and obesity across the population.

The priorities

Six key priorities have been identified to tackle overweight and obesity in North Yorkshire, which include:

- Supporting children's healthy growth and healthy weight
- Promoting healthier food choices
- Building physical activity into our daily lives
- Providing the right personalised, accessible weight management services
- Ensuring people have access to the right information and resources to make healthy choices that support weight loss
- Building healthier workplaces that support employees to manage their weight

The action

Within each priority are a number of proposed areas for action, which will require a cohesive response from key stakeholders and community groups.



Priority

Supporting children's healthy growth and healthy weight



Proposed action

Breastfeeding

Support local organisations, including health care providers, to implement the UNICEF Baby Friendly Initiative standards and achieve Baby Friendly accreditation.

Support all health care professionals, families and carers to confidently and sensitively encourage breast feeding initiation and maintenance.

Food provision in schools and child care settings

Influence food contracts such as catering in schools to ensure they are compliant with relevant nutritional frameworks.

Continue to improve the standard of school meals through the effective implementation of the School Food Plan, particularly in academies where the school food standards are not mandatory.

Develop existing and planned programmes and projects that increase nutritional literacy for pre-school and school aged children.

Work with local child care providers, children's centres and parents to increase the number of child care organisations that serve healthy food, snacks and beverages through implementation of Children's Food Trust revised menu suggestions.

Work with schools and child care organisations to increase access to tap water, replacing drinks high in sugar content i.e. fizzy drinks, fruit juices, squash in schools, children centres and child care settings.

Encourage primary schools to sign up to the Department of Health voluntary healthy rating scheme.

Work with schools, children and parents to increase the uptake of school meals, particularly in the transition from primary to secondary education.

Work with schools, children and parents to design and implement interventions that encourage children at secondary schools to stay in school for lunch.

Encourage and support local Healthy Schools Programmes using Healthy Schools resources and toolkits. (These toolkits are still available although the programme ended in 2011).

Encourage participation in the Eat Better, Do Better programme.

Access to sweets and other high calorie foods outside of the school or child care setting

Restrict planning permission for takeaways and other food retail outlets in specific areas i.e. walking distance from schools.

Restrict trading from fast food vans near schools.

Establish and regulate the boundaries of fast food exclusion zones near schools i.e. 400-800m radius.

Improve the quality of the food environment around schools including takeaways, fast food vans, access to sweets and other high calorie foods in shops near schools.

Ensure children and young people, and their parents or carers, using vending machines in local authority and NHS venues can buy healthy food and drink options.

Ensure children and young people, and their parents or carers, see details of nutritional information on menus at local authority and NHS venues.

Children and young people, and their parents or carers, see healthy food and drink choices displayed prominently in local authority and NHS venues.

Food poverty

Promote Healthy Start vitamins and encourage target groups to take up the offer.

Work with schools, children and families to increase the uptake of free school meals; de-stigmatising the initiative and ensuring the application process is quick and easy.

Weight measurement

Ensure a proactive approach to the National Child Measurement Programme (NCMP) so that parents are supported and know where to get advice and support if their child is overweight or obese.

Growing up in North Yorkshire

Utilise data from the Growing up in North Yorkshire survey to support key stakeholders including schools to address the health and wellbeing needs of their pupils and to measure progress against key indicators.

Physical activity

Work with North Yorkshire Sport to support the effective use of the PE and Sport Premium for Primary schools, in particular the strands around using the premium to support Whole School Improvement and increasing pupil engagement in physical activity.

Work with North Yorkshire Sport to specifically target inactive pupils through delivery of Change4Life clubs in schools and Change4Life festivals.

Work with primary schools to support all children to complete the 'Daily Mile'.

Work with primary schools to implement the Fit for Sport 'Activity Challenge' to test and improve on levels of fitness each term.

Priority

Promoting healthier food choices



Proposed action

Sustainable food

Increase markets for local food producers.

Increase access to food growing opportunities.

Promote community food growing through the 'Growing Health' initiative.

Promote the use of local sustainable food.

Support local businesses to reduce food surplus, loss and waste.

Develop a cross-sector food partnership which works to create a better food system.

North Yorkshire food partnership [once established] to join the Sustainable Food City Network to share successes and challenges and learn from other areas.

Ensure planning policies support local food growing by:

Providing space for growing food within new developments.

Including edible plants and trees in planting schemes in new developments.

Encouraging local groups starting a community food growing space.

Protecting open space under threat from a proposed development.

Using land for food growing on a temporary basis e.g. pending its redevelopment.

Support jobs in the food and farming sector by encouraging small and medium-sized food enterprises (SMEs), such as markets and on-site farm shops, and local and regional distribution infrastructure.

Community food provision

Reduce the proximity of fast food outlets to schools, colleges and leisure centres.

Use regulatory and planning measures to address the increase of hot food takeaways.

Ensure children and young people, and their parents or carers, see details of nutritional information on menus at local authority and NHS venues.

Increase the level of support to local businesses to reduce the levels of fats, sugars and salts in foods sold on their premises i.e. take-away and cafes.

Explore the possibility of reducing access to unhealthy food options via food licencing and planning.

