CONSULTATION DRAFT

Healthy Leicester

LEICESTER’S OBESITY STRATEGY

Tackling Obesity

Draft 6 – 11 January 2007
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EXECUTIVE SUMMARY

Obesity is a very significant public health issue. The prevalence of obesity is increasing rapidly in all age groups across the UK and around two thirds of people in England are now over-weight or obese. The proportion of obese and overweight children is rising at an alarming rate. Obesity has very serious consequences for health – it is associated with many serious health problems including heart disease and strokes, diabetes, cancers. It has been estimated that obesity is responsible for 9,000 premature deaths each year and can reduce an individual’s life expectancy by, on average, nine years.

Being overweight or obese are more common issues in less affluent and socially disadvantaged groups, particularly amongst women. Levels of obesity also vary with ethnicity in both men and women in England. Among women, obesity prevalence is high for Black Caribbean, Black African and Pakistani women; Irish women all have levels of central obesity above that of the general female population, while Bangladeshi women are nearly twice as likely to have a raised waist to hip ratio as women in the general population.

Understanding the causes of obesity is central to tackling it. At a simple level, body weight is about the balance between energy intake and energy expended. Obesity is caused when people overeat in relation to their energy needs. This document identifies that there are complex economic, environmental, social and cultural factors influencing both the diet and the physical activity sides of the ‘energy equation’.

Evidence suggests that only a small proportion of people consume what is regarded as a healthy diet. The majority consume less fruit and vegetables and fibre than is recommended and eat more than recommended amounts of fat, saturated fat and added sugar and salt. Energy-dense foods (high in calories without being filling) are increasingly available, strongly marketed and relatively inexpensive. At the same time as it has become easier to take in more calories, energy expenditure has dropped considerably. Jobs are more sedentary and labour-saving devices continue to remove the need for physical activity from the tasks of daily life. Levels of walking and cycling have fallen dramatically, while the number of cars has doubled in 30 years. In Leicester, the recent Active People Survey showed relatively low levels of participation in sport and active recreation and increasing participation for females, deprived communities and ethnic minority communities presents a particular challenge.

Tackling obesity requires a long-term, multi-agency and multi-faceted approach to encouraging and enabling people to eat more healthily and become more physically active. Existing mainstream and innovative programmes need to be maintained and strengthened whilst new initiatives and approaches targeting communities that are most in need of support need to be developed and evaluated.

KEY MESSAGES
To be added
KEY FACTS - OBESITY

- In England, the proportion of men classed as obese increased from 13.2 per cent in 1993 to 22.1 per cent in 2005 and from 16.4 per cent to 21.9 per cent for women during the same period.

- In 2003, ex-regular cigarette smokers were more likely to be obese than current smokers and those that have never smoked.

- In 2004, among ethnic minority groups, Black Caribbean and Irish men had the highest prevalence of obesity (25 per cent each). For women, obesity prevalence was higher for Black African (38 per cent), Black Caribbean (32 per cent) and Pakistani ethnic groups (28 per cent).

- In 2002, the direct cost of treating obesity in England was estimated at between £45.8 and £49.0 million and between £945 million and £1,075 million for treating the consequences of obesity.

- Obese women are almost 13 times more likely to develop Type 2 Diabetes than non-obese women, whilst obese men are nearly 5 times more likely to develop the illness.

- In 2005, almost 871,000 prescriptions items were dispensed in England for the treatment of obesity compared with just over 127,000 prescriptions in 1999 (an increase of 585 per cent).

- Among boys and girls aged 2 to 15, the proportion who were obese increased from 10.9 per cent in 1995 to 18.0 per cent in 2005 among boys, and from 12.0 per cent to 18.1 per cent among girls. For those aged 2 to 10, the increase over the same period was from 9.6 per cent to 16.6 per cent for boys and 10.3 per cent to 16.7 per cent for girls.

Reproduced from The Information Centre – Statistics on Obesity, Physical Activity and Diet: England, 2006 (www.ic.nhs.uk)
INTRODUCTION

Obesity is associated with many serious health conditions, including heart disease, stroke, diabetes and cancer. It is also allied with psychological and social problems, including reduced self-esteem, increased social isolation, anxiety and depression.

It has been estimated that obesity is responsible for 9,000 premature deaths each year in England and can reduce life expectancy by, on average, nine years. It may soon overtake smoking as the greatest cause of preventable premature death in this country.

The 2004 Wanless report “Securing good health for the whole population” highlighted that a step change will be required to reach the ‘fully engaged scenario’ in which the level of public engagement in relation to health is high, life expectancy goes beyond current forecasts, health status improves dramatically, use of resources is more efficient and the health service is responsive with high rates of technology uptake. All providers – health service, schools, local authorities, other public sector agencies, employers, the private and voluntary sectors – will need to work together to develop opportunities for people to secure better health.

Tackling obesity was highlighted in the Director of Public Health’s Annual Reports of 2005 and 2006. Reducing the upward trend in obesity in both adults and particularly children remains a significant issue in Leicester’s Public Health Challenge.

Obesity is one of five key areas to be targeted in the Healthy Leicester campaign, launched in September 2006 and is backed by the city’s Primary Care Trust and Leicester City Council and supported by Voluntary Action Leicester representing the voluntary and community sector. It is an ideal opportunity to engage with people to tackle the growing numbers of overweight and obese people in the city.

Childhood and adult obesity are highlighted in Leicester’s Local Area Agreement, recognising the multi-disciplinary nature of the problem. It requires a focussed and co-ordinated response across all sectors if the upward trend in obesity is to be reversed.

BACKGROUND

The Health Scrutiny Committee in January 2006 had a comprehensive debate about tackling obesity in Leicester and agreed a way forward; to coordinate a multi agency group to develop a strategy for the city.

A multi-agency forum involving the Leicester City Primary Care Trust, Leicester City Council and Voluntary Action Leicester together with other groups and individuals was established to identify the issues, to drive forward joined-up planning and action and to develop a strategy for the city. It aims to
reduce obesity by encouraging increased physical activity and healthier eating, whilst also tackling the wider social and environmental factors.

Over the last 20 years there has been a rapid rise in the number of obese people in England and around two-thirds are now classified as overweight or obese.

In Leicester in 2005 there were an estimated:
- 82,000 adults considered to be overweight
- 43,000 adults who are obese
- around 5,000 adults who are very obese

Those 48,000 people in Leicester, who are obese, have much increased risks of heart disease, diabetes and other causes of early death.

**Developing a strategy to tackle obesity in Leicester**

This first consultation draft of the strategy highlights the issues, problem and prevalence of obesity in Leicester.

The drafting group have examined evidence on causes, costs, risks, prevention, management, interventions, initiatives happening locally and good practice from elsewhere to help shape the proposals.

The group considered the wealth of past and current initiatives and interventions that have happened in Leicester. Whilst many valuable and innovative solutions have been developed they have often been in isolation, in localities, with no mechanism to spread the good practice.

Before the strategy is finalised in Spring 2007 it will enable an opportunity to respond to a number of emerging issues; the NICE guidelines (published December 2006) and the Department of Health campaign ‘small change, Big Difference’ to be launched in January 2007. “Lightening the Load – tackling overweight and obesity - a toolkit for developing local strategies to tackle overweight and obesity in children and adults” a revision is to be published by the National Heart Forum and the Faculty of Public Health in Spring 2007 to incorporate the NICE guidelines and will be an important resource locally.

