

Havering Joint Strategic Needs Assessment

2011/12

Obesity



Outer North East London



Havering
LONDON BOROUGH

Obesity SUMMARY

What Is The Level of Need in Havering?

- It is estimated that 27.3% of adults in Havering are obese. This is higher than the England average of 24.2% and the London average of 20.7%
- Although there are pockets of high obesity prevalence across the Borough, it tends to be clustered in the north and south of the Borough, and in the less affluent wards of Gooshays, Heaton and South Hornchurch
- 1 in 10 (10.8%) of reception year children in Havering are obese, whilst almost 1 in 5 (19.3%) of year six children are obese
- Childhood obesity in Havering is more prevalent than in other similar locations, and obesity in reception year appears to be increasing over time

Current Service Provision in Havering

- Services for preventing and treating obesity in Havering include universal preventative services such as leisure facilities and Havering active campaign, targeted services such as the national child measurement programme and breastfeeding support, and specialist services such as obesity medication, the MEND programme (for ages 7-13) and bariatric surgery.

Gaps in Knowledge and Service Provision in Havering

- Limited information about the number of expectant mothers in Havering who are overweight (a risk factor for the child becoming overweight)
- Lack of information about what local people think about obesity and what services they would like to see in the Borough
- No targeted community obesity prevention or weight management services for children under the age of seven
- No weight management programmes designed for adolescents
- There are no NHS funded community weight management programmes for adults in Havering (although commercial programmes available at a cost)

Obesity: for decision makers and commissioners to consider:

- Undertake community engagement with local stakeholders
- Commission an NHS funded weight management programme for Havering.
- Ensure that women who are pregnant or trying for a baby are supported to achieve a healthy weight before or after the birth: either through the provision of a NHS funded weight management service, a specialist service, or support from health professionals
- Continue investment in the assessment, treatment, and prevention of childhood obesity: Continue to commission the MEND programme, promote breastfeeding, work with early years settings and schools to act as environments that promote healthy weight
- Reduce the obesogenic nature of the environment in Havering: Options for future work here include improving housing, providing options for active travel, and working with local businesses to improve the food environment

1. WHAT DO WE KNOW ABOUT OBESITY IN HAVERING?

a) Introduction

Obesity can be defined as the accumulation of excess fat to the point that it has a negative impact on health. It is usually measured using body mass index (BMI) which is a ratio of height to weight, and adults with a BMI 30 kg/m^2 are generally considered to be obese. In simplest terms, obesity is caused by an imbalance of the energy in, energy out equation; with more calories being consumed through food and drink, than expended through exercise. However, obesity is a complex issue which is affected by a range of behavioural, psychological, social, cultural and environmental factors. The 2007 Foresight report details these factors, and the intricate feedback loops that impact on a persons' weight status, but are outside of their immediate control (1).

b) Why is obesity an issue?

The prevalence of obesity has been rising amongst both adults and children in England, but also in many other areas of the world (2). Being obese increases the likelihood of the development of a range of health conditions, and the most important of these in terms of the burden on health services are type II diabetes, cardiovascular diseases and several types of cancer. However, obesity is also linked to increased risk or complication of the following conditions: benign prostate hypertrophy, sleep apnoea, asthma, infertility and musculoskeletal problems (3).

Obesity further costs society through the loss of disability-free life years, additional pension payments due to early retirement through ill health, increased absenteeism and/or reduced productivity at work due to ill health (3).

The long-term consequences of obesity in children are similar as in adults, but where adults have been obese since childhood they may develop these health issues at an earlier than would normally be expected. There are also impacts of obesity that occur during childhood, such as sleep apnoea, exacerbation of asthma, joint and muscular problems, type II diabetes, and mental health issues such as low self-esteem (4,5).

c) Who's at risk and why?

The prevalence of obesity has increased amongst all populations in England, and so everyone can be considered at risk. However, there are particular subsets of the population who are at a greater risk of obesity, and there are recognised risk factors.

Age: Risk of obesity increases with increasing age, and rates of obesity are higher amongst the older population (6). In recent years the increase in obesity amongst young age groups is of particular concern due to the health impacts of long-term obesity (4).

Deprivation: Rates of childhood and adult obesity, are higher in deprived areas than in more affluent neighbourhoods (7,8,9).

Gender: Rates of overweight and obesity in total are higher for men however the proportion of adults of each gender in the obese or morbidly obese category is the same (10).

Ethnicity: Ethnicity is related to risk of obesity, with higher rates found amongst Black African or Caribbean women, whilst Indian, Bangladeshi and Chinese women have a significantly lower prevalence. It is also worth noting that the risk of obesity and ethnicity may be confounded by deprivation. Although rates of obesity are lower amongst South Asian populations, they are thought to be more susceptible to the metabolic complications of excess body fat, and so a more appropriate obesity 'cut off' for this group may be a BMI of 28 kg/m^2 (11).

Maternal and Parental Obesity: Children are more at risk of obesity if their mother was overweight or obese during their pregnancy, or if one or more of their parents are obese (12,13).

Disability: People with some specific learning difficulties are more susceptible to obesity. Certain physical disabilities may also increase the risk of obesity due to restrictions on physical activity (14).

d) The prevalence of adult obesity

e) Health Survey for England (HSE) Data

Figure 1: Prevalence of adult obesity. Modelled estimates based the 2006-08 health survey for England, 2011 (15).

	Prevalence Obesity (%)
Havering	25.9
London	20.7
England	24.2

The HSE modelled (Figure 1) data are estimates of the prevalence of obesity, based on individual data from the HSE, applied to local population data. Havering has a higher prevalence of adult obesity than both the London and England averages, and is the third most obese Borough in London. It is important to note that these data are not age standardised, and risk of obesity increases with age. Therefore Havering's relatively older population may explain the comparatively higher prevalence. However, it does not detract from the impact of obesity on the local health and social care system. Additionally, the older (60+) population in Havering is projected to increase significantly over the next few years, which could lead to an even higher proportion of overweight and obese people.

f) Quality Outcomes Framework (QOF) Data

QOF is a way of measuring GP performance. In terms of obesity, the QOF database records the proportion of patients on a GPs list who have a recent height and weight recorded. It is also possible to produce a figure for the proportion of those people who are overweight.

According to the 2009/10 QOF data for Havering, 35.1% of the total practice population have their weight status recorded on the GP database, below the target of 70% (16). The prevalence of obesity amongst those patients with their status recorded is 8.9%. This is well below the HSE estimated prevalence of obesity in Havering. However, it is likely this is due to underreporting on the QOF database, and the lack of records for the majority of patients.

g) The geographic distribution of adult obesity across Havering

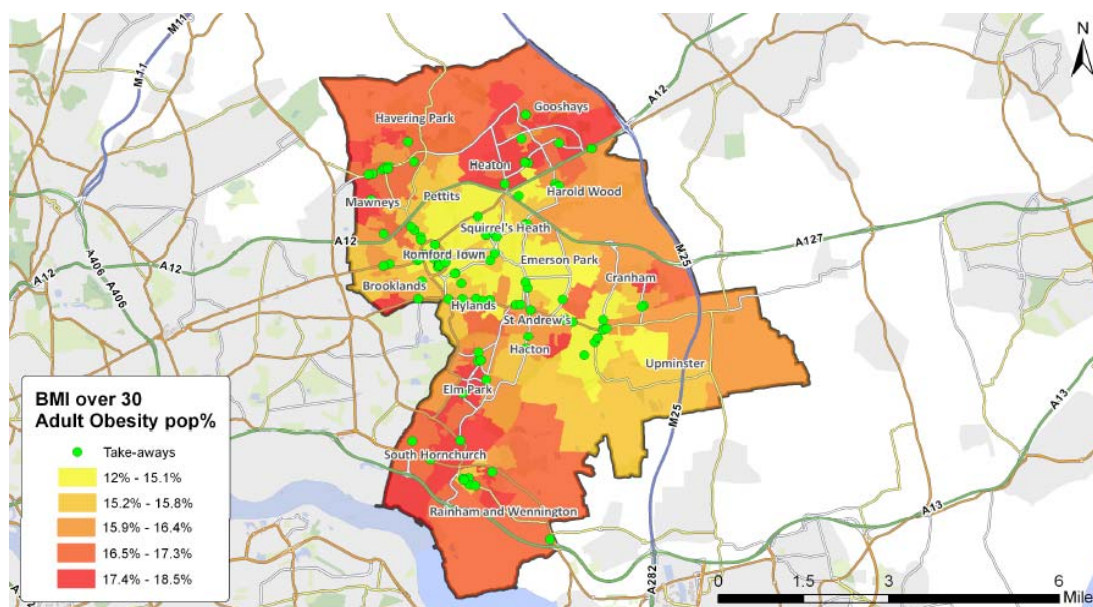
Fig 2 below shows the electoral wards of Havering ranked by the penetration of obesity within that ward. As might be expected, obesity rates are highest in the two most deprived wards of Heaton and Gooshays.