Ensure that health and wellbeing is considered in planning for new development in North Yorkshire.

Ensure all local authority planning decisions are subject to a health impact assessment.

Children and young people, and their parents or carers, see healthy food and drink choices displayed prominently in local authority and NHS venues.

Work with the local the food industry to resize portions and reformulate products (e.g. through the Responsibility Deal).

Encourage manufacturers, retailers, the out of home dining/catering sector and bars and pubs to register as Responsibility Deal partners and commit to delivering on actions relating to the alcohol, physical activity, food and health at work pledges.

Food poverty

Increase access to healthier foods in deprived areas.

Promote local fruit and vegetable schemes and support target groups to access these.

Develop a County-wide food poverty plan.

Priority

Building physical activity into our daily lives

Proposed action

Walking, cycling and active travel

Ensure a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity that is safe and attractive and accessible from the workplace, home, school and other public facilities.

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.

Ensure public open spaces and public paths are maintained to a high standard. They should be safe, attractive and welcoming to everyone.

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.

Those involved with campus sites, including hospitals and universities, should ensure different parts of the site are linked by appropriate walking and cycling routes.

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).

Work with local communities and highways to reduce residents' car use and switch to more active methods of travel.

Support schools to implement and review school travel plans to promote safe, sustainable and less car dependent patterns of travel.

Identify a senior member of the public health team who is responsible for promoting walking and cycling to support coordinated, cross-sector working, for example, by ensuring programmes offered by different sectors complement rather than duplicate each other.

Ensure walking and cycling programmes form a core part of local transport investment planning, on a continuing basis.

Provide appropriate and timely support for those interested in changing their travel behaviour to make small, daily changes by commissioning personalised travel planning programmes.

Provide training for those who are interested in cycling, either as a form of transport or as a recreational activity i.e. Bikeability.

Promote inter-generation activity to increase interaction between children and young people and older people.

Community safety

Support community safety and enforcement activities which will help create an environment in which people feel safe, are able to get out and be active.

Active play and planned physical activity

Provide and promote family friendly environments that enable opportunities for active play and planned physical activity.

Ensure school playgrounds and early years settings' outdoor areas are designed to encourage varied, physically active play.

Increase access to school facilities available to children and young people before, during and after the school day, at weekends and during school holidays.

Increase access to school facilities for the public, voluntary, community and private sector groups and organisations offering physical activity programmes and opportunities for physically active play.

North Yorkshire Sport to work with National Governing Bodies, clubs and physical activity settings to broaden their offer, to make them more appealing to inactive groups.

North Yorkshire Sport to produce and deliver (with partners) an Outdoor Sports and Physical Activity Strategy specifically designed to increase the number of people active in the natural environment.

North Yorkshire Sport to target sport and physical activity programmes and funding to inactive groups.

To support key campaigns designed to reduce inactivity, namely 'This Girl Can' and Change4Life.

Priority

**Providing the right
personalised,
accessible weight
management services**

Proposed action

Assessment, brief advice and tailored support

Work with primary health care professionals to increase the number of adults identified as not currently meeting UK physical activity guidelines.

Ensure commissioned services that prevent or treat conditions such as cardiovascular disease, type 2 diabetes and stroke or improve mental health incorporate brief advice on physical activity into their care pathway.

Ensure brief advice on physical activity is incorporated into services for groups that are particularly likely to be inactive. This includes people aged 65 years and over, people with a disability and people from certain minority ethnic groups.

Ensure individual support is available for anyone who is walking on their own, walking informally with others in a group, or participating in local walking programmes. This includes helping to assess their activity levels and to set goals which build on this.

Children and young people identified as being overweight or obese, and their parents or carers are given information about local lifestyle weight management programmes.

Parents or carers of children are given advice about physical activity as part of the National Child Measurement Programme (NCMP).

Ensure additional, one-to-one support is offered at regular intervals to help people develop a long-term walking habit.

Ensure consistency in the provision of tailored brief advice to all adults assessed as inactive.

All adults having their NHS Health Check are given brief advice about how to be more physically active.

Parents or carers of children are given advice about physical activity during their child's Healthy Child Programme two year review.

All local authority leisure and community services offer women with babies and children the opportunity to take part in a range of physical or recreational activities.

Service design and pathways

All services that have the primary outcome of weight loss and maintenance are family focussed and evidence based.

Family members of, or carers of, children and young people who are overweight or obese are invited to attend lifestyle weight management programmes, regardless of their weight.

Ensure services meet the needs of rural and most at risk community groups.

Walking and cycling are included in chronic disease pathways.

Assessment of physical activity, the delivery and follow up of brief advice are built into local long-term disease management strategies.

All health care professionals implement protocols for mothers' 'antenatal weight gain' or 'postnatal weight management' according to current guidance.

Through Healthwatch, ensure service providers and commissioners maximise the opportunity to improve services through service user feedback.

Broaden the scope of social prescribing to include physical activity such as gardening.

Competencies and skills

The early years workforce are equipped to deliver evidence based healthy weight support to families.

All primary care practitioners* who have a remit for weight management receive up to date information and training on physical activity and nutrition.

All primary care practitioners are able to effectively refer and signpost into evidence-based services and programmes that support prevention and management of excess weight.