It also enables an opportunity to consider and incorporate findings from the Department of Health LEAP pilots and Sport England (Active People) on physical activity published in early December.

Evidence suggests that most interventions across the world have so far failed to halt the rise in obesity. Hence it is important to create a long-term strategy for Leicester that is informed, innovative, driven by local circumstances and needs with an inbuilt flexibility to respond to trends, emerging evidence and needs over the life of the strategy.

Tackling obesity will not be solved by short term, quick fixes. Changing lifestyles needs a long-term strategy with a 20-year vision and timeframe. This will need to be broken down into short (1-2 years), medium (3 – 7 years) and long term (8 – 20 years) action plans.
This consultation draft looks at the current situation in Leicester in the light of national, regional and local information. It identifies the gaps in our knowledge, but uses available evidence to identify priorities, recommend actions and develop a strategy for the city. This in turn will inform implementation planning for all partner organisations, to enable them to translate the broad priorities of this strategy into actions specific to their remits.

Identifying the resources to develop and implement the strategy will require creativity from all organizations and everyone involved. Earmarking money and resources that can be levered to address the problems is crucial if we are to halt the upward trends in obesity in the city.

**What is obesity? Measuring obesity**

When people become overweight or obese it is caused by an excessive accumulation of fat in the body, created when more calories are eaten than are burned off over a period of time.

It is often defined as being more than 20% above the desirable weight (overweight), or 30% above (obese), that is considered healthy for people of a certain age, gender, height and bone structure. Ethnicity is another important factor to take into consideration as levels of obesity vary with ethnicity in both men and women.

The traditional clinical definition of obesity in adults is based on Body Mass Index (BMI). This is calculated by dividing a person's weight in kilograms by their height in metres squared (kg/m2). From this, a person’s weight status is derived:

<table>
<thead>
<tr>
<th>BMI</th>
<th>Weight status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 18.5</td>
<td>Underweight</td>
</tr>
<tr>
<td>20.0 – 25.0</td>
<td>Normal</td>
</tr>
<tr>
<td>25.0 – 29.9</td>
<td>Overweight</td>
</tr>
<tr>
<td>30.0 and above</td>
<td>Obese</td>
</tr>
<tr>
<td>Above 40</td>
<td>Very obese</td>
</tr>
</tbody>
</table>

A person is considered obese if they have a body mass index or BMI of 30 or greater. A BMI of 25 – 29.9 is indicative of being overweight. More information about BMI and how to calculate it is given in Appendix 1.

**Risks of obesity**

Obesity increases the risk of premature deaths and diseases such as coronary heart disease, stroke, cancer and diabetes. It is estimated that obesity can reduce life expectancy by between 3 and 13 years with excess mortality being greater the more severe the obesity and the earlier it develops.
Excess weight creates complications and mortality rates have been shown to increase progressively with a BMI above 24. The risk of coronary heart disease (CHD) is doubled with an increase in BMI from 25 to 30, and nearly quadrupled if it is 29 or more. The risk of developing diabetes is 40 times greater if BMI is greater than 35.

Complications of excess weight
- Increased blood pressure
- Type 2 diabetes
- Stroke
- Coronary heart disease
- Gallstones
- Weight-related musculoskeletal disorders and arthritis (especially in weight-bearing joints)
- Cancers
- Breathlessness, sleep problems, respiratory disease
- Menstrual abnormalities
- Pregnancy complications
- Urinary stress incontinence
- Psychological problems e.g. social isolation, low self esteem, depression, binge eating, night eating, reduced employment prospects
- Physical mobility problems, perhaps resulting in incapacity

Costs of obesity

The House of Commons Health Select Committee estimated that, in England, in 2002 the economic costs of obesity were between £3.3 billion and £3.7 billion per year with 15.5 -16 million days of certified incapacity attributable to obesity. Illness associated with obesity gives rise to costs to the NHS and current figures do not take into account the amount of undiagnosed obesity, which if identified and treated would put huge demands on the NHS.

The societal cost of inactivity is estimated to cost the country in the region of £8.2 million.

Factors influencing obesity

At a simple level, body weight is about the balance between energy taken in and energy expended. People become obese when they eat more than their energy needs require. However complex economic, environmental, social and cultural factors influence both the diet and the physical activity sides of this energy equation, together with psychological factors.

The main causes of obesity have been brought about by environmental and behavioural changes that have led to more energy dense diets and a more sedentary way of life.

_Diet_
Only a small proportion of people eat what is regarded as a healthy diet. The majority consume less fruit and vegetables and fibre than is recommended, and eat more than recommended amounts of fat, saturated fat and added sugar and salt.

The current Government recommendation is that people should eat five portions of fruit and vegetables a day.

Evidence suggests that many people are aware of what constitutes a healthy diet, but there are many barriers to putting this into practice particularly for low-income households. They, as others, often do not have access to fresh fruit and vegetables locally, as many greengrocers have disappeared. Additionally, price is an issue.

Conversely energy-dense foods (high in calories without being filling) and convenience meals are strongly marketed and relatively inexpensive. People spend less time preparing meals and eat more processed food, and eating out and snacking are more common. Some 90% of food products advertised on children’s TV are high in fat, salt and/or sugar. In the absence of practical cookery lessons, young people are growing up without the skills to prepare healthy meals.

**Physical activity**

At the same time as it has become easier to take in more calories, people are expending less energy. Jobs are more sedentary and labour-saving devices continue to make the tasks of daily life less physical. Levels of walking and cycling have fallen dramatically, while the number of cars has doubled in the last 30 years. Television viewing has doubled since the 1960s, too, and other screen-based entertainment, such as computer games, has increased significantly.

The current Government recommendation is that adults should take a minimum of 30 minutes of at least moderately intense activity on at least five days a week.

In the UK only 37% of men and 25% of women currently meet these guidelines and over a third of adults are inactive. A fifth of children do less than 30 minutes of physical activity a day.

**Health inequalities**

Being overweight or obese are more common issues in less affluent and socially disadvantaged groups, particularly amongst women. Women in unskilled manual households are twice as likely to be obese (38%) than women in professional or managerial households (19%).

Levels of general and central obesity vary with ethnicity in both men and women in England.
Compared with the general population, levels of obesity are much lower in Black African, Indian, Pakistani, and, most markedly, Bangladeshi and Chinese men, who are around four times less likely to be obese than men in the general population. Black Caribbean and Irish men have similar levels of obesity to the general population. Despite low levels of general obesity, Pakistani, Indian and Bangladeshi men, have similar levels of raised waist to hip ratio compared to the general population. Black Caribbean, Black African and Chinese men are less likely to have a raised waist hip ratio.

Among women, obesity prevalence is high for Black Caribbean, Black African and Pakistani women and low for Chinese women. Again the pattern is different for levels of central obesity. Black Caribbean, Pakistani and Irish women all have levels of central obesity above that of the general female population, while Bangladeshi women are nearly twice as likely to have a raised waist to hip ratio as women in the general population.

**National policy framework**

*Choosing Health* commits to a cross-Government campaign to raise awareness of the health risks of obesity and the steps people can take to prevent it through diet and physical activity.

It’s two supporting action plans *Choosing A Better Diet* includes action on advertising and promotion of foods to children, simplified food labeling, obesity education and prevention, and nutritional standards in schools, hospitals and the workplace whilst *Choosing Activity* includes the drive to increase school PE and sport, local action to encourage activity through sport, transport plans, the use of green spaces and increasing activity through the use of pedometers.