Figure 2: The penetration of adult obesity in Havering by electoral ward, ranked from highest to lowest. Modelled estimates from HSE 2005-2008 and MOSAIC data, Experian Ltd, 2010 (17).

Ward Name	Ranked Penetration of Obesity (1-18 Highest to Lowest)
Heaton	1
Gooshays	2
South Hornchurch	3
Elm Park	4
Havering Park	5
Mawneys	6
Rainham and Wennington	7
Harold Wood	8
Hacton	9
Brooklands	10
Cranham	11
St Andrew's	12
Hylands	13
Pettits	14
Upminster	15
Squirrel's Heath	16
Romford Town	17
Emerson Park	18

The map below (Fig 3) shows the distribution of adult obesity at Lower Super Output Area.

Figure 3: Penetration of adult Obesity by Havering at **LSOA level**. Source: APHO modelled estimates from HSE 2005-2008 using MOSAIC data.¹⁷ Experian Ltd, 2010.

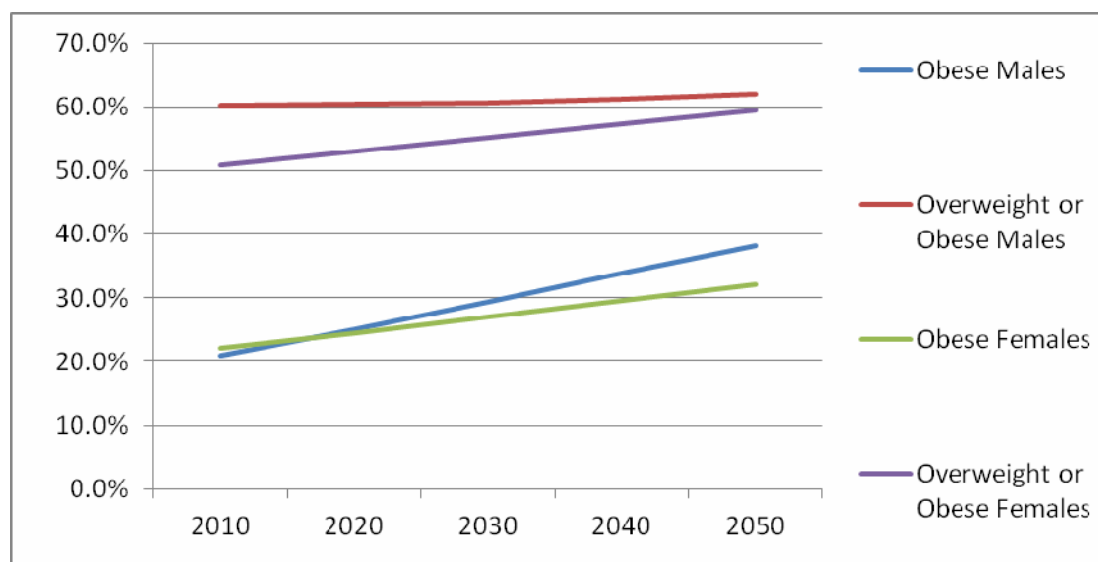


Although there are pockets of high obesity prevalence across the Borough, it tends to be clustered in the north and south of the Borough, and in the less affluent wards of Gooshays, Heaton and South Hornchurch.

h) Forecasting obesity

Forecasts of overweight and obesity suggest that prevalence is set to increase nationally and regionally, and as the local older population increases it is likely that rates in Havering will continue to rise, increasing the cost burden on the local NHS (1).

Figure 4: Forecast increase in the prevalence of obesity, and the prevalence of adults who are overweight or obese, for the London region 2010-2050. The Foresight Report, Tackling Obesities, 2007 (1).



i) Mortality

In addition to costs on health services, obesity has a significant impact on mortality and morbidity, and is thought to be responsible for almost 250 deaths each year from cancer and cardiovascular disease in Havering (18). The table below (Fig 5) shows the number of deaths from cancer, heart disease and stroke that are attributable to obesity, and the number of deaths that could be reduced if the prevalence of obesity in Havering was reduced by 5%.

Figure 5: Estimated number of deaths from cancer and cardiovascular disease attributed to obesity. Department of Health, 2011 (18).

Cancer	Annually (Havering)
Number of deaths from cancer	900
Estimated number of those deaths caused by obesity	75
Estimated number of deaths if obesity reduced by 5%	896
Reduction in number of deaths	4
Heart Disease and Stroke	Annually (Havering)
Number of deaths from Heart Disease and Stroke	555
Estimated number of those deaths caused by obesity	170
Estimated number of deaths if obesity reduced by 5%	547
Reduction in number of deaths	8

j) The prevalence of childhood obesity Havering, England and London data

Figure 6 below shows the prevalence of childhood obesity in Havering as measured through the national child measurement programme (NCMP) in Reception Year and Year 6. Obesity in Reception year is higher than the England average, but below the London average. Obesity in Year 6 is similar to the England average.

Figure 6: Prevalence of childhood obesity in Havering, London and England. Source: 2010/11 NCMP (20)

	Havering	London	England
Reception Year	10.8	11.1	9.4
Year 6	19.3	21.9	19.0

k) Time trends and statistical neighbours

The graphs below show data on the prevalence of childhood obesity in Havering compared to some of Children's Services statistical neighbours, and the variation over time.

Figure 7: Prevalence of childhood obesity in Reception Year for Havering and statistical neighbours, 2006-2010. National Child Measurement Programme Data, 2011 (19).

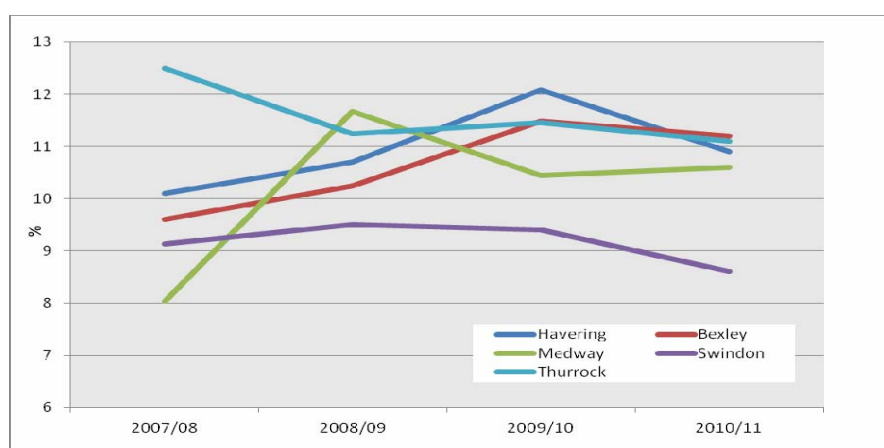
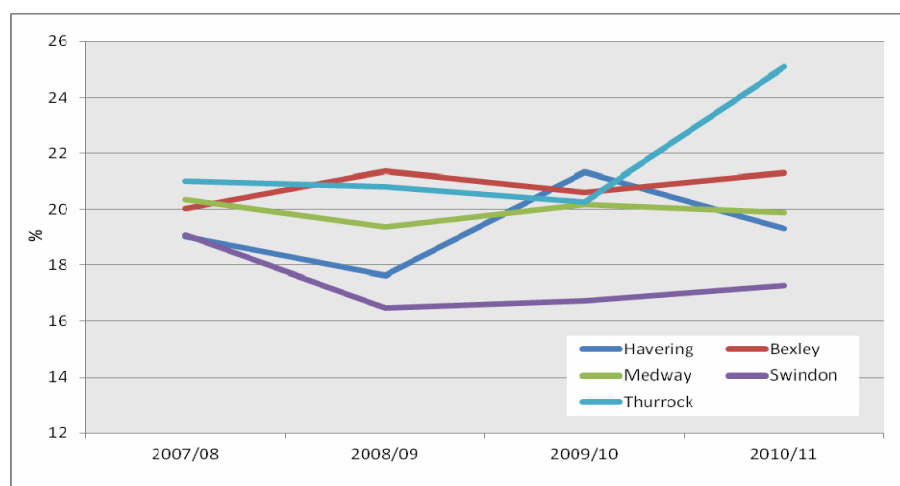


Figure 8: Prevalence of childhood obesity in Year 6, for Havering and statistical neighbours, 2006-2011. National Child Measurement Programme Data, 2011 (19).