Ensure all primary care practitioners have the skills to motivate people to positively change lifestyle behaviour.

Ensure all practitioners providing information or advice to children and adults in primary care, community based settings, early years settings, schools and workplaces provide physical activity and nutritional information in line with current advice and guidance.

Ensure health professionals, healthcare assistants and support workers have the skills to advise on the health benefits of weight management and risks of being overweight or obese before, during and after pregnancy, or after successive pregnancies.

Increase the number of primary care professionals trained to implement the Making Every Contact Count concept.

* Examples include: exercise professionals, GPs, health trainers, health visitors, mental health professionals, midwives, pharmacists, physiotherapists and practice nurses.

Priority

Ensuring people have access to the right information and resources to make healthy choices that support weight loss

Proposed action

Services and community programmes

Children and young people, and their parents or carers, have access to a publicly available up to date list of local lifestyle weight management programmes across the weight management pathway (tiers 1-4).

Health and social care practitioners have access to up to date information on local lifestyle weight management programmes across the weight management pathway (tiers 1-4).

Better connect people with community programmes in their locality i.e. through the Stronger Communities Programme.

Increase the mobilisation of communities living in rural areas and in isolation i.e. through community transport initiatives and library services.

Health education and skills

Maximise the opportunity for residents to have access to an expanding set of accredited health apps and digital information services to self manage their physical activity levels and nutrition.

Develop a cross-sectional health education approach to increasing community health literacy and skills to make practical change for individuals and families i.e. healthy cooking interventions.

Ensure all members of the health, care and social care workforce have the knowledge and skills to embrace the opportunities of evidence-based and approved lifestyle information.

Maximising the use of social media to share evidence based and approved information.

Campaigns

Develop a cross-sector approach to local promotion of campaigns such as Change4Life and One You campaigns.

Priority

Building healthier workplaces that support employees to manage their weight



Proposed action

Policy and intervention

Local employers and public sector organisations to receive a co-ordinated, consistent level of support for the development of workplace health policy, infrastructure and planned interventions.

Support local employers to develop and implement travel plans that encourage employees to walk, cycle or use another mode of transport involving physical activity to travel part or all of the way to and from work.

Key stakeholders signed up to the Strategy to lead by example in the provision of healthier and more sustainable catering for the workforce and for events.

Support local organisations to meet Government buying standards for food and catering services.

Encourage organisations to become a Public Health Responsibility Deal partner and commit to delivering on specific actions related to the health at work pledge.

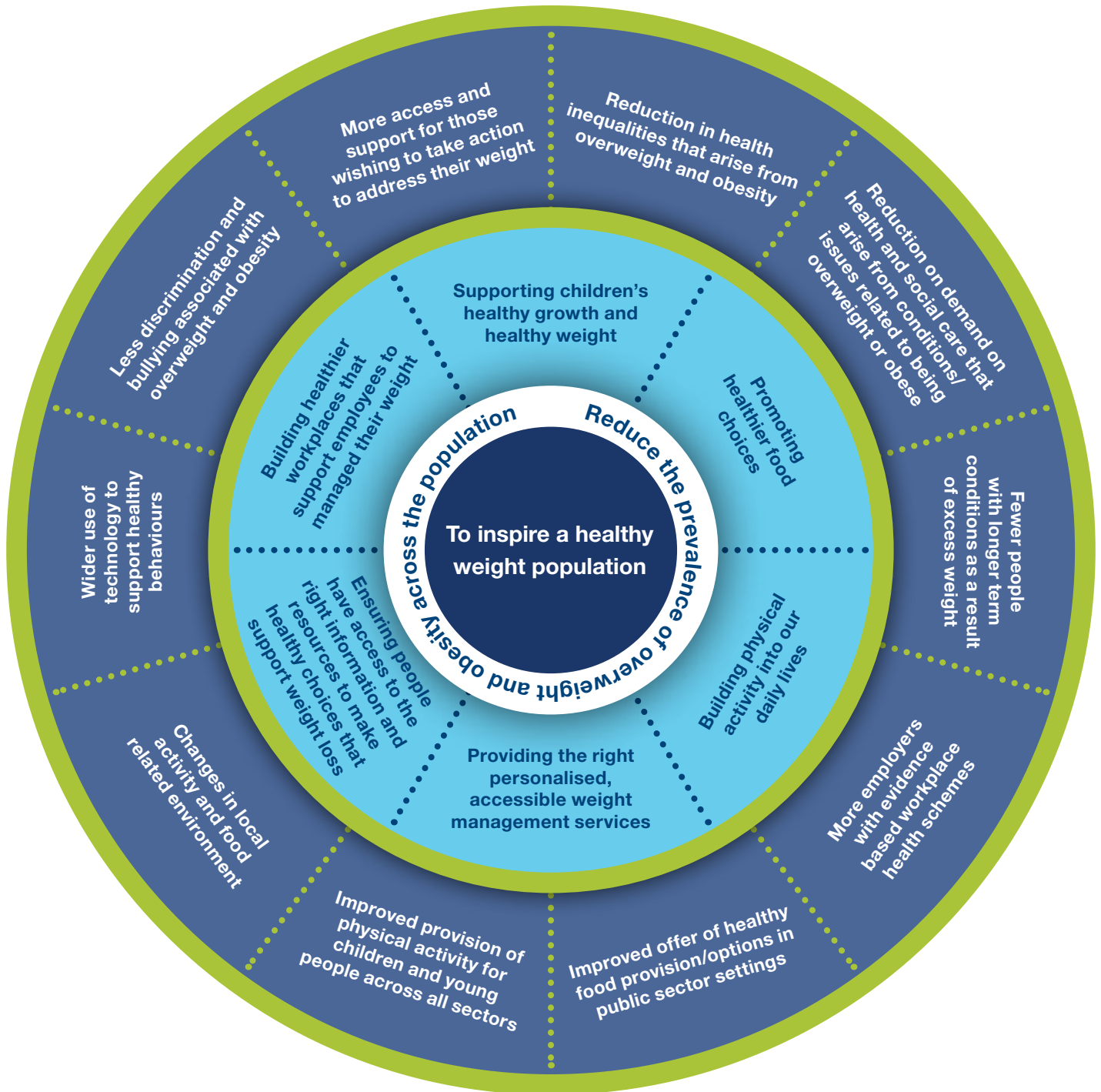
Increase the number of local employers and public sector organisation achieving the Workplace Wellbeing Charter accreditation, key stakeholder organisations who are signed up to the Strategy to lead as role models.