The delivery of all these actions will be essential to meeting the targets for life expectancy and health inequalities. In addition, Choosing Health introduced a new target: to halt the year-on year rise in obesity among children under 11 by 2010.

The Government’s ‘Choosing Health’ paper identifies that activity and exercise is crucial if health is to improve recognising that increasing exercise will reduce the risk of chronic diseases and premature death and effective action on diet, activity and exercise will help tackle heart disease, cancer, diabetes, stroke, high blood pressure and high cholesterol.

**NICE guidelines**

The NICE clinical guideline (December 2006) is the first ever national guideline addressing the prevention and treatment of obesity in adults and children. It contains recommendations for the NHS, schools and early years providers, local authorities, employers and town planners whilst also setting out what individuals can do to help maintain a healthy weight. The NICE recommendations are attached at Appendix 5.
Active People Survey – results for Leicester

Sport England conducted the largest ever survey of sport and active recreation ever undertaken in Europe, over a twelve month period October 2005 - 2006.

The headline results for the East Midlands show that 20.8% of the adult population takes part regularly in sport and active recreation, compared to the national figure of 21%. 27.9% of people have built some exercise into their lives, however 51.3% of adults have not taken part in any moderate intensity sport and active recreation of 30 minutes duration in the last 4 weeks.

In Leicester the proportion of the adult population regularly (30 minutes moderate intensity exercise at least three days a week) participating is only 18.2%, putting Leicester in the bottom 25% nationally. Out of 354 local authorities Leicester was ranked 315.

The report showed disappointing levels of participation in sport and lower levels of participation for females, lower socio economic groups and ethnic minority groups presenting a challenge on how to motivate the public. Nationally recreational walking was the most popular activity, followed by swimming and the gym, the only activities recording over 10% of adults participating at least once a month.

The survey also measured the percentage of the adult population contributing at least one hour a week volunteering to sport. This can be an indicator of whether voluntary sports clubs and activities are available locally, and if opportunities for participation exist locally.

In the East Midlands the figure was 5.1% compared to a national figure of 4.7%. In Leicester the figure was only 3.4%, the second lowest in the East Midlands of the 40 local authorities.

National, regional and local context – statistics and targets

The proportion of obese and overweight children is rising at an alarming rate. Between 1995 and 2003, the prevalence of obesity among children in England aged 2-10 rose by nearly 4% from 9.9% to 13.7%. Overall, levels of obesity are similar between girls and boys, although there was a greater increase in obesity among boys during this period. The most significant rise in the eight years was among older children aged 8-10 and obesity was generally found to be highest among those living in inner city areas.

In England the proportion of overweight or obese adults has risen significantly in ten years (between 1993 and 2002), to 70% of men (up 8%) and to 63% of women (+7%). The proportion of these categorised as obese was 21% of men (+6%) and 22% of women (+4%).

More people in the East Midlands are obese than in England as a whole: 23% of men and 26% of women, which is 4% higher than the national figure.
Across all age bands, the prevalence of obesity in women in the East Midlands is consistently higher than nationally.

At a local level the implications for Leicester are enormous. The city is in the top 20% of areas in the country with the worst health and deprivation indicators. It has been identified by Government as a ‘spearhead area’ and is expected to achieve a bigger improvement in health at a faster rate than elsewhere.

**Government targets for the city**

**Local Area Agreement**

Reducing the year on year rise in obesity has been established as a target in the Healthier Communities and Older People’s block of Leicester’s Local Area Agreement (LAA). This recognises the multi-disciplinary nature of the problem and the need for a coordinated response across all sectors. However the lack of statistical evidence means that it is a development target – baselines and forecasts will be established once robust proxy indicators are established.

**Public Service Agreements (PSA) - Childhood Obesity**

In July 2004 a Public service Agreement target specifically on obesity was set for the first time - ‘halting the year-on-year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole’. The target is shared jointly by the Department of Health, the Department of Culture Media and Sport and the Department for Education and Skills in recognition that delivery will depend upon a concerted, joined-up effort across government and at local level.

Achieving the PSA target relies on effective action both nationally and locally by different agencies working together. Nationally, progress on meeting the target is being tracked through the Health Survey for England. But there is no existing comprehensive and reliable data at local level on child obesity. As a result local data is required to inform local planning and target resources and interventions; and to enable tracking of local progress against the PSA target. Guidance to PCTs, published on 11 January 2006, provides advice on how to measure the height and weight of children in maintained schools in two age groups: the reception year (ages 4-5 years) and year 6 (ages 10-11 years). DH expects PCTs to make arrangements with primary school headteachers to carry out measurement in schools and this is expected to take place in Leicester schools on the 2006/07 school year. This will provide an invaluable source of local information in future.

As an example, a neighbouring city in the East Midlands measured 81.29% of the target group of children and identified that 16.45% fall into the obese category.
PSA target - Quality and Outcomes Framework

Improving the quality of local information has been highlighted as a development goal. From April 2006 General Practices (GPs) have been required to record Body Mass Index (BMI) information for patients registered with them. Numbers of patients on GP registers aged 15 to 75 years with their BMI recorded in the last 15 months are now measured as part of the PSA target.

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There are no exact figures for the number of overweight or obese people in Leicester hence proxy indicators and other sources of information and data have been utilised.

The Leicester Lifestyle Survey was conducted during the first half of 2002, commissioned by what was then the Health Action Zone (HAZ). It was a survey of health related behaviour and attitudes of people living in Leicester, aged 18 years and over. Almost 9,500 adults were randomly sampled across the city, with an over sample in the HAZ priority areas, which equate to the current Leicester Partnership’s priority areas.

To begin to build up a picture of the extent of the problem locally the Annual Report of the Director of Public Health 2006 gives statistics by ward level for each of the nine localities designated as an Area Committee. Taken from the Health Survey for England it provides estimates on adult obesity (an estimate of those with a Body Mass Index over 30) and an estimate of adults consuming five or more portions and children consuming three or more portions of fruit and vegetables a day, following healthier diets. All the estimates can be found in Appendix 2. Consumption information is self reported and as such it should be treated as indicative, not robust.

Adult obesity - Leicester

The wards with the highest level of adult obesity (16+ year olds) are Eyres Monsell and New Parks at 28.3% and the ward with the lowest is Castle at 16.6%. These compare with the figure for the city as a whole of 23.9% and with England at 21.8%.

Fruit and vegetable consumption – Leicester

The Leicester Lifestyle Survey carried out in 2002 found that only one in ten people in the sample ate the recommended number of portions a day.

The ward with the highest estimate of adults consuming 5 or more portions of fruit and vegetables a day is Latimer at 33.4% and the lowest consumption is estimated to be Eyres Monsell at 13%. This compares with the estimate for Leicester at 23.2% and England at 23.8%.
For children the estimate of those consuming 3 or more portions a day is highest in Latimer at 60.8% and lowest in Eyres Monsell at 19.2%.

**Physical activity – Leicester**

The Leicester Lifestyle Survey found that only 26% of adults met the guideline that adults should take a minimum of 30 minutes of at least moderately intense activity on at least five days a week.

The Active People Survey, a survey of adults (16 years and over) participation in sport and active recreation in England, has been conducted by Sport England.

The interim figures for Leicester were that 18.9% of adults participate in at least 30 minutes sport on 3 or more days a week. This is adjusted for the CPA to take into account deprivation, which gives a figure of 23.8%. The final results put Leicester’s participation at 18.2%. Adjusted for deprivation that figure is 23.12%

The target for participation is 70% and Sport England’s target is at least a 1% rise in participation each year.