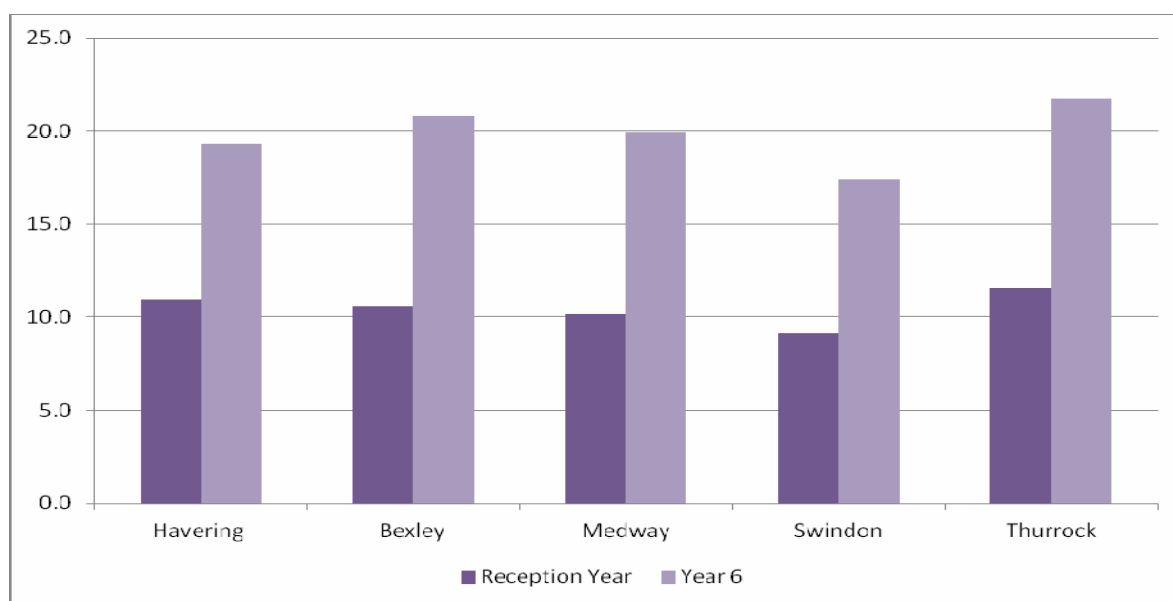


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The graphs show that obesity in reception year has declined in the last year, but prior to this was on an upwards trend, and in 2009/10 was higher than in other similar areas. Rates of obesity in Year 6 also show a small reduction between 2009/10 and 2010/11 with some variation over time.

Due to this variation over time, a rolling average for the previous four years was taken. The graph below shows the rolling average for childhood obesity in Havering and some statistical neighbours, over the previous four years (Fig. 9). The rolling average data shows that obesity in Reception Year is second highest amongst these statistical neighbours, and obesity in Year 6 is the second lowest.

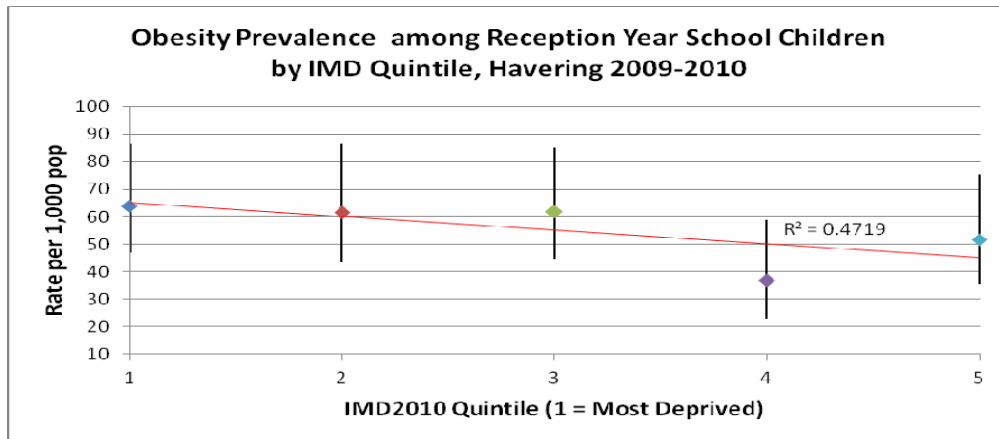
Figure 9: Prevalence of childhood obesity in Reception Year and Year 6, for Havering and statistical neighbours, Rolling Averages 2006-2011. National Child Measurement Programme Data, 2011 (19).



I) 2010/11 local NCMP data and deprivation

Local NCMP data was analysed to identify potential links with deprivation. A similar trend to the national one was found, with little association between deprivation and overweight, but a statistically significant association between obesity and deprivation in Reception year, with obesity increasing with increasing deprivation (Fig 10). No association was found for Year 6. Although useful, these results should be treated with caution due to the relatively small sample sizes involved.

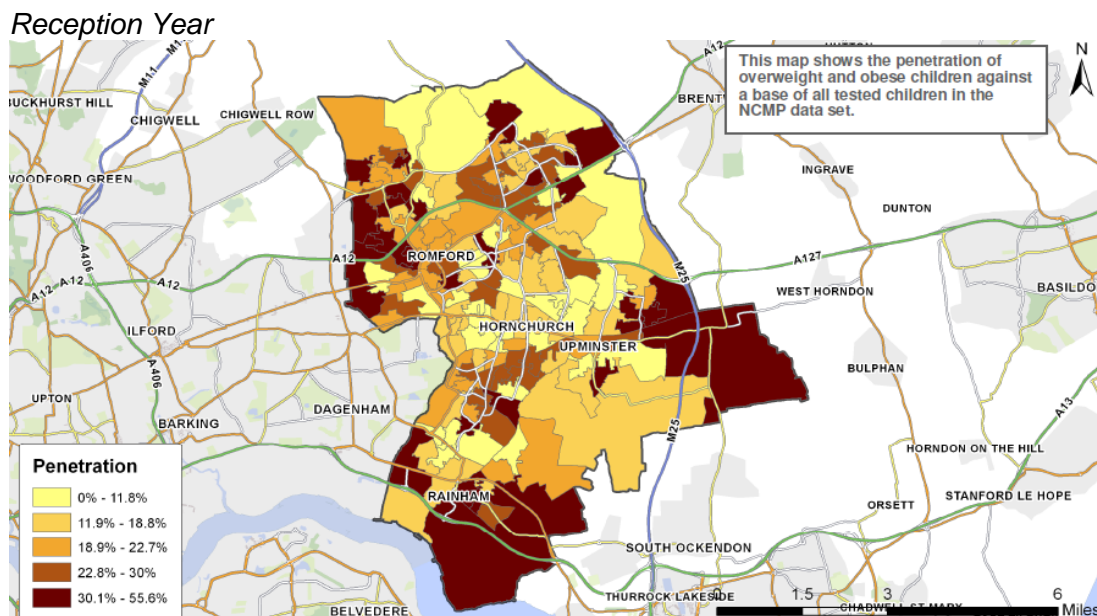
Figure 10: NCMP data by Index of multiple deprivation quintile. Local NCMP data 2009/10, NHS Havering, 2011 (19).



m) Geographical distribution of childhood overweight and obesity in Havering

The maps below (Figure 11) show the geographical distribution of childhood overweight and obesity in Havering.

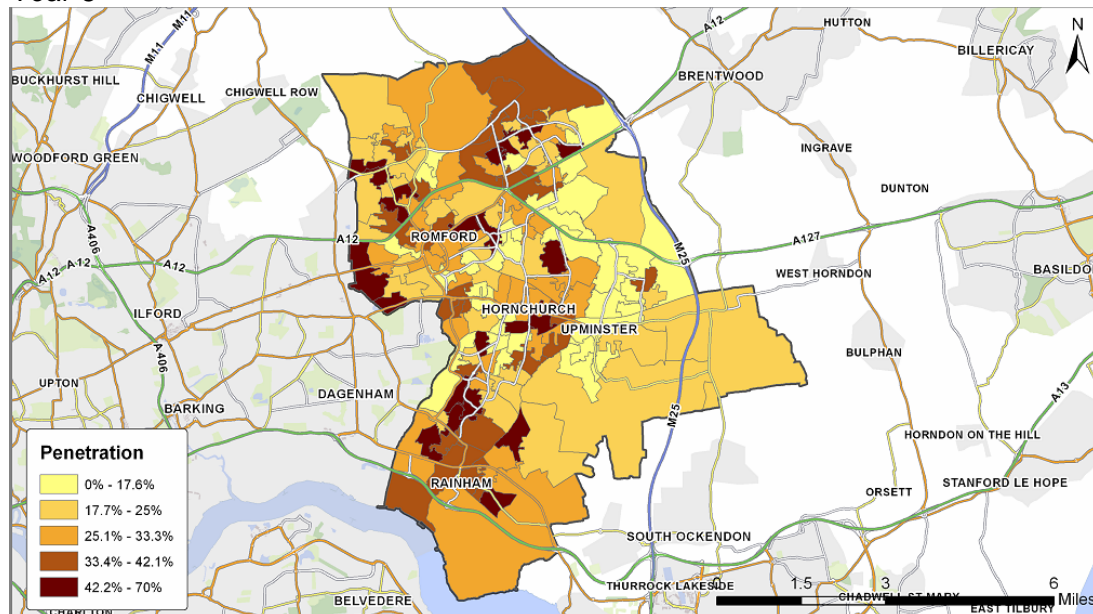
Figure 11: Prevalence of childhood overweight and obesity in **Reception Year only** in Havering by Lower Super Output Area (LSOA). Data from 2010/11 NCMP (19). Map produced by Experian Ltd, 2011.