The outcomes

The outcomes that are to be achieved over the lifetime of the Strategy are:

- Reduction in health inequalities that arise from overweight and obesity.
- Reduction on demand on health and social care that arise from conditions/issues related to being overweight or obese.
- Fewer people with longer term conditions as a result of excess weight.
- More employers with evidence based workplace health schemes.
- Improved offer of healthy food provision/options in public sector settings.
- Improved provision of physical activity for children and young people across all sectors.
- Changes in the local activity and food related environment such as changes in transport infrastructure or town planning which address the obesogenic environment.
- Wider use of technology to support healthy behaviours.
- Less discrimination and bullying associated with overweight and obesity.
- More access and support for those wishing to take action to address their weight.

Figure 7 summarises the vision, ambition, priorities and outcomes of the Strategy



Section 4:

Implementation and evaluation



In order to effectively implement and evaluate the Strategy, some core principles are proposed.

Sharing the responsibility

There is an increasing emphasis on the need for local government, primary care, other NHS organisations, voluntary and community organisations, and other public sector organisations to work together to develop a shared vision for health and wellbeing for their local communities. This Strategy requires a truly joined up approach to tackling obesity and increasing physical activity across the life course and for target populations most at risk. A clear and sustainable governance structure is required to ensure key stakeholders and communities agree and achieve action against the priorities set out in this Strategy.

Sign up to the priorities and outcomes within this Strategy from key partners and community groups is essential to its success.

Universal and targeted action

The approach for the prevention and management of obesity should be modelled on tackling this issue across the life course, targeting groups where there are periods of metabolic change, which are linked to spontaneous changes in behaviour, or periods of significant shifts in attitude.

There is also a need to take a universal and targeted approach ensuring that actions taken are universally proportionate. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. 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. This is called proportionate universalism.

- Universal interventions, e.g. physical activity and green spaces, food access and choice, social norms, built environment and infrastructure, active transport, workplace approaches, school approaches, economic development

- Targeted interventions, e.g. lifestyle interventions, cooking skills, I want to get active etc.
- Specialist interventions, e.g. specialist weight management services.

Population groups who are more at risk of developing obesity require a more targeted approach.

Improving the way we work

To ensure the focus of any weight management or physical activity service or intervention delivered in North Yorkshire is on outcomes, and that services and interventions have a clear framework for planning and managing performance, the Strategy recognises the need for local partners to adopt The Mark Friedman Outcomes Based Accountability (OBA) approach.

Key features of OBA include:

- population accountability, which is about improving outcomes for a particular population within a defined geographical area
- performance accountability, which is about the performance of a service and improving outcomes for a defined group of service users.

Using OBA allows us to distinguish between ‘How much did we do?’, ‘How well did we do it?’ and, the most important category, ‘Is anyone better off?’. The Strategy needs to adopt an OBA approach to maximise outcome and quality of intervention across North Yorkshire.

Connecting people

Recent engagement activity with key stakeholders confirmed the significant amount of organisations that have a direct or indirect role in tackling overweight and obesity in North Yorkshire. Key partners such as sport, leisure and physical activity providers, planners, health care providers and commissioners, weight management providers, third sector and those in research all need to be connected. This is important to achieve the following:



- better understanding of available services for more effective signposting and referral
- more connected care pathways
- shared learning for effective planning, commissioning and delivery of services
- shared intelligence on population need.

Taking a place-based approach that utilises existing assets

The conditions in which people grow, live, work and age have a powerful impact on our health. Strong communities with high levels of resilience thrive. Those who live in strong communities where resilience is high and people have good social networks live longer and healthier lives. Recognising and understanding the enormous impact communities have on health and wellbeing is the first step to take in transforming the way overweight and obesity is tackled in North Yorkshire. Shifting the focus from the more traditional or medical approach to health improvement, to recognising and embracing the social determinants of health, is crucial in improving the health of the County.