**Life expectancy - Leicester**

Diet and physical activity are factors contributing to life expectancy and Appendix 2 details what the expected life expectancy is by ward, compared to Leicester, 75.1 for males and 79.9 for females, and England, 76.6 for males and 80.9 for females.

The table also enables correlation of that information with the Index of Deprivation 2004, which identifies the percentage of the population in the 5% most deprived Super Output Areas (SOA’s).

The inequalities that exist between wards and localities in Leicester and the gap between Leicester and England give cause for concern, and will be addressed in the strategy implementation plan and ongoing work on health inequalities.

**Lifestyle factors - Leicester**

The Health Action Zone Leicester Lifestyle Survey (2002) surveyed health related behaviour and attitudes in Leicester. Only two-thirds of the sample rated their own health in general as being either good or very good.

Two lifestyle factors surveyed significantly influence obesity levels in the city – these are physical exercise and diet.

In terms of physical exercise only 24% of the overall sample reported doing physical activity 5 times a week, for 20 – 30 minutes (the recommended
level). 5% were too embarrassed by their size or weight to take more exercise, whilst 40% were too busy or had no time.

With respect to changes people would like to make to their diet 61% wanted to eat more fruit and vegetables, 44% wanted to cut down on fat in their diet, 42% wanted to eat less and 34% wanted to eat less convenience foods and take-aways.

**Prevalence of obesity in different age groups**

An obesity prevalence ready-reckoner developed by the national Heart Forum in association with the Faculty of Public Health has been used to estimate the number of adults (aged 16 and over) and the number of children aged 4 – 10 years who are overweight and obese. The ready-reckoner based on the registered population of Leicester as at the end of September 2006 gives the following picture. However, it uses national data from the Health Survey for England 2004 and does not take into effect local factors such as ethnicity, deprivation or other factors that might affect prevalence. The figures should be treated as indicative only but do help us understand the likely prevalence of obesity in different age groups.
### Obesity ready-reckoner – Adults aged 16 or over in Leicester

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
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<tr>
<td>16 - 24</td>
<td>25494</td>
<td>27009</td>
<td>2,040</td>
<td>3,241</td>
<td>2,294</td>
<td>5,672</td>
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<tr>
<td>25 - 34</td>
<td>29118</td>
<td>25993</td>
<td>5,241</td>
<td>4,419</td>
<td>5,824</td>
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<td>35 - 44</td>
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<td>6,450</td>
<td>5,361</td>
<td>7,739</td>
<td>8,265</td>
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<td>45 - 54</td>
<td>20783</td>
<td>18669</td>
<td>6,235</td>
<td>5,041</td>
<td>7,898</td>
<td>7,841</td>
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<tr>
<td>55 - 64</td>
<td>14487</td>
<td>13357</td>
<td>4,346</td>
<td>4,274</td>
<td>5,940</td>
<td>6,812</td>
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<tr>
<td>65 - 74</td>
<td>9398</td>
<td>10267</td>
<td>2,631</td>
<td>2,977</td>
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<td>6,263</td>
</tr>
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<td>75 plus</td>
<td>7670</td>
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<td>1,457</td>
<td>2,459</td>
<td>3,528</td>
<td>6,557</td>
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<td>Sub total</td>
<td>132,748</td>
<td>117,633</td>
<td>28,400</td>
<td>27,772</td>
<td>37,828</td>
<td>49,208</td>
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<td>Total</td>
<td>250,381</td>
<td>56,172</td>
<td>87,036</td>
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</tbody>
</table>

### Obesity ready-reckoner – Children aged 4 – 10 years in Leicester

<table>
<thead>
<tr>
<th>Age</th>
<th>Boys</th>
<th>Girls</th>
<th>Boys</th>
<th>Girls</th>
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<th>Girls</th>
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<tbody>
<tr>
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<td>2062</td>
<td>97</td>
<td>151</td>
<td>291</td>
<td>243</td>
</tr>
<tr>
<td>5</td>
<td>2075</td>
<td>1885</td>
<td>102</td>
<td>136</td>
<td>288</td>
<td>196</td>
</tr>
<tr>
<td>6</td>
<td>2134</td>
<td>1971</td>
<td>92</td>
<td>150</td>
<td>256</td>
<td>258</td>
</tr>
<tr>
<td>7</td>
<td>2124</td>
<td>1982</td>
<td>93</td>
<td>145</td>
<td>236</td>
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*International classification
*UK National BMI Percentile Classification
*Classifications to be clarified and added as footnote*
WEIGHT LOSS

Benefits of weight management - associated improvements in health

Weight loss in individuals that are overweight and obese can improve physical, psychological and social health. Even a moderate weight loss of 5 - 10% of body weight, in obese individuals, is associated with many health benefits. A weight reduction of 10kg can result in a 20% fall in total mortality, more than a 30% fall in diabetes related deaths and more than a 40% fall in obesity-related cancer deaths. Additionally, blood pressure improves, cholesterol levels fall and people report improved lung function and reduced back, joint pain and breathlessness.

The benefits of weight management are not only physical. Weight reduction in overweight and obese people can improve confidence, self-esteem and can help to tackle some of the psychosocial problems associated with being overweight.

Small changes can have a very positive impact on health and well-being.

Achieving modest weight loss

Two approaches are commonplace - either a whole population approach which aims to reduce the average risk of becoming overweight or obese across the whole population or an individuals-at-risk approach that aims to identify those at increased risk of becoming overweight or obese and offer them appropriate advice on how to reduce the risk.

At the whole population level, the aim is to improve the nutritional balance of the average diet with an emphasis on lower calorie alternatives, and to increase community-wide levels of physical activity.

With scarce healthcare resources, an individual’s at-risk approach may need to be identified before recommendation for intervention.

People at higher risk of becoming obese, with increased risk of health complications

- Children from low-income families. There is a correlation between low income and risk of developing obesity seen in children as well as adults
- Children from families where at least one parent is obese
- Individuals of Asian especially south Asian origin, for whom obesity carries an increased risk of metabolic syndrome and its consequences
- Ethnic groups with higher than average prevalence of obesity. The Health Survey for England (2004) showed the highest prevalence as follows: black African women (33.5%), black Caribbean women (27.9%), Pakistani women (26%), black Caribbean men (25%), Irish men (23.6%)
- Adults in semi-routine and routine occupations: 18.7% of women in managerial and professional households are obese compared to 29.1% of women in routine and semi-routine households
• People who have a physical disability which makes exercise difficult
• People with learning difficulties
• People with long term conditions
• Older people. Increasing age is associated with increasing prevalence of obesity up to the age of 64 years
• Those with BMI over 30
• Those with BMI 25-29.9 if other risk factors are present e.g. family history, smoking, hypertension, high cholesterol levels or those with two or more concurrent illnesses

Individuals are most likely times to put on weight around specific life events: men in their late 30’s, women entering long term partnerships, women during and after pregnancy, people with psychosocial problems like stress or depression, people who retire, people giving up smoking and women at the menopause.

WEIGHT MANAGEMENT AND PREVENTION OF OBESITY

Children

Evidence has shown that multi-faceted school-based interventions can help to reduce weight and obesity, especially in girls. Interventions include education about nutrition, promoting physical activity, reducing in sedentary behaviour, modification of school meals and tuck shops, behavioural therapy, teacher training and appropriate curricular material. Appendix 6 starts to capture this.