There is a high prevalence of childhood overweight and obesity amongst reception year children in the Cranham area of Upminster. There are also clusters of high prevalence in Rainham & Wennington and South Hornchurch, parts of the north of the Borough such as around Brooklands, Mawneys, Heaton and Gooshays.

*Figure 12: Prevalence of overweight and obesity in **Year 6** only in Havering by Lower Super Output Area (LSOA). Source: Data from 2010/11 NCMP (19). Map produced by Experian Ltd, 2011.*

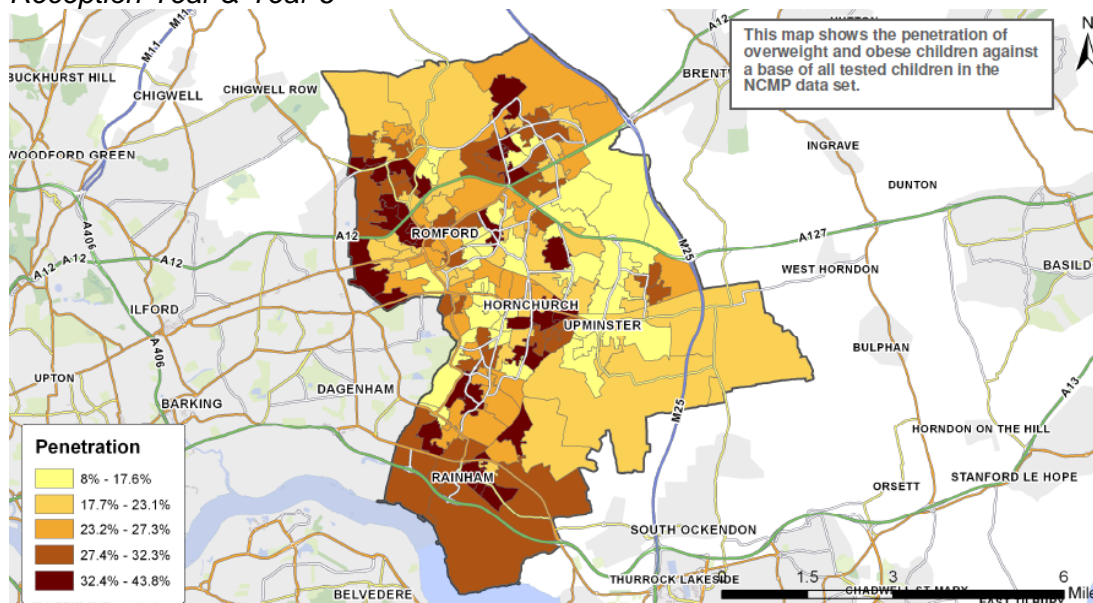
Year 6



Overweight and obesity in Year 6 is less clustered (Fig 12), with pockets of high prevalence across the Borough, however there is still a comparatively high prevalence in the north (Heaton, Gooshays and Brooklands) and south of the Borough (South Hornchurch, and Rainham & Wennington) with a cluster in central Hornchurch (Hacton and St Andrews wards). The east of the Borough (Upminster and Cranham) has a comparatively lower prevalence of obesity.

*Figure 13: Prevalence of childhood obesity in **Reception Year & Year 6** in Havering by Lower Super Output Area (LSOA). Source: Data from NCMP 2010/11 (19). Map produced by Experian Ltd, 2011.*

Reception Year & Year 6

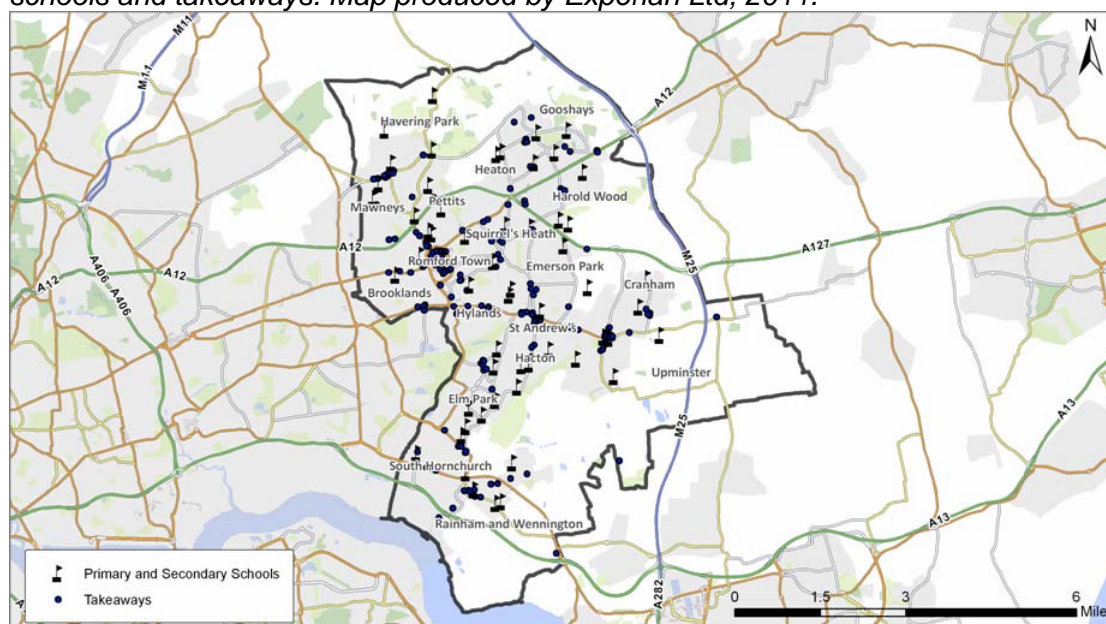


When overweight and obesity in Reception and Year 6 is combined (Fig 13) there is a clear clustering of high rates in the north and south of the Borough. However as with Year 6 there is also a cluster of high prevalence areas in the centre of the Borough around the St Andrews and Hacton wards.

o) The food environment: Schools and take-away outlets

Some studies have linked a concentration of fast food takeaways and the subsequent increase in the availability of fast food with higher rates of obesity, although the link is not yet conclusive (20, 21). However the link between excessive consumption of fast food and obesity is well known, and so it is useful to know more about the food environment in Havering (22). Therefore a mapping was undertaken to identify hotspots of fast food availability, and in particular their proximity to vulnerable populations such as school children (Fig 14).

Figure 14: Map of Havering schools and local takeaway food outlets Source: Local data on schools and takeaways. Map produced by Experian Ltd, 2011.



The neighbouring Boroughs of Barking and Dagenham (23) and Waltham Forest (24) have implemented saturation policies to restrict the proliferation of new fast food outlets, particularly those that are located close to schools. Both Boroughs have implemented 400m exclusion zones for new applications around schools and community premises. 400m is used as a reference as it is considered 'easy walking distance' taking approximately ten minutes. More than thirty of the primary and secondary schools in Havering are already within 400m of at least one fast food or takeaway outlet, five of which are secondary schools. Therefore there may be potential to reduce consumption of fast food amongst school children, either during lunch breaks or on the way to and from school, by implementing policies to restrict further proliferation of such outlets.

2. WHAT CURRENT SERVICES ARE THERE FOR OBESITY IN HAVERING?

a) National Context

The government's latest obesity strategy *Healthy Lives, Healthy People: a call to action on obesity in England* (2011) was published in October (25). The latest strategy emphasises the expanding role of local governments in tackling obesity at a local level. From April 2013 public health responsibilities will be transferred to local authorities, who will become responsible for commissioning interventions to tackle obesity.

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The strategy has a focus on reducing calorie consumption with a target for reducing our nation's calorie consumption by 5 billion calories a day (equivalent to one hundred calories per person). The approach of the government will be to put more focus on individual responsibility to lose weight, but to continue to provide support and advice to people to lose weight. The table below (Fig 15) outlines the policy direction for the four main partner agencies in tackling obesity nationally, and the responsibilities that they will adopt by the implementation of the public health white paper in 2013.

The new government approach to public health and obesity suggests a smaller role for the state in reducing obesity. Instead the government has launched the responsibility deal. This encourages industry to adopt a more responsible attitude towards their business and its impact on public health (26). Industry partners who sign up to the responsibility deal must work towards voluntary improvements in their products or service which will have a positive impact on public health. An example is a food industry partner committing to improving the nutritional content of their food such as reducing salt or fat content, and responsible advertising and promotion of their products.

Figure 15: Responsibilities of partner agencies in tackling obesity from 2013, Summary produced by NHS Havering, 2011.