That is why this Strategy will take a place based approach that utilises existing assets. Strategic partners will start by looking at what individuals and communities have and can offer, whether this be skills, capacity, knowledge or resources that can be used to improve the health of the community. Currently, need is often used as the criteria for developing services. As a result there is always a focus on deficits rather than assets. This drives dependency rather than solutions. As a result, need grows and people and communities are less empowered to support themselves and one another in the community. All communities have assets; finding, understanding and developing them will build resilience of communities.

Working with our community

Since ‘Community engagement: approaches to improve health’, NICE guideline PH9 (2008), was published there has been a substantial increase in the evidence on how community engagement can improve health and wellbeing.

The Marmot Review notes the importance of involving local communities, particularly disadvantaged groups, as being central to local and national strategies in England for promoting health and wellbeing and reducing health inequalities. Statutory and voluntary sector organisations cannot improve people’s health and wellbeing on their own. Working with local communities will lead to services that better meet people’s needs, improve health and wellbeing and reduce health inequalities.

Key principles to a community engagement approach that the Strategy will adopt include:

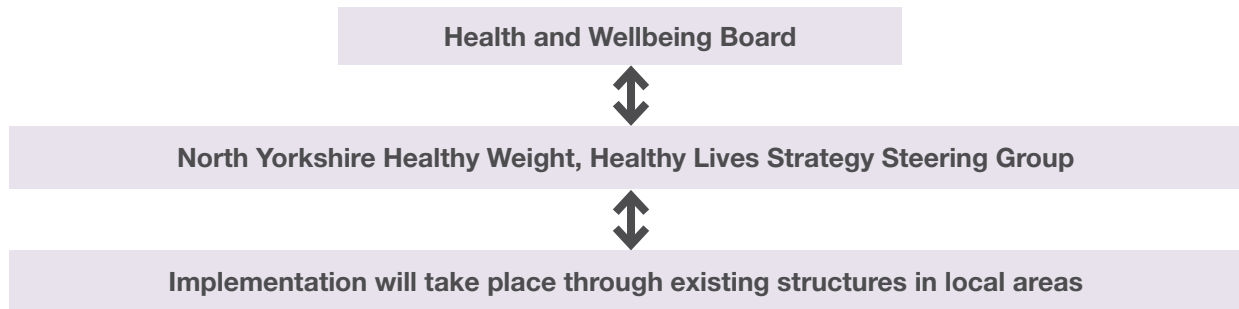
- ensuring local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate weight management and physical activity interventions
- recognising that building relationships, trust, commitment, leadership and capacity across local communities and statutory organisations needs time
- supporting and promoting sustainable community engagement by encouraging local communities to get involved in all stages of weight management and physical activity initiatives.

Clear governance

It is proposed that a place based approach will be applied with each district having its own action plan to address the Strategy’s six priorities. Expert groups will be established to provide specialist support to the working groups on priority areas. The proposed governance structure is illustrated in Figure 8.



Figure 8 – Proposed governance structure



Measuring the impact

The suggested Public Health Outcome Framework indicators that will be used to measure impact of the Strategy are included in Figure 9. Current trends are illustrated which will be reviewed annually through the governance arrangements proposed. It is also important that obesity interventions are evaluated.

Work is currently being undertaken to compare local performance of these indicators against national baseline rates. Based on this analysis of current local performance, targets for each indicator will be set for the lifecycle of the Strategy. These targets will need to be agreed by members of the Strategy steering group and then reviewed and reported on annually.

Figure 9 – Public Health Outcome Framework indicators

Better ■ Similar ■ Worse ■

Healthy Weight and Healthy Lives - 2016									North Yorkshire Districts						
England & North Yorkshire									Craven	Hambleton	Harrogate	Richmondshire	Ryedale	Scarborough	Selby
	Recent Year	Gender	Age group	North Yorkshire		Unit	Trend	England							
1.096i - Sickness absence - the percent of working days lost due to sickness absence	2011 - 13	Persons	16+ yrs	1.3	↑	%		1.5	1.6	3.0	1.0	1.0	n/a	0.7	1.3
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2014 Feb 2015	Persons	16+ yrs	20.6	↓	%		17.9	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2.02i - Breastfeeding - breastfeeding initiation	2014/15	Female	All ages	73.8	↔	%		74.3	82.4	73.5	81.9	n/a	n/a	n/a	n/a
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth	2014/15	Persons	6-8 weeks	n/a	n/a	%		43.8	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2014/15	Persons	4-5 yrs	21.1	↔	%		21.9	18.9	21.6	20.5	25.6	18.1	23.1	19.8
2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2014/15	Persons	10-11 yrs	30.1	↔	%		33.2	26.4	34.5	28.6	34.8	32.3	28.5	31.4
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	2015	Persons	16+ yrs	57.9	↓	%		52.3	60.5	56.2	59.3	47.8	64.6	60.1	54.7
2.11ii - Average number of portions of fruit consumed daily (adults)	2015	Persons	16+ yrs	2.7	↔	N/A		2.5	2.5	2.8	2.9	2.4	2.9	2.6	2.5
2.11iii - Average number of portions of vegetables consumed daily (adults)	2015	Persons	16+ yrs	2.5	↔	N/A		2.3	2.7	2.4	2.6	2.2	2.5	2.6	2.4
2.11iv - Proportion of the population meeting the recommended '5-a-day' at age 15	2014/15	Persons	15	54.5	n/a	%		52.4	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2.12 - Excess weight in Adults	2012 - 14	Persons	16+ yrs	66.7	n/a	%		64.6	65.5	66.7	64.9	62.5	68.8	65.5	69.9
2.13i - Percentage of physically active and inactive adults - active adults	2015	Persons	16+ yrs	58.9	↔	%		57.0	58.8	58.6	56.8	59.7	61.4	59.4	60.1
2.13ii - Percentage of physically active and inactive adults - inactive adults	2015	Persons	16+ yrs	26.6	↔	%		28.7	26.2	28.2	25.5	26.6	26.6	29.7	23.1
2.23i - Self-reported wellbeing - people with a low satisfaction score	2014/15	Persons	16+ yrs	4.7	↔	%		4.8	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Section 5: Feedback