Targeting parents and children together can be effective, where family based interventions involve at least one parent in physical activity and health promotion.

In primary schoolchildren multi-faceted family-based behaviour modification programmes, where parents take primary responsibility for behaviour change can be successful.

In the long-term management of obese children, treatment should only be considered when the family is ready to change and willing to make appropriate changes to lifestyle. Lifestyle changes both within the family and social settings must be addressed (NICE, 2006).

To reflect this, the draft guidelines from the National Institute of Health and Clinical Excellence (2006) recommend multi-component interventions as the treatment of choice. These should encompass behavioural interventions to increase activity, decrease inactivity, and improve eating behaviour and quality of the diet.

In healthy children, 60 minutes of moderate intensity physical activity has been recommended per day as well as reducing physical inactivity to less than 2 hours a day. To reduce inactivity may mean focussing on after school time when many of Leicester’s children are involved activities in their faith and
cultural communities. It will be important to engage those communities in seeking innovative solutions within their curriculums.

The overall objective, a joint DfES and DCMS Public Service Agreement target, is to enhance the take up of sporting opportunities by 5-16 year olds. The aim is to increase the percentage of school children in England who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum to 75% by 2006 and 85% by 2008.

**Adults**

Community-based interventions for prevention of obesity and reducing weight in adults e.g. seminars, mailed educational information and mass media participation have not provided any conclusive evidence of effectiveness. The development of effective strategies is considered a priority given the scale of the problem (NICE, 2006).

A variety of approaches to weight management in adults have been assessed, including diet, physical activity, behavioural modification, drug therapy and surgery.

Multi-component interventions are the treatment of choice, and should include behavioural interventions to increase physical activity, decrease inactivity, improve eating behaviour and improve the quality of the diet (NICE, 2006).

It is recommended that pharmacological treatment should be recommended only after diet and exercise advice has been initiated (NICE, 2006). Anti-obesity medication treatments may have side effects especially if dietary advice is not followed alongside taking the medication. Side effects include diarrhoea, abdominal pain and discomfort, flatulence and fatty stools. Some medication can also cause headaches, anxiety, sleeplessness and palpitations.

Surgery is a treatment option for those who are severely obese provided a number of criteria are fulfilled. Evidence is necessary that all non-surgical interventions have been tried and failed to achieve and/or maintain clinically beneficial weight loss for at least six months.

**Medicines Management**

The preferred treatment of obesity is dietary, exercise and behavioural interventions, preferably with support and counselling. Drug treatment in adults should only be considered after dietary, exercise and behavioural interventions alone have been unsuccessful in achieving target weight.

Consideration of safety, evidence and achieving best value from prescribing should be involved in the decision to prescribe and the choice of medication. Discussions should take place with the patient regarding potential benefits, limitations, adverse effects, and mode of action and monitoring arrangements.
Prescribing anti-obesity drugs should not happen in isolation, but be used in conjunction with interventions and support. The anti-obesity drugs currently available are orlistat, which is a locally acting drug that affects fat absorption and sibutramine, which is a centrally acting appetite suppressant.

**Delivery of interventions**

Workplace settings have proved successful in introducing weight loss and treatment of obesity supporting workplace health promotion programmes to adults. Successful programmes were intensive interventions incorporating regular participation, associated dieting and supervised exercise supplemented with outreach and personal counselling together with reorganisation of the workplace.

**Joined up working with healthcare**

Healthcare professionals are an important consideration in any proposed intervention and should be involved them in the development phase. Successful interventions have included reminders to GPs to prescribe diets, brief educational interventions on obesity management delivered by behavioural psychologists to GPs, encouraging shared care between GPs and hospital settings, use of inpatient obesity treatment services and training for both healthcare professionals and leaders of self-help weight loss clinics.

**SUCCESSFUL WEIGHT LOSS AND MANAGEMENT**

Diet, increased physical activity and behaviour change are the main components that constitute effective management of obesity, including weight loss.

**Reaching the individual**

Individuals appeared to lose more weight at all times when treated on an individual basis compared to those treated in a group setting. When a spouse or friend accompanied individuals, weight loss was greater at 12 and 24 months, compared to those who were unaccompanied.

The need for a community based approach must recognise the difficulties individuals face when placed into an ‘obesogenic’ environment. It is clear that giving people information is not enough, when faced with the overwhelming lifestyle choices now available.

The successfulness of any approach should incorporate the 3 E’s: encouragement, empowerment and environment (Maryon-Davis 2005).

Encouragement encompasses simple interventions i.e. leaflets, one to one advice, campaigns or advertisements. Whilst a useful trigger to help people make healthy choices, by itself it is unlikely to be effective or sustainable without empowerment.
Empowerment involves the development of the skills, confidence and knowledge to enable people to make healthy choices. In turn, its effectiveness can be greatly increased by the environment created.

Environment – the right environment can make healthy choices the easy choices.

The NICE draft guidelines (2006) recognise this and are clear that a joined-up approach is required between local partners, both to identify what is already available and to facilitate change within a local context, tailored to the needs of the local community.

PRIORITIES FOR ACTION

The areas, communities and individuals with the worst problems need to be tackled first. Further work needs to be done to establish the priorities in respect of the obesity agenda, within the consultation process.

However, the strategy will need to be evolutionary with the flexibility to respond to emerging problems and issues.

The initial priorities identified by the drafting group from the information and data available to it are as follows:
- Children, particularly those under 11
- Deprived communities
- Ethnic minority communities identified with high prevalence

The lack of hard data and evidence locally means that further priorities may emerge as the implementation plan is put together.

Some sectors of the population are more at risk of developing obesity or its complications and where not covered by the priorities above, will be given further consideration as priorities for targeting preventive initiatives. These include:
- Children from low income families
- Children from families where at least one parent is obese
- Individuals of Asian origin, particularly those of south Asian origin
- Ethnic groups with a higher than average prevalence of obesity
- Adults in semi-routine and routine occupations
- People who have a physical disability
- People with learning difficulties
- Older people

Many factors affect a person’s ability to stay at a healthy weight or succeed in losing weight, and barriers to lifestyle change must be explored. Possible barriers include:
- lack of knowledge about buying and cooking food, and how diet and exercise affect health
- cost and availability of healthy foods and opportunities for exercise
• safety concerns, eg. walking, cycling
• lack of time
• personal tastes
• views of family and community members
• low levels of fitness, or disabilities
• low self esteem and lack of assertiveness

With these barriers in mind advice will need to be tailored for different groups particularly those from black and minority ethnic groups, vulnerable groups and people at life stages with increased risk of weight gain (pregnancy, menopause, stopping smoking).

A key theme throughout the strategy will be a focus on enabling and empowering people to take more responsibility for their own health.

A LOCAL OBESITY STRATEGY

The National Heart Forum/Faculty of Public Health “Lightening the Load” proposes a ten stage structure for developing a local strategy:

1. Making the case for a local strategy
2. Partnership working
3. Resource mapping – reviewing current activity and identifying gaps
4. Identifying priorities and target groups
5. Deciding aims, objectives, standards, targets and milestones
6. Choosing interventions
7. Understanding barriers and facilitating change
8. Infrastructure support
9. Monitoring and evaluation
10. Mainstreaming and sustainability

This consultation draft has followed a similar approach and stages 1 – 4 are well advanced. Following the consultation process and agreement of priorities and targets the Obesity Forum will develop an implementation plan. Appendix 6 gives the possible interventions that that the group will consider.