	Responsibilities from April 2013
<i>Public Health England</i>	<ul style="list-style-type: none"> - Commitment to invest in and support the NCMP - Develop a new measure for adult and maternal obesity at a local level - Absorption of the data analysis and evaluation functions of the National Obesity Observatory, and the Obesity Learning Centre - Investing in research, supporting commissioning, disseminating best practice (incl. new NICE guidance) - Supporting health professionals contribution through NHS Health Checks and the Healthy Child Programme
<i>Local Authorities</i>	<ul style="list-style-type: none"> - Develop a local obesity strategy encompassing: sustainable active transport, planning, use of green space, opportunities for physical activity and sport, healthier catering in LA run premises, and influence on the local food industry - Utilise health and wellbeing boards to 'pull together' a wide range of partners in a coalition to tackle obesity - Work with clinical commissioning groups to commission a spectrum of interventions from brief intervention, to weight management and bariatric surgery and agree local pathways
<i>the NHS</i>	<ul style="list-style-type: none"> - Delivery of healthy lifestyle messages by health professionals, especially to pregnant women, or those trying for a baby - Raising the issue of obesity, providing advice, and referring to services - Supporting individuals to change their behaviour - Commissioning of bariatric surgery (at which level e.g. CCGs or NHS commissioning board, is to be determined).
<i>Central Government</i>	<ul style="list-style-type: none"> - Building on the responsibility deal - Improving nutrition information in partnership with industry

	<ul style="list-style-type: none"> - Continue to support statutory guidelines for school food - New national ambition and guidelines for physical activity - Initiatives and opportunities to support the 2012 Olympics - Promoting physical activity through Change4Life clubs in schools, supporting active travel and Bikeability - Advice and support through NHS Choices
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b) Local Strategies & Key Local Actions

The local obesity strategy, Healthy Weight, Healthy Lives, Healthy Havering (2010) is based on the same themes as the previous the previous Labour administration's Healthy Weight, Healthy Lives: A cross government strategy for England (2007) (27,28). It sets out how partners in Havering will tackle obesity, and includes a variety of actions to both prevent, and treat obesity in Havering.

Both the local NHS and the council recognise the importance of the issue of obesity in Havering. Havering Children's Trust have selected raising the prevalence of breastfeeding as a priority issue for the Borough, as breastfeeding has been shown to have a positive effect on individual risk of obesity. Childhood obesity has been included in the Children and Families transformation programme, and was one of the indicators used during the innovation events to develop and action plan. In light of the recently published government strategy, a new local strategy will need to be developed in keeping with the transfer of public health responsibilities in 2013.

c) Overview of current services in Havering and their delivery structure

The figure below (Fig 16) is an overview of the services, which are available to Havering residents. Not all of these services are publicly funded, for example there is currently no funding for referral to commercial weight management programmes.

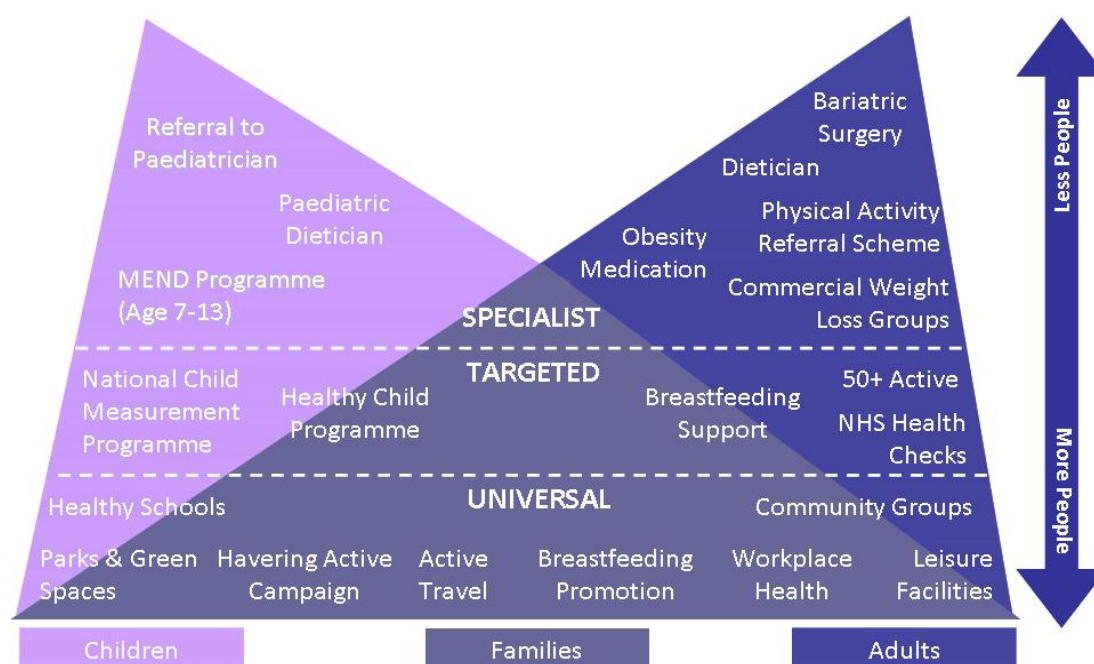
Specialist services: These are specialist weight management interventions for people who are already overweight or obese. These might include NHS funded interventions, as well as commercial weight loss groups.

Targeted services: These include interventions or programmes that are specifically targeted to segments of the population, and aid in the identification or prevention of obesity. The majority of these are public funded, although there may be additional voluntary sector services that support people in maintaining a healthy weight.

Universal services: These are whole population activities which can have an impact on helping the whole population to maintain a healthy weight.

By ensuring there are effective universal and targeted activities, we can help to reduce the number of people requiring specialist services to treat their obesity.

Figure 16: Services in Havering to prevent or treat obesity (Based on a similar service model from Nottingham City). NHS Havering, 2011 (29).



d) Management of existing obesity

Adults

NHS Health Checks: The NHS Health check's scheme enables all adults age 40-74 the opportunity for a free health check from their GP. The health check covers a range of basic medical issues, but is particularly designed to identify individuals with high risk factors for cardiovascular disease such as obesity.

Physical Activity Referral Scheme (PARS): Although not a dedicated weight management scheme, the PARS programme helps people who are currently inactive to safely increase their physical activity levels and so contribute towards reducing their energy balance. Patients who are obese, or overweight with existing co-morbidities are eligible for referral on the programme.

Bariatric Surgery: There is currently a bariatric surgery service available for patients in Havering, delivered by Barking, Havering and Redbridge University Hospitals Trust (BHRUT).

Children

MEND Programme: The MEND programme is a family based, weight management programme for children age 7-13 that are overweight for their age and height. MEND is a multi-component programme that incorporates structured physical activity, nutrition information and behaviour change strategies.

National Child Measurement Programme (NCMP): As part of the national child measurement programme, we weigh and measure all children in Year 6 and Reception Year. This contributes to the national and local data set on childhood obesity. Parents are advised of the result of their child's measurement, and the healthy weight status of their child.

e) Preventative actions and tackling the wider obesogenic environment

Breastfeeding Support: Breastfeeding rates in Havering are low, and there are a range of actions being undertaken to improve rates due to the protective effect of breastfeeding on the development of obesity. Peer support services, a social marketing campaign, and a scheme to promote breastfeeding friendly public places are currently underway.

Planning & Active Travel: There are several schemes running in the Borough to promote active modes of travel, including cycle purchase schemes for council employees, cycling safety training, and campaigns to promote active travel. New planning applications are reviewed by the public health team for any impact on health, including healthy lifestyle impacts.

Culture and Leisure: The Havering Active campaign provides and promotes opportunities for activity in Havering, including an 'Active Ageing' programme, yoga, badminton, and more traditional sports. The Havering active campaign runs in collaboration with the local leisure centres that also provide a programme of physical activity. Havering Libraries will soon be home to 'Healthy Living' points where people can access advice and information on healthy lifestyles. Residents of Havering benefit from a wealth of high quality parks and open space, and access to green space is the second best of all London Boroughs. The Havering Culture strategy provides more information on how the culture and leisure services in the Borough support the people to lead healthier lives (30).