For an alternative version of this Strategy or feedback please email:

healthyweighthealthylikes@northyorks.gov.uk



Section 6: Appendices

Appendix 1 – child centile charts

When measuring an individual child (for example in clinic or feeding back National Child Measurement Programme results to parents) weight status is defined using the UK90 clinical cut points which are as follows:

BMI centile range:	
Underweight	2nd BMI centile or lower
Healthy weight	Above the 2nd to the 91st BMI centile
Overweight	Above the 91st to the 98th BMI centile
Very overweight (clinically obese)	Above the 98th BMI centile

Appendix 2 – list of associated NICE guidance

Cardiovascular disease prevention (PH25) June 2010

Community Engagement: approaches to improve health PH9 (2008)

Maternal and child nutrition (PH11) March 2008

Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition (CG32) February 2006

Obesity prevention (CG43) December 2006

Obesity: identification, assessment and management (CG189) November 2014

Preventing excess weight gain (NG7) March 2015

Weight management before, during and after pregnancy (PH27) July 2010

Weight management: lifestyle services for overweight or obese adults (PH53) May 2014

Weight management: lifestyle services for overweight or obese children and young people (PH47) October 2013

Behaviour change: general approaches (PH6) October 2007

Behaviour change: individual approaches (PH49) January 2014

Physical activity and the environment (PH8) January 2008

Physical activity for children and young people (PH17) January 2009

Physical activity in the workplace (PH13) May 2008

Physical activity: brief advice for adults in primary care (PH44) May 2013

Physical activity: exercise referral schemes (PH54) September 2014

Physical activity: walking and cycling (PH41) November 2012



Section 7: Glossary

BMI	Body Mass Index
CMACE	Centre for Maternal and Child Enquiries
Excess weight	Body mass index of 25 or above
FFL	Food for Life
GUNY	Growing up in North Yorkshire
kcal	Kilo calorie
kJ	Kilo joule
JSNA	Joint Strategic Needs Assessment
LTP	Local Transport Plan
NCMP	National Child Measurement Programme
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OBA	Outcomes Based Accountability
Obese	Body mass index of 30 or above
Overweight	Body mass index of 25-29.9
PHE	Public Health England



Section 8: References

- ¹ Foresight Tackling Obesity: Future Choices Project Report (2007)
- ² National Institute for Health and Care Excellence (2015) Preventing Excess Weight Gain (NG7)
- ³ National Child Measurement Programme 2013/14
- ⁴ Fair Society, Healthy Lives (Marmot Review), 2010 <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>
- ⁵ Department of Health Public Health Research Consortium, Law, C., Power, C., Graham, H. and Merrick, D. (2007), Obesity and health inequalities. *Obesity Reviews*, 8: 19–22
- ⁶ Han, T S, Tajar, A. and Leon, M E J (2001) Obesity and Weight Management in the Elderly. *British Medical Bulletin*, vol 97, Issue 1, pages 169-196
- ⁷ Public Health England, 2016 <http://www.noo.org.uk>
- ⁸ Health Survey for England (2006-2020)
- ⁹ Shiri R, Karppinen J, Leino-Arjas P, Solovieva S, Viikari-Juntura E. The association between obesity and low back pain: a meta-analysis. *Am J Epidemiol*. 2010 Jan 15;171(2):135–54.
- ¹⁰ Alley DE, Chang VW. The changing relationship of obesity and disability, 1988-2004. *JAMA*. [Research Support, N.I.H., Extramural Research Support, Non-U.S. Gov't]. 2007 Nov 7;298(17):2020–7
- ¹¹ Kyrou I, Osei-Assibey G, Williams N, Thomas R, Halder L, Taheri S, et al. Self-reported disability in adults with severe obesity. *Journal of obesity*. 2011; 2011:918402
- ¹² Liou TH, Pi-Sunyer FX, Laferrere B. Physical disability and obesity. *Nutr Rev*. 2005;63(10):321–31
- ¹³ Doody CM, Doody O. Health promotion for people with intellectual disability and obesity. *Br J Nurs*. 2012;21(8):460, 2–5
- ¹⁴ Emerson E, Baines S, Allerton L, Welch V. Health Inequalities and People with Learning Disabilities in the UK: 2012: Learning Disabilities Observatory
- ¹⁵ Samele C, Seymour L, Morris B, Cohen A, Emerson E. (2006) A Formal Investigation into health inequalities experienced by people with learning disabilities and people with mental health problems - Area Studies Report. Report to the Disability Rights Commission (DRC): The Sainsbury Centre for Mental Health.
- ¹⁶ Haveman M, Heller T, Lee L, Maaskant M, Shooshtari S, Strydom A.(2010) Major Health Risks in Aging Persons With Intellectual Disabilities: An Overview of Recent Studies. *Journal of Policy and Practice in Intellectual Disabilities*. 7(1):59–69.
- ¹⁷ Bloom, S (2007) Hormonal Regulation of Appetite. *Short Science Review*