Appendix 6 gives a summary of national projects that may help determine interventions. It also gives initial thoughts around local priorities for physical activity and diet and nutrition.

A MULTI-AGENCY APPROACH

The successful implementation of Leicester’s Obesity Strategy will require the engagement and ownership of everyone in the city.

The Primary Care Trust and wider health economy have an important role to play in providing the leadership to the strategy’s next stages of development.
Leicester City Council as a regulator will continue through its interventions, to ensure food businesses meet their legal obligations and in particular that food sold in the city is safe to eat and appropriately labelled.

Through Trading Standards and Environmental Health it can promote more choice for the consumer by encouraging food manufacturers to adopt the Food Standards Agency voluntary traffic light colour labelling scheme to highlight high, medium or low amounts of fat, salt and added sugars in foods.

The City Council has power to control street trading, but at the moment its policy is only to do so in the City Centre. It intends to review its policy during the next twelve months to consider, in the light of consultation with stakeholders, whether controls should be extended to other parts of the City. If controls are extended, they could for instance apply to vendors located close to schools. Where the location or food was considered to be unsuitable it could decide not to issue street trading consents.

WHAT NEXT

This document provides a rationale and long-term strategic framework for obesity reduction in Leicester. Within this framework, a multitude of activities and programmes are already contributing to improving diet and increasing physical activity in Leicester. These programmes and important but they are not sufficient.

Existing programmes and activities need to be strengthened and maintained, including monitoring and evaluation to assess the relative success of different programmes and approaches. Based on existing successful local programmes and evidence from elsewhere, additional programmes of activity need to be developed and co-ordinated through an annual multi-agency action planning process. New programmes and activities should be targeted towards communities with the greatest health need.
APPENDIX 1 MEASUREMENT AND TABLES

BMI ready-reckoner

Circulated as a separate document as not yet imported into text
## APPENDIX 2
LEICESTER – OBESITY & LIFESTYLE DATA BY WARD

Lifestyle and deprivation data by wards in Leicester

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<th>Lifestyle ward estimates for 16+ year olds: (2000-2002)</th>
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Lifestyle ward estimates: Health Survey for England
Obesity Prevalence: Estimate of adults with a Body Mass Index greater than 30
Fruit & Veg consumption (adults): Estimate of adults consuming 5+ portions of fruit and vegetables in a day
Fruit & Veg consumption (children): Estimate of children (5-15 yrs) consuming 3+ portions of fruit and vegetables in a day
APPENDIX 3

INTERVENTIONS, INITIATIVES IN LEICESTER AND ITS LOCALITIES

There are a multitude of projects tackling obesity across the city at city, community and local level, too numerous to go into in this summary.

However it is important we identify the successful initiatives and build upon them and that we acknowledge the particular challenges that some localities face and seek to address them.

This section sets the scene for each of Leicester’s localities, where in October 2006 the community health development workers drew on their local networks and knowledge of their communities to develop a starting point for the development of locality Health Improvement Networks and Health Improvement Plans.

The localities match the 9 area committee neighbourhoods of Leicester drew together some of the opportunities and challenges they are facing that will be key factors in tackling obesity. This short summary from Choosing Health in Leicester’s Localities (Annual Report of the Director of Public Health 2006) captures the key factors appertaining to obesity and provides the local focus for an implementation plan for the city.

Of the many initiatives already happening in Leicester several are highlighted to show the sort of action possible such as the Healthy Schools programme, the Exercise Alliance and Local Sports Alliance, and other projects such as Bikes for All and Safe Routes to School. Dietary work includes projects involving community food workers in some deprived communities, community groups, youth workers and dieticians.

Area 1 Rushey Mead / Belgrave / Latimer

Characteristics
• over 50% of the population are from the Asian British community
• CHD mortality is high in Latimer and Belgrave wards
• adult obesity rates high in all wards, lack of exercise and dietary factors are risk factors

Good practice
• peer educators promote walks, health events, exercise classes
• both schools are accredited Healthy Schools
• Peepul Centre offers many social welfare and health care services

Priorities
• more physical activity incorporated into people’s daily lives
• weight management classes with healthy eating advice, culturally appropriate
• education about obesity and related diseases

Area 2 Humberstone and Hamilton / Thurncoat

Characteristics
• older population profile
• around a quarter of population could be described as obese
• mortality from circulatory disease significantly higher

Good practice
• planned Children’s Centres
• new library offers many community initiatives

Priorities
• coordinate efforts to improve health
• provide lifestyle and health advice

Area 3 Charnwood / Coleman / Evington

Characteristics
• around 50% of people from Black Minority Ethnic Groups
• over 25% in Charnwood and Coleman are estimated to be obese

Good practice
• sports activities, run by LCC sports development team but fixed term funding
• projects offering support and practical help to asylum seekers
• active tenants and residents associations

Priorities
• mental health issues, particularly depression and social isolation
• access to fresh fruit and vegetables
• counteracting high levels of take away food consumption
• lack of sporting activities

Area 4 Spinney Hills / Stoneygate

Characteristics
• 65.6% of residents are Asian and significant Somali communities
• prevalence of Type 2 diabetes is very high
• high rates of untreated diabetes, abnormal cholesterol levels and high blood pressure

Good Practice
• 2 Sure Starts and 6 accredited Healthy Schools
• GPs and health services work with community
• Actively involved voluntary organisations and faith groups

Priorities
• dietetic input to tackle obesity
• develop and sustain good practice, joining up communities and agencies

Area 5 Castle / Knighton

Characteristics
• large student population
• homeless and transient people

Good practice
• services and support for homeless and asylum seekers
• St Peters Health centre has good community involvement

Priorities
• community health development work
• diabetes management and education

Area 6 Freemen / Aylestone / Eyres Monsell
Characteristics
• majority are White British
• adult intake of fruit and vegetables low in Freeman and Eyres Monsell
• high incidence of CHD, cancers, diabetes
Good practice
• Saffron and Sure Start “Cook and Eat” programmes – healthy cooking
• Lifestyle Focus programme covers all aspects of health and well being
• community health alliance
Priorities
• partnership working
• improving diet
• increasing physical activity

Area 7 Braunstone Park and Rowley Fields / Westcotes / Western Park
Characteristics
• high levels of obesity and low levels of fruit and vegetable consumption in Braunstone Park and Rowley Fields
• significantly higher death rates from circulatory disease and cancers
Good practice
• leisure centre - opportunities for exercise and advice on healthy eating
• lifestyle initiatives: Fit and Active Buddies, Calorie Killers, Fit Chicks and TLC (teenage lifestyle club for sedentary 8-16 year olds)
• community food project
Priorities
• sustain and spread successful initiatives, securing long term funding
• lifestyle initiatives
• community food project

Area 8 New Parks / Fosse
Characteristics
• high proportion of young people
• over 20% of people have a limiting long-term illness
• fruit and vegetable consumption are believed to be low
Good practice
• walking group
• healthier lifestyles community initiatives
Priorities
• health and physical activity
• food and health

Area 9 Beaumont Leys / Abbey
Characteristics
• diversity of resident groups, speaking 11 different languages
• reports highlight obesity and low levels of fruit and vegetable consumption
Good practice
• 3 Healthy living centres
• Leicester NW Community Forum, empowering and inspiring local people
Priorities
• increasing physical activity
• improving diet

This summary enables us to realise how messages and interventions in the Implementation Plan and subsequent Action Plans will need to be tailored to meet local needs, but also helps us recognise the good practice that exists which can be shared between communities and localities.