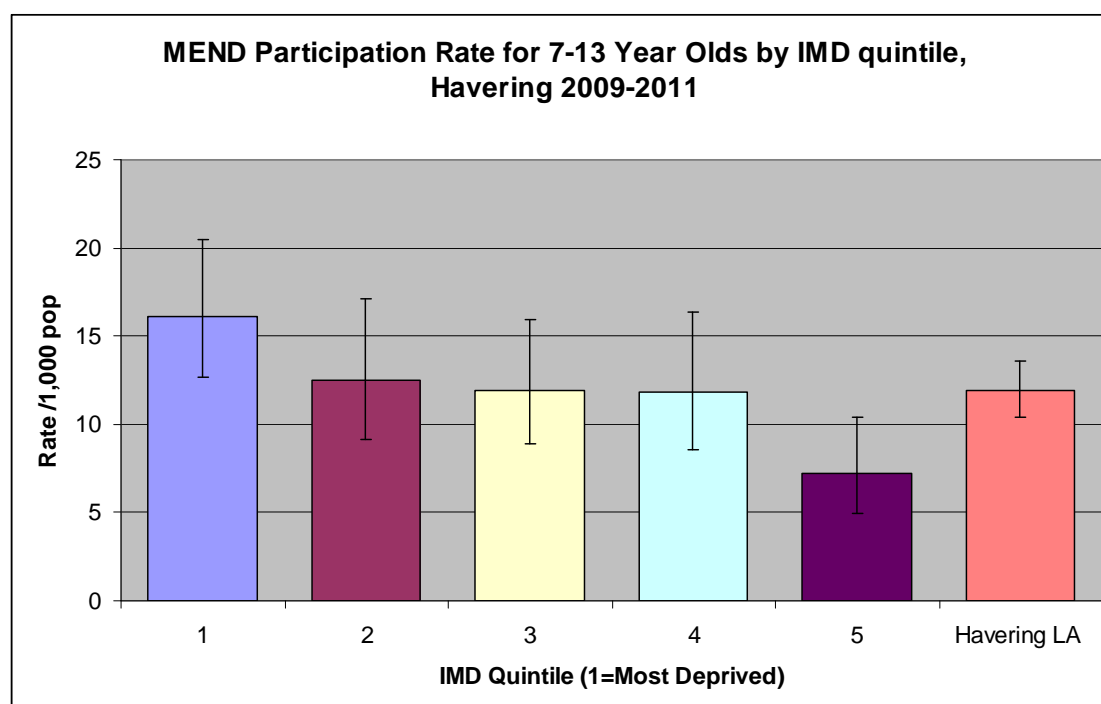
Schools: Schools Havering Council continues to maintain a target around the proportion of children who access free school meals. The School Sports Collective aims to continue to support school sport through contributions from participating schools, rather than relying on national funding. Funding has been allocated for thirty 'Change 4 Life' clubs to run in schools across the Borough to help get children active. Schools continue to develop travel plans to increase the number pupils and staff who use active travel methods to attend school

Food Environment: Havering is participating in a London wide scheme to promote healthier eating by running a charter mark scheme for take-away restaurants that offer healthier options. Other options for improving the food environment, such as restricting the proliferation of take-aways close to schools, are being explored.

f) Evaluating our Services

A recent equity audit of the MEND programmes that have been delivered in Havering since 2009 found that the most participants on the programme were from more deprived neighbourhoods (Figure 17). As the prevalence of obesity is associated with deprivation, this result suggests that the programme is successful in promoting access to the populations that need it most.

Figure 17: Result of an equity audit of participants on the Havering MEND Programme by deprivation quintile of home postcode. NHS Havering, 2011 (31).



An evaluation of the programme identified that participants achieved improvements in a range of health measures including: a reduction in their body mass index, waist circumference, and time spent in sedentary activity, and improvements in their self esteem, their physical fitness, the time they spend being physically active, and their knowledge of nutritional issues.

g) Partnership Working

The NHS and the council have worked very closely and effectively on tackling childhood obesity, for example in the delivery of the MEND programme, which has involved close partnership working and in-kind contributions from both partners to ensure the programme is cost effective and successful. The council and NHS also collaborated closely on the Healthy Schools programme, and succeeded in ensuring that 90% of the schools in the Borough have achieved National Healthy School's Status (NHSS). The local obesity strategy is a multi-agency document which sets out how partners have previously, and continue to make contributions to tackling obesity in Havering.

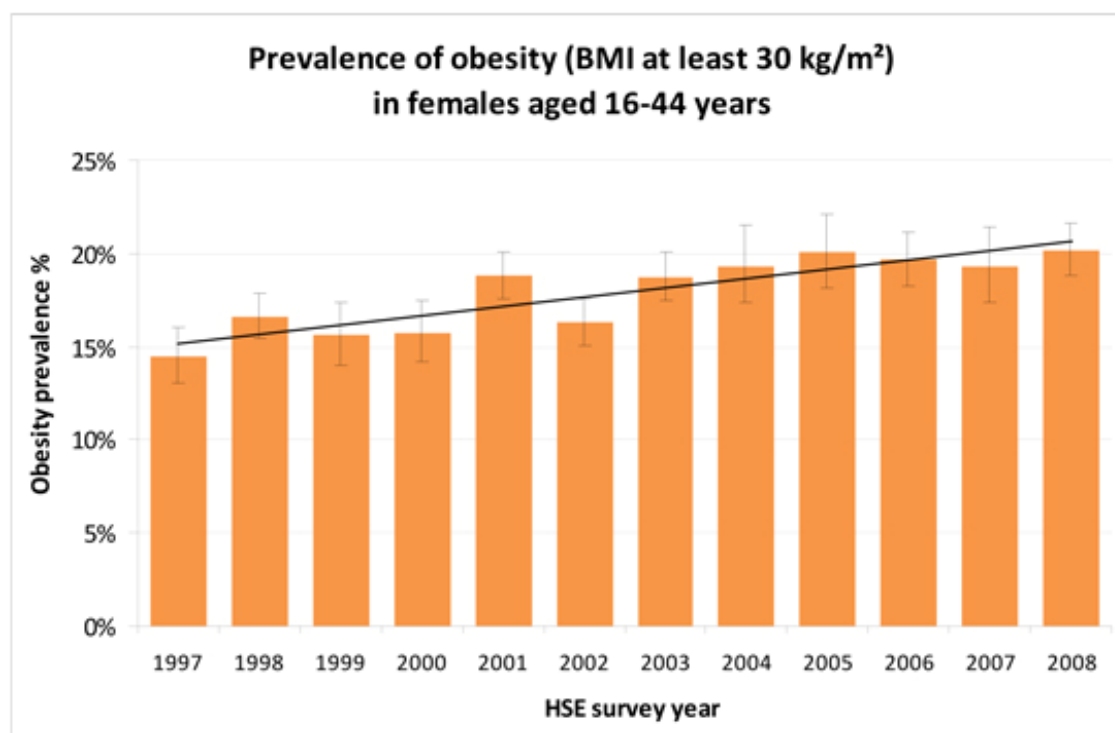
3. WHAT GAPS ARE THERE IN SERVICES OR KNOWLEDGE IN THIS AREA?

a) Knowledge Gaps

Obesity during pregnancy: It is known that women who are overweight or obese during pregnancy are at greater risk of health complications for both themselves and their baby (32). We also know that children born to obese mothers are more likely to become obese themselves, continuing the cycle of obesity. Research suggests that obese mothers have greater care needs (33). Knowing the extent of obesity amongst pregnant women in Havering would be useful for service planning and delivery of both weight management and maternity services. This information could be obtained from the maternity database, where 80% of women have their BMI recorded. The prevalence of maternal obesity is listed as part of the proposed public health outcomes framework, however the definition and method for how this will be obtained is yet to be determined.

National trends suggest that maternal obesity is on the increase (Figure 17), and if the prevalence of maternal obesity in Havering is similar to the England average, around 18% of women of childbearing age could be obese. This amounts to approximately 7,900 women in Havering and suggests that up to 18% of the 3,000 or so births that occur in Havering each year could be to obese mothers.

Figure 18: Prevalence of obesity in females of child bearing age. National Obesity Observatory, 2011 (34).



Public engagement: There is currently a lack of knowledge on what Havering residents think about the issue of obesity, and the kind of services that they would like to see provided in the Borough.

b) Gaps in Services

- Prevention

As discussed above there are many activities or policies in place within Havering to improve the obesogenic environment and to help prevent the development of obesity. It is always possible to 'do more' in terms of prevention, but in a time of financial austerity the cost of doing more has to be balanced against potential gains. However there are some areas in particular where there is potential to either limited action or risks.

Schools: Considerable time and financial investment into the National Healthy Schools Status, school food legislation, and funding for school sports mean that Havering's Schools are considerably more health promoting environments than they were several years ago. However, recent cuts in funding and support for the National Healthy Schools programme, changes to the way schools receive funding for school meals, and the removal of minimum targets for physical activity may lead to a stagnation of this improvement.

Workplaces: Most adults spend the majority of their waking hours either at and travelling to work, and so it is important that workplace policies and environments protect and improve the health of employees. This particularly important for large public sector employees such as the NHS and local authority who should act as role models in supporting staff to be

healthier. Although most public sector organisations do offer a level of health promotion activities for staff, it often lacks a strategic direction or drive, or evaluative process.

- Treatment

Younger Children: There are no community based weight management programmes (or targeted obesity prevention services) for children below the age of seven in Havering. This is a concern as there is a high prevalence of obesity in five year olds in the Borough, and evidence suggests that excess weight gain in the early years of life has the greatest impact on future obesity risk (35). There are alternatives for support such as referral to a dietician, or support by GPs, health visitors and school nurses, depending on the child's age group.

Adolescents: There are currently no weight management services designed for adolescents in Havering as the MEND programme is only suitable for children up to the age of 13. This is partly due to a lack of evidence based interventions and services for young people in this age group. Many commercial slimming clubs restrict access before the age of sixteen, and so dietetic referral is the only option available for this group. This is an important gap as adolescence is a key period in building self esteem and personal identity, and overweight or obese young people may be more prone to mental health issues (36).