- ¹⁸ Rolls, E.T. (2007) Undersanitng the Mechanisms of Food Intake and Obesity. Short Science Review
- ¹⁹ Wardle, J (20017) Eating Behaviour and Obseity. Short Science Review
- ²⁰ Fox, K. R. & Hilsdon, M (2007) Physical Activity and Obesity. A Short Science Review
- ²¹ Wijga A, Scholtens S, Bemelmans W, de Jongste J, Kerkhof M, Schipper M, et al. (2010) Comorbidities of obesity in school children: a cross-sectional study in the PIAMA birth cohort. BMC Public Health 10(1):184
- ²² Department of Health (2011). Healthy Lives, Healthy People: A call to action on obesity in England
- ²³ PHE (2014) Adult obesity and type 2 diabetes https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338934/Adult_obesity_and_type_2_diabetes_.pdf
- ²⁴ Ali S, Stone MA, Peters JL, et al. The prevalence of co-morbid depression in adults with Type 2 diabetes: a systematic review and meta-analysis. Diabet Med 2006;23(11):1165-73
- ²⁵ Roy T, Lloyd CE. Epidemiology of depression and diabetes: a systematic review. J Affect Disord 2012;142 Suppl:S8-21
- ²⁶ Diabetes UK. Diabetes in the UK (2012) Key statistics on diabetes
- ²⁷ Haines L, Wan KC, Lynn R, Barrett TG, Shield JPH. Rising incidence of type 2 diabetes in children in the U.K. Diabetes Care 2007;30(5):1097-101
- ²⁸ Mental Health and chronic physical illnesses: The need for continued and integrated care. World Federation for Mental Health, 2010.
- ²⁹ National Obesity Observatory (2011) Obesity and mental health http://www.noo.org.uk/uploads/doc/vid_10266_Obesity%20and%20mental%20health_FINAL_070311_MG.pdf
- ³⁰ Cornette R. The emotional impact of obesity on children. Worldviews on Evidence- Based Nursing 2008;5(3):136-41
- ³¹ Hill AJ. Fed up and friendless? The psychologist 2005;18(5):280-83
- ³² Griffiths LJ, Parsons TJ, Hill AJ. Self-esteem and quality of life in obese children and adolescents: a systematic review. Int J Pediatr Obes. 2010;5(4):282-304
- ³³ Sjoberg RL. Obesity, Shame, and Depression in School-Aged Children: A Population-Based Study. Pediatrics 2005;116(3):e389-e92
- ³⁴ Luppino FS, de Wit LM, Bouvy PF, Stijnen T, Cuijpers P, Penninx BWJH, et al. Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. Archives of General Psychiatry 2010;67(3):220-9

- ³⁵ National Obesity Observatory (2010) Briefing note: Obesity and life expectancy http://www.noo.org.uk/uploads/doc/vid_7199_Obesity_and_life_expectancy.pdf
- ³⁶ Kings fund (2012) Transforming the delivery of health and social care
- ³⁷ Gatineau M, Dent M (2011) Obesity and Mental Health. Oxford: National Obesity Observatory
- ³⁸ Marchesini G, Moscatiello S, Domizio SD, Forlani G (2008) Obesity Associated Liver Disease. *Journal of Clinical Endocrinology Metabolism*. 93:74-80
- ³⁹ National Audit Office. Tackling Obesity in England. London: The Stationery Office, 2001
- ⁴⁰ Butland B, Jebb S, Kopelman P, et al. Tackling obesities: future choices – project report (2nd Ed). London: Foresight Programme of the Government Office for Science, 2007
- ⁴¹ NICE (2014) Press release archive <https://www.nice.org.uk/news/press-and-media/adults-who-are-obese-can-improve-their-health-by-losing-even-a-small-amount-of-weight>
- ⁴² Mario, G., Manstead, A., Verplanken, B et al (2001&. Lifestyle change. Evidence Review
- ⁴³ PHE (2015) Sugar reduction: the evidence for action https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/470179/Sugar_reduction_The_evidence_for_action.pdf
- ⁴⁴ Diabetes UK (2016) https://www.diabetes.org.uk/About_us/News/New-Eatwell-Guide-from-Public-Health-England/
- ⁴⁵ British Nutrition Foundation (2016) <https://www.nutrition.org.uk/healthyliving/basics/fats.html>
- ⁴⁶ National Obesity Observatory (2012) Obesity and alcohol: an overview http://www.noo.org.uk/uploads/doc/vid_14627_Obesity_and_alcohol.pdf
- ⁴⁷ Bates B, Alison Lennox A, G S. National diet and nutrition survey: headline results from year 1 of the rolling programme (2008/2009). London: Food Standards Agency, 2009
- ⁴⁸ Alcohol and calories. Cardiff: Alcohol Concern Cymru, 2010
- ⁴⁹ Dennis EA, Flack KD, Davy BM. Beverage consumption and adult weight management: A review. *Eating Behaviors* 2009;10(4):237–46
- ⁵⁰ Institute of Alcohol Studies, IAS Factsheet: Alcohol consumption in the UK, 2010
- ⁵¹ Active People’s Survey (2013-2014) <https://www.sportengland.org/research/about-our-research/what-is-the-active-people-survey/>
- ⁵² Public Health England (2014) Everybody active, every day: an evidence-based approach to physical activity https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf



⁵³ NICE (2014) Press release archive <https://www.nice.org.uk/news/press-and-media/adults-who-are-obese-can-improve-their-health-by-losing-even-a-small-amount-of-weight>

⁵⁴ Cole TJ, Freeman JV, Preece MA. Body mass index reference curves for the UK, 1990. Archives of Disease in Childhood. 1995;73(1):25-9

⁵⁵ Weight management: lifestyle services for overweight or obese adults. www.nice.org.uk/guidance/ph53 National Institute for Health and Care Excellence, 2014.

⁵⁶ Weight management: lifestyle services for overweight or obese children and young people <https://www.nice.org.uk/guidance/ph47> National Institute for Health and Care Excellence, 2013

⁵⁷ Report of the working group into joined up clinical pathways for obesity. <https://www.england.nhs.uk/wp-content/uploads/2014/03/owg-join-clinc-path.pdf> NHS England, 2013

⁵⁸ Jones et al (2007). Obesogenic environments: Evidence review

⁵⁹ Vandenboeck et al. (2007) Building the obesity system map

⁶⁰ Vandenbrook et al. (2007) Obesity systems atlas

⁶¹ Public Health England (2016) <https://www.noo.org.uk/LA/tackling/workplaces>

⁶² National Institute for Health and Care Excellence (2015) NICE guidelines [NG13] Workplace health: management practices

⁶³ Department of Health (2016) Childhood Obesity: A Plan for Action

⁶⁴ Department for Transport (2013) National Travel Survey

⁶⁵ Department of Transport (2016) Cycling and Walking Investment Strategy

⁶⁶ Fox, K. R. and Hillsdon, M (2007) Physical Activity and Obesity. Short Science Review

⁶⁷ Sustrans (2009) Active Play and Travel information sheet <http://www.playscotland.org/wp-content/uploads/assets/Activeplayandtravel.pdf>



- ⁶⁸ Jones et al (2000) Young people, transport and risk: comparing access and independent mobility in urban, suburban and rural environments, *Health Education Journal*, 59
- ⁶⁹ Davis and Jones (1996) Children in the urban environment: an issue for the new public health agenda, *Health and Place*
- ⁷⁰ O'Brien et al (2000) Children's independent spatial mobility in the urban public realm, *Childhood*, 7
- ⁷¹ Swinburn E., Egger, G Preventive strategies against weight gain and obesity. *Obesity Reviews* 2002;3:289-301
- ⁷² The Strategy Unit Cabinet Office. Food: an analysis of the issues. 2008
- ⁷³ Burgoine T, Lake AA, Stamp E, Alvanides S, Mathers JC, Adamson A. Changing foodscapes (1980-2000) using the ASH30 study. *Appetite*2009;53:157-65
- ⁷⁴ McPherson K, Marsh K, Brown M. Tackling obesities: future choices—modelling future trends in obesity and the impact on health. Government Office for Science, 2007
- ⁷⁵ Pereira MA, Kartashov AI, Ebbeling CB, Van Horn L, Slattery ML, Jacobs Jr DR, et al. Fast-food habits, weight gain, and insulin resistance (the CARDIA study): 15-year prospective analysis. *Lancet*2005;365:36-42
- ⁷⁶ Lachat, C , Nago E, Verstraeten R, Roberfroid D, Van Camp J, Kolsteren P. Eating out of home and its association with dietary intake: a systematic review of the evidence. *Obesity Reviews*2012;13:329-46
- ⁷⁷ Powell, LM, Nguyen BT, Han E. Energy intake from restaurants: demographics and socioeconomics, 2003-2008. *Am J Prev Med*2012;43:498-504
- ⁷⁸ Cavill N, Rutter H. Healthy people, healthy places briefing: obesity and the environment: regulating the growth of fast food outlets. Public Health England, 2013
- ⁷⁹ Mitchell, C , Cowburn G, Foster C. Assessing the options for local government to use legal approaches to combat obesity in the UK: putting theory into practice. *Obesity Reviews*2011;12:660-7
- ⁸⁰ Sustainable Food Cities (2016) <http://sustainablefoodcities.org/>



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