CURRENT INTERVENTIONS IN LEICESTER

ACTIVITY AND EXERCISE

Fit Active Buddies

The FAB (Fit and Active Buddies) project uses sport to address health inequalities and works with isolated and excluded individuals to enable them to make lifestyle changes, resulting in long-term health benefits and increased self-esteem. FAB provides tailor made one-to-one mentoring and group support to participants who are sedentary, lack confidence, and have poor mental and physical health.

Sport acts as a catalyst and has delivered an impressive range of results many that directly address health inequalities, including organising over 10,500 exercise sessions, developing 95 volunteers, achieving 70 qualifications and supporting six people into employment. Participants have lost weight reduced cholesterol, lowered blood pressure and reduced diabetic and other medication.

Walking for Health

The Walking for Health campaign, in partnership with the Countryside Agency and the Primary Care Trust, offers a series of self-guided walks. Promoting healthy lifestyles, reducing obesity and improving high blood pressure are key objectives within LCC Community Plan and the city’s Local Area Agreement.

The scheme initially included Abbey Park, Spinney Hill Park, Cossington Recreation Ground, Watermead Country Park, Evington Park and Humberstone Park. Sites being developed include Rushey Fields, Knighton Park, Aylestone Hall Gardens, Victoria Park, Braunstone Park, Western Park, Bede Park and Fosse Park.

The walks are accessible for all and provide a healthy, picturesque, safe, friendly atmosphere for individuals to enjoy. The aim is to enable individuals to monitor their own health improvements over a ten-week period at a pace and time level that is suitable to the individual.
DIETARY WORK

Diet initiatives

Braunstone Community Food Project tackles health inequalities in Braunstone by improving food access, knowledge of healthy eating and food preparation skills. The project works with Sure Start, schools, youth groups, adults, elderly people, FAB and the Braunstone Health and Social Care Centre to deliver activities such as cook and eat sessions, after school family learning, single gender weight management groups, teenage lifestyle groups and weaning and breastfeeding support.

Leicester City Sure Start Children’s Centres Food Policy – developed in partnership between Leicestershire Nutrition and Dietetic Service and Leicester City Council this policy will be introduced into all Children’s Centres across the city to ensure that food provision in the centres meets nutritional guidelines and that consistent, evidence based nutritional information is available to staff and parents. The policy encourages a whole centre approach to food and nutrition.

Sure Start – In addition to the food policy, 3 Sure Start local programmes in the city commission the services of dietitians, nutritionists and community food workers to deliver weaning, breastfeeding, and healthy eating sessions to work towards preventing childhood obesity. Weight management groups also run for parents and carers.

Shape Up sessions – These are intensive weight management courses focusing on behavioural change. Courses have run successfully in both the east and west of the city.

Obesity training – Three 3 day training courses have been delivered to healthcare professionals, exercise professionals, community workers and community health development workers. These courses ensure that the public receive consistent, evidence-based messages and interventions from a large range of people who have a remit for obesity in their role.

ACTIVITY AND DIET

Muslim Women’s Healthy Lifestyle Club

The project sought to educate different women’s groups on exercise, healthy eating and nutrition by introducing regular exercise linked to healthier lifestyles and promoting a Muslim Women’s Healthy Lifestyle Club that engages with Muslim women who have not participated in sport for a number of years.

Targeting Somalian and Muslim women the women were asked to partake in gentle exercises to help gain back some movement and help build their confidence. The group started with gentle aerobics, gradually building up to
skill and team games thus enabling them to engage on a group basis for the first time in years.

**Allotments for All**

Allotments for All promote the wider health benefits of gentle aerobic exercise, organic vegetables and being outdoors. The measure of success is the number of allotment holders, which continue to increase.

**SCHOOLS**

**Healthy Schools**

The current healthy schools position in Leicester in implementing the National Healthy School programme, with specific reference to obesity, is positive. Since the local accreditation in 2001, the local healthy school programme has been successful in recruiting schools for accreditation. At the end of the summer term 2006 96 schools were registered. Of these 45 have received accreditation, 33 have achieved the now defunct healthy school standard which may have included the healthy eating theme. 12 schools are currently accredited to National Healthy School Status, which means they have met the requirements of the current healthy eating and physical activity themes.

The programme is closely linked with government targets to reduce obesity among children. These are addressed within the programme via the physical activity and healthy eating themes.

A community dietician has been employed from the Leicester, Leicestershire and Rutland Dietetics Service to work specifically with the local programme. All registered schools are entitled to one day’s support. This has taken many forms such as encouraging healthier eating by choosing healthy options at lunch time or during the school day and working with parents to provide healthier packed lunches.

A school chef of the year competition has been held for the last two years where local secondary schools have been tasked with encouraging students to produce a healthy meal on a fixed sum. This has been both popular and successful.

The local healthy schools programme has engaged with the Leicester Tigers Rugby Football Club to develop a healthy eating/physical activity programme for primary schools in the city. Evaluation of the programme has shown it to be a great success in getting over the healthy eating message and encouragement of physical activity.

Links have been established with the School Sports Co-ordinator Scheme and training and support is being developed to ensure that healthy eating, physical activity and consistent healthy lifestyle messages are an integral part of school ethos.
**School Meals in Leicester**

Whilst a school meal can only contribute to 18% of a child’s diet what children eat outside of the school day will always be more important than what they eat at school. However the school environment is crucial for modelling healthier choices and a healthier lifestyle in order to reduce childhood obesity as much as possible.

A registered dietitian currently works one day each week with City Education Catering, to monitor menus and ensure they comply with the Governments nutritional standards.

Following the high media profile of school food during 2005/6 and the introduction of new Government standards, primary school menus have been reviewed and a healthier menu of mainly kitchen prepared dishes using more fresh produce has been introduced.

From the Government’s injection of extra money into school food a School Food Co-ordinator has been appointed to work with catering staff and schools to promote and develop healthier food. A professional marketing company specialising in school meals has been appointed to drive up the take up of meals in secondary schools, which have seen a serious drop in numbers since the new standards were introduced.

**Activity and Healthy Eating After School Clubs**

The project educates young people and parents to eat a better-balanced diet and to increase the number of young people participating in physical activity out of school hours.

As part of the project, schools were invited to select groups of young people to take part in activities that would help to promote the development of personal and social skills, communication, teamwork and leadership as well as an awareness of the benefits of a healthy lifestyle linked to diet and exercise. The children attend sessions at the local leisure facilities where the staff delivered a sport/activity session followed by a healthy meal and discussion around diets and healthy eating options.

The short-term results show that young people continued in physical activity, had healthier eating habits and their self-esteem and confidence improved.
APPENDIX 4 – ADVICE AND GUIDANCE

The DH, amongst others, provides guidance on nutritional recommendations for the population and on the amounts and types of physical activity recommended and their effects on health.

Dietary advice:

Top Tips for Healthy Eating (taken from FSA Eat Well 8 tips for making healthier choices)

- Base meals on starchy foods
- Eat lots of fruit and vegetables
- Eat more fish – including a portion of oily fish each week
- Cut down on saturated fat and sugar
- Try to eat less salt – no more than 6g a day for adults
- Get active and try to be a healthy weight
- Drink plenty of water
- Don’t skip breakfast

Others suggest establishing a regular meal pattern, balancing food groups and reducing portion size all assist.