Adults: A pilot GP led weight management programme (the Counterweight Programme) was delivered between March 2009 and March 2011 (37). Although this was partially successful as the participants that attended achieved the desired weight loss, the uptake of the programme was very low, and practitioners found it very time consuming to deliver. Since this programme was decommissioned, there has been no NHS funded community weight management programmes for adults in Havering. This should be considered a gap in services given the considerable prevalence of obesity amongst the adult population.

4. WHAT DO LOCAL PEOPLE THINK?

a) Feedback on the NCMP

During the 2010/11 NCMP we wrote to parents with feedback on their child's measurement. They also received a booklet with tips on how to help their children stay healthy, and details of local services. Twenty four parents returned the attached freepost feedback forms. Feedback on the booklet was generally positive, with 76% of parents commenting that the booklet was appealing to read. We also received comments on the booklet, and the NCMP measurement process in general.

Parents particularly liked:

"Websites on local activities"

"The Havering Active website and the MEND contact number"

"Helped me to know more about my child's health, and reminded us of some important points about healthy lifestyles"

"Reassurance we are already doing everything"

"Straightforward enough for my 10 yr old daughter to read it"

"Clear layout and information Easy for children to read"

"Colourful and informative"

They disliked or suggested:

"I have no worries as my children are as they should be, but very few activities for under 6s or 5s."

"Felt like it was aimed at just overweight children"

"More activities relating to 4-6 years of age"

"Most people throw leaflets away, parenting workshop locally would help"

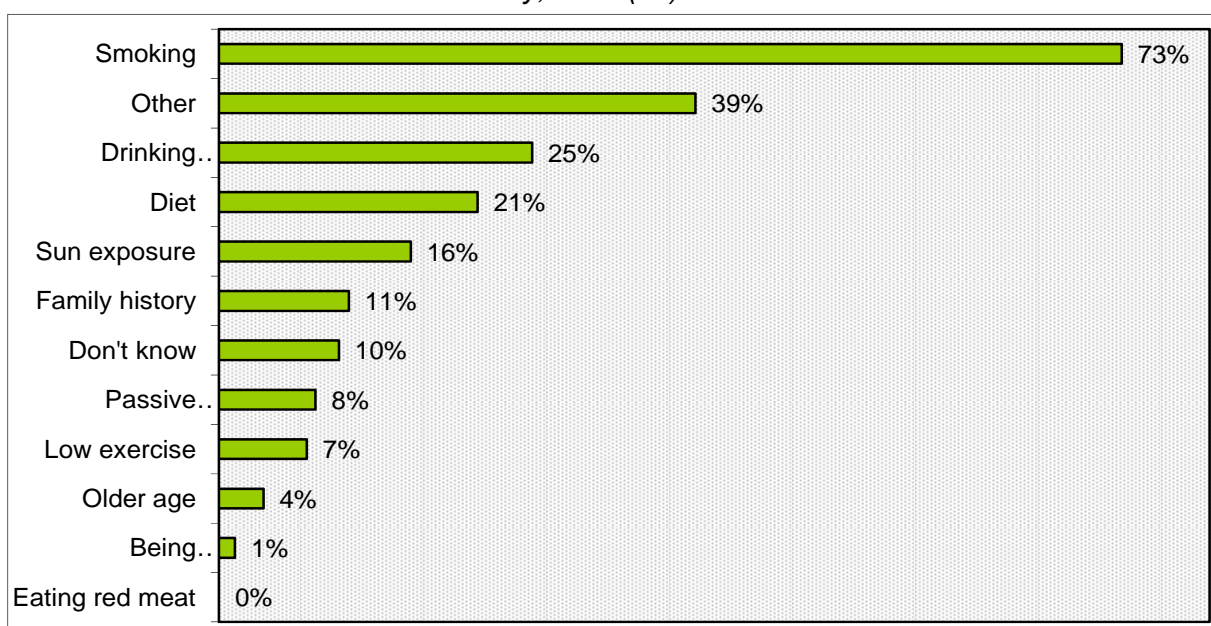
“If we knew somewhere that we could take our kids e.g. a special clinic where they explain healthy living to them it would be very useful, and they could get checked regularly”
“I didn't feel it was applicable to me so didn't bother to read it”

b) Awareness of obesity as a risk factor for cancer

The North East London Cancer Network conducted a public survey of awareness of cancer (38). 623 people across Havering were invited to participate, and 500 agreed to take part in interviews, a response rate of 80%. During the survey questions were asked to learn more about public awareness of risk factors for cancer.

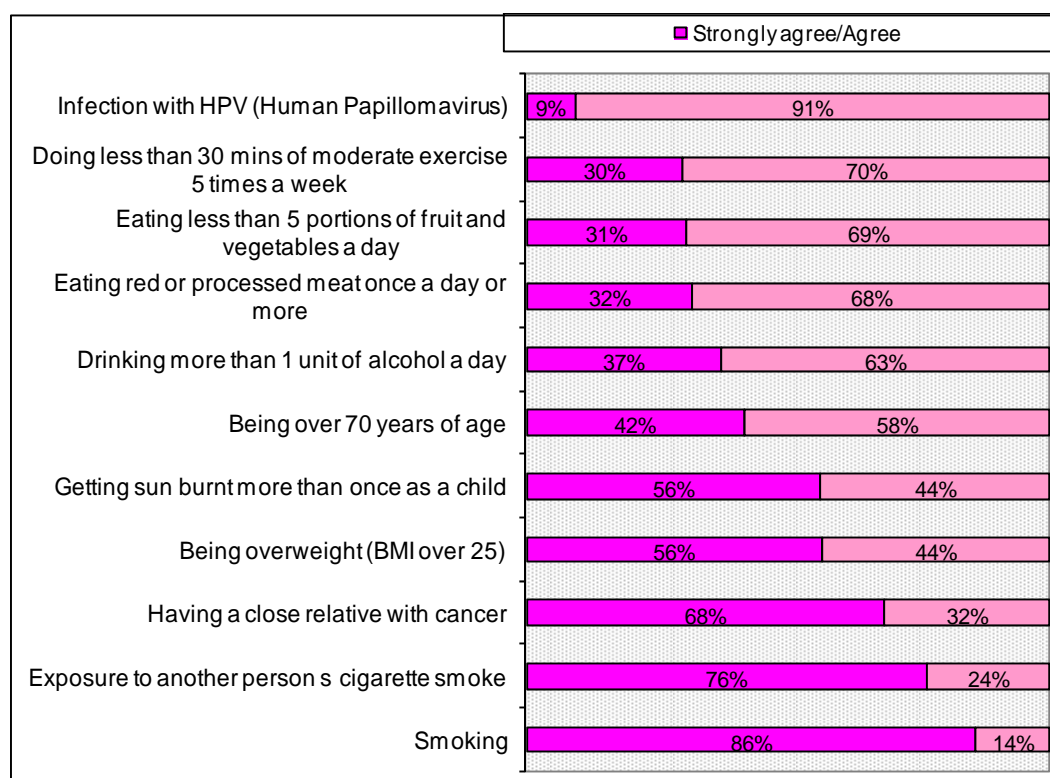
When asked to spontaneously recall risk factors for cancer, being overweight or obese did not feature highly, with only 1% of participants specifying 'being overweight' as a risk factor (Figure 19). Awareness of risks of eating red meat, and not exercising enough were also low.

Figure 19: Percentage of participants who spontaneously recalled cancer risk factors for cancer. ONEL Cancer Awareness Survey, 2011 (38).



When asked whether they agreed with certain factors as increasing risk of cancer, awareness of obesity as a risk factor was improved, with 55% of participants agreeing that being overweight was a risk factor. However few agreed that associated lifestyle behaviours such as not getting enough exercise or maintaining a healthy diet were risk factors (Figure 20).

Figure 20: Percentage of participants that agree with a specified risk factor as contributing to the risk of developing cancer Source: ONEL Cancer Awareness Survey, 2011 (38).



5. EVIDENCE OF WHAT WORKS

This section considers NICE guidance and cost effectiveness of obesity interventions. It is estimated that by 2015 the cost to the local NHS of treating diseases attributable to overweight or obesity (BMI > 25 kg/m²) will be £70.6 million per year, whilst costs attributable to obesity alone (BMI > 30 kg/m²) will be £42.1 million (18). This cost, along with the associated mortality and morbidity, means that evidence based and cost effective action is required to tackle the issue. Interventions tend to fall into two broad categories: population level preventative actions, and treatment of existing overweight and obesity.

a) Population wide prevention of obesity

The Foresight report states that there is a lack of strong evidence effective interventions to prevent obesity (1). However, the report does highlight the many systems which play driving role in the development of obesity, and by reducing the impact of each of these drivers is likely to multiply the impact of preventative action. NICE have developed guidance for local authorities, early years providers, schools and workplaces about preventing obesity (39).

Figure 21: NICE Guidance for non-NHS partners in preventing obesity. NICE, 2011 (40).

Local Authorities and Partners	Identifying local barriers for physical activity, Encouraging physical activity through the design of open spaces and buildings, and active travel, Support and promote physical activity schemes Encourage local shops and caterers to promote healthy food choices
Foundation Years	Regular opportunities for active play Structured physical activity sessions

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	Ensuring children eat regular, healthy meals in a pleasant environment
Schools	<p>Ensure that the school environment and policies encourage physical activity, and a healthy diet, and staff are able to implement them</p> <p>Create links with sports clubs and partnerships</p> <p>Promote physical activities children can enjoy outside school and into adulthood</p> <p>Ensure children and young people eat meals in a pleasant, sociable environment free from distractions</p>
Workplaces (as employers)	<p>Policies and working practices should support active travel and healthy eating</p> <p>Provide showers, and secure cycle parking</p> <p>Support out-of-hours activities such as walks or reduced price gym memberships</p> <p>Provide healthy options in workplace canteens</p> <p>Implement health education and promotion campaigns</p> <p>Offer health checks that address diet and activity</p>

The OECD undertook research in six countries, including England, on the cost effectiveness of various prevention-level interventions for obesity (41). The table below shows the results for England (Table 6).

In the table below, disability adjusted life years (DALYs) refer to the number of years of disability free life that is gained per million people, cost effective ratio represents the cost of gaining one DALY through intervention, compared to no preventative action. The NICE threshold for interventions considered to be cost effective is US \$ 50,000. This information is displayed after 20 and 50 years, in order to show the relative change in cost effectiveness over time.

*Figure 22: Cost per head of delivery, DALYs saved by per million, and cost effectiveness (CE) ratios of **preventative** interventions to tackle obesity (cost per DALY saved) for UK interventions. NICE threshold for cost effectiveness is \$50,000 per DALY. OECD, 2011 (41)*

	\$US per Head	20 Years		50 Years	
		DALYs	CE	DALYs	CE
School Based Interventions	1.41	0	>1 000 000	245	152,989
Worksite Interventions	5.48	1,725	45,630	6,078	20,506
Mass Media Campaigns	2.32	1,361	25,897	4,025	13,796
Primary Care Counselling	10.12	1,496	Cost Saving	6049	Cost Saving
Fiscal Measures	0.11	5,562	6,155	14,776	15,731
Food Advertising and Regulation	0.3	245	3,186	2,,179	4,278
Food Labelling	1.05	1,134	9,52	4,019	5,268

Physician counselling refers to counselling by a primary care health professional, to patients who are at risk of obesity or its complications. The table displays the effectiveness of these

interventions over time. As can be seen in the table above, the benefit of school based interventions is a very long term process, and even 50 years the cost effective profile is still poorer than the NICE threshold of \$50,000 per DALY. However, there is more recent evidence which suggests a stronger cost effectiveness profile for school based interventions (43). Interventions aimed at reducing obesity in adults show faster health gains. Unfortunately the evidence explored in the study does not extend to aspects of the environmental impact on obesity such as access to green space or active travel option etc. Is it also important to note that these are national government level interventions and some of the most cost effective measures such as fiscal measures or food industry regulation and labelling are limited by what is possible at a local level.

b) Cost effective management and treatment of obesity

NICE have published detailed guidance on the management of overweight and obesity in children, adults and pregnant women (39,42).

Figure 23: NICE recommendations for treatment of obesity. NICE, 2011 (39).

	Children	Adults
1 st Line	Lifestyle change approach	Lifestyle change approach
2 nd Line	Consider referral to paediatrician or specialist dietician	Use of obesity medication, in combination with dietary and physical activity approaches
3 rd Line	Surgery or use of obesity medication (only in exceptional circumstances where physical co-morbidities exist, and under the care of a specialist multi-disciplinary team)	Consider Bariatric surgery for people with a BMI of 40 kg/m ² (or 35 kg/m ² with co-morbidities) if other measures have failed Consider surgery as a first line option for people with a BMI of 50 kg/m ²

For adults a weight reduction of 5 - 10% from baseline is considered to produce clinically significant improvements in health outcomes, and is a realistic target for weight loss (39).

NICE states that the most successful lifestyle change interventions should address both physical activity and dietary improvements, and incorporate behaviour change strategies. Commercial programmes that meet these guidelines are recommended.

c) Guidance in Pregnancy

NICE have also published guidance for weight management in women before, during and after pregnancy (42).

- Provide advice and support for women of childbearing capacity who have a BMI < 30 kg/m² to achieve a healthy weight before pregnancy
- Offer specialist advice to women to ensure that weight gain during pregnancy is at an appropriate rate
- Support women after childbirth to achieve a healthy weight, especially those with a BMI of > 30 kg/m²
- Ensure that there are adequate community based services, and professional skills to offer the above

NICE have produced a costing template for local areas to help estimate costs and potential cost savings of implementing the NICE guidance on treating obesity in adults and children

(43) according to the costing template, if commissioning to NICE guidance, a first year outlay of £186,000 in Havering would produce cost savings of £264,000 through reductions in prescribing, and GP contacts. This cost includes paediatric referral, obesity medication and bariatric surgery, implementation of publicly funded lifestyle change interventions would represent an additional cost.

d) Interventions with an evidence base

Weight Management Interventions (Adults): A National Institute for Clinical Research (NICR) health technology assessment of multi-component weight management interventions found that these interventions resulted in a small weight loss (44). The overall significance of the weight loss observed in the interventions is unclear due to the differences between how weight loss was measured, and differences between what is considered significant for health benefits to each patient. However, eventual weight regain was common in most studies. The study also investigated the cost-effectiveness however this was only based on the results from two interventions. Cost effectiveness from savings in the treatment of overweight and obesity were found to be between -£473 and £7,200 per QALY.

Specific interventions with a published evidence base include for weight management include, but are not restricted to: the Counterweight Programme (37) and commercial weight management such as Weight Watchers (45) (for adults), and the MEND (46) and Carnegie Weight Management (47) programmes (for children).

6. ACTIONS AND RECOMMENDATIONS

- *Undertake community engagement with local residents:* Through public engagement, identify what Havering residents think of the provision of obesity services in Havering.
- *Commission an NHS funded weight management programme for Havering:* Havering has a large number of adults who are overweight or obese. Given that obesity is linked to deprivation, and those living in deprived areas are at greater risk of being obese, an NHS funded weight management service would provide residents with support to lose weight. Evidence suggests that relatively small reductions in excess body weight (as little as 5-10%) can deliver significant improvements in health, and savings in the health budget from treating conditions related to obesity (35).
- *Ensure that women who are pregnant or trying for a baby are supported to achieve a healthy weight before or after the birth:* Either through the provision of an NHS funded weight management service, a specialist service, or support from health professionals, ensure that women in Havering receive the correct advice about healthy weight, and support to achieve a healthy weight either before conception or after birth.
- *Continue investment in the assessment, treatment and prevention of childhood obesity, especially for under 5s:* Continue to commission the MEND programme, capitalise on opportunities through the NCMP to identify and overweight and obese children, and signpost them to treatment, continue to commit to raising the rates of breastfeeding. Investigate options for work with foundation years settings such as children's centre
- *Prevent the development of obesity by addressing the obesogenic nature of the environment in Havering:* Through partnership actions continue to reduce the obesogenic nature of the environment with a continuing commitment to the obesity strategy, and culture and leisure strategies, and active travel plans. Work to ensure that prevention of obesity is considered in other partnership strategies e.g. planning, housing and environmental health. Refresh the current obesity strategy in at a time appropriate to the 2013 transfer of public health responsibility.

7. FURTHER INFORMATION AND REFERENCES

a) Further information

Association of Public Health Observatories

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

Association for the Study of Obesity

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

BMJ Learning: Obesity Modules

[Obesity in Adults: Assessment and Management](#)

[Obesity in Children: Assessment and Management](#)

[Obesity: A guide to prevention and management - in association with NICE](#)

Change4Life

<http://www.dh.gov.uk/en/News/Currentcampaigns/Change4Life/index.htm>

Cochrane Library

<http://www.cochrane.org/>

Department of Health: Obesity Search

<http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=obesity>

Department of Health: Obesity publications for health professionals

http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Obesity/DH_078102

DirectGov – Children and Healthy Weight

http://www.direct.gov.uk/en/Parents/Yourchildshealthandsafety/YourChildsHealth/DG_066077

International Obesity Task Force

<http://www.ietf.org/>

Lancet Series on Obesity

<http://www.thelancet.com/series/obesity>

MEND Programme

<http://www.mendprogramme.org/>

National Obesity Forum

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

National Obesity Observatory

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

National Child Measurement Programme

http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthyliving/DH_073787

NHS Information Centre for Health and Social Care

<http://www.ic.nhs.uk/>

NHS Choices

<http://www.nhs.uk/>

NICE – for Obesity guidance

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

Obesity Learning Centre

<http://www.obesitylearningcentre-nhf.org.uk/>

School Foods Trust

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

World Health Organisation – obesity pages

<http://www.who.int/topics/obesity/en/>

<http://www.euro.who.int/physicalactivity>

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