Guidance on the management of weight and obesity in children and young adults (2-18 years) issued by the Royal College of Paediatrics and Child Health and the National Obesity Forum is:

Dietary advice

- Whole family should have a balanced diet
- Regular family meals should be held around a table and snacking avoided
- Snacks as rewards should be avoided
- Healthy snacks such as fruit should be used as an alternative to crisps, sweets and biscuits
- Diet should include more whole foods that take time to eat and break down like fruit and wholemeal bread, chapatti or roti
- Diet should include at least 5 portions of fruit and vegetables a day
- Drinks should be low calorie preferably water
- Food should be grilled, boiled and baked rather than fried
- Less energy-dense foods like semi-skimmed milk should be consumed

Physical activity advice:

- Incorporate activity into normal lifestyle
- 10,000 steps a day

Guidance on the management of weight and obesity in children and young adults (2-18 years) issued by the Royal College of Paediatrics and Child Health and the National Obesity Forum is:

Physical activity advice
• Any increase in activity helps
• Sustainable lifestyle activity like walking, cycling and using stairs instead of lifts should be encouraged
• Whole family should develop an active lifestyle
• Children should be encouraged to walk or cycle to school
• Active play that is enjoyable and does not cause embarrassment should be encouraged

**Behavioural advice:**

• Set clear and realistic goals and targets
• Plan ahead
• Problem solve
• Small sustainable changes
• Small change, big difference

One portion of chips = 5,723 steps,
Translate these into calories? Weight Watchers points?
One doughnut = 3,215 steps
One onion bhaji = 2,286 steps

Impact

Statements from FAB, one-liners from Choosing Health commissioning pack.
Humanise.

Impact statements to be inserted – longer, happier, healthier lives - less deaths
APPENDIX 5 – NICE GUIDELINES

Individuals:

NICE recommends eating a healthy diet, basing meals on starchy foods, fibre-rich foods eating at least five portions of a variety of fruit and vegetables a day in place of foods higher in fat and calories, avoiding foods containing a lot of fat and sugar, eating breakfast, watching the portion sizes of meals and snacks, and how often you are eating and avoiding taking in too many calories from alcohol.

NICE also recommends that small everyday changes to your activity levels can make a real difference such as walking or cycling to the shops and avoiding sitting for too long in front of the television, at a computer or playing video games.

Adults could try to build physical activity into the working day. For example, by taking the stairs instead of the lift, or going for a walk at lunchtime.

The guideline also sets out how parents can help their children maintain a healthy weight. For example, parents can encourage children to play games that involve moving around a lot like skipping, dancing, running or ball games. Families should also try to be more active, by walking or cycling to school and the shops, or going swimming or to the local park together.

Local authorities

Local authorities should work with local organisations in the private and voluntary sector to create safe spaces for physical activity addressing, as a priority any concerns about safety, crime and inclusion. Specifically, they should:

- provide cycling and walking routes, cycle parking, area maps and safe play areas
- make streets cleaner and safer, by introducing measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, walking schemes and better lighting
- ensure buildings and spaces are designed to encourage people to be more physically active (for example, through the positioning and sign posting of stairs, entrances and walkways).

Schools

Schools should make sure the school environment and all school policies help children and young people to maintain a healthy weight, eat a healthy diet and be physically active. This includes policies relating to building layout and recreational spaces, catering (including vending machines), food and drink brought into school by children, the taught curriculum (including PE), school travel plans and cycling provision.
Workplaces

Workplaces should provide opportunities for staff to eat a healthy diet and be physically active, through:

- active and continuous promotion of healthy choices in restaurants, hospitality events and vending machines, in line with existing Food Standards Agency guidance
- working practices and policies such as active travel policies for staff and visitors
- a supportive environment for physical activity, such as well lit stairwells, and provision of showers and secure cycle parking
- support for out-of-hours social activities, lunchtime walks and use of local leisure facilities.

Healthcare

- Healthcare professionals should initially encourage adults who are overweight or obese to change their diet and become more physically active. If these lifestyle interventions don’t work, they should be given drug treatments
- Healthcare professionals should advise adults and children on how to maintain a healthy weight. This should include advice on:
  - how to be more physically active
  - eating five portions of fruit and vegetables a day
  - avoiding foods high in fat or sugar.
- Healthcare professionals should initially address lifestyle issues within the family when dealing with children who are overweight or obese. Drug treatments are recommended only if there are other physical problems (such as orthopaedic problems or sleep apnoea) or severe psychological problems.
- Healthcare professionals should only offer surgery as a last resort for adults with morbid obesity, if all appropriate non-surgical measures have failed to lead to weight loss after at least 6 months.
- Healthcare professionals should only consider surgery for young people in exceptional circumstances, and only after they have gone through puberty.

Key priorities for implementation

The prevention and management of obesity should be a priority for all, because of the considerable health benefits of maintaining a healthy weight and the health risks associated with overweight and obesity.
Public health

*NHS*

Managers and health professionals in all primary care settings should ensure that preventing and managing obesity is a priority, at both strategic and delivery levels. Dedicated resources should be allocated for action.

**Local authorities and partners**

- Local authorities should work with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned physical activity, addressing as a priority any concerns about safety, crime and inclusion, by:
  - providing facilities and schemes such as cycling and walking routes, cycle parking, area maps and safe play areas
  - making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes
  - ensuring buildings and spaces are designed to encourage people to be more physically active (for example, through positioning and signing of stairs, entrances and walkways)
  - considering in particular people who require tailored information and support, especially inactive, vulnerable groups.

**Early years settings**

- Nurseries and other childcare facilities should:
  - minimise sedentary activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions
  - implement Department for Education and Skills, Food Standards Agency and Caroline Walker Trust¹ guidance on food procurement and healthy catering.

**Schools**

Head teachers and chairs of governors, in collaboration with parents and pupils, should assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active, in line with existing standards and guidance. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), school travel plans and provision for cycling, and policies relating to the National Healthy Schools Programme and extended schools.

**Workplaces**

- Workplaces should provide opportunities for staff to eat a healthy diet and be physically active, through:

  ¹see www.cwt.org.uk
– active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients, in line with existing Food Standards Agency guidance
– working practices and policies, such as active travel policies for staff and visitors
– a supportive physical environment, such as improvements to stairwells and providing showers and secure cycle parking
– recreational opportunities, such as supporting out-of-hours social activities, lunchtime walks and use of local leisure facilities.

**Self-help, commercial and community settings**

Primary care organisations and local authorities should recommend to patients, or consider endorsing, self-help, commercial and community weight management programmes only if they follow best practice (see recommendation 1 in section 1.6.9.2 for details of best practice standards).

**Clinical care**

*Children and adults*

- Multicomponent interventions are the treatment of choice. Weight management programmes should include behaviour change strategies to increase people’s physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person’s diet and reduce energy intake.

*Children*

- Interventions for childhood overweight and obesity should address lifestyle within the family and in social settings.
- Body mass index (BMI) (adjusted for age and gender) is recommended as a practical estimate of overweight in children and young people, but needs to be interpreted with caution because it is not a direct measure of adiposity.
- Referral to an appropriate specialist should be considered for children who are overweight or obese and have significant comorbidity or complex needs (for example, learning or educational difficulties).

*Adults*

The decision to start drug treatment, and the choice of drug, should be made after discussing with the patient the potential benefits and limitations, including the mode of action, adverse effects and monitoring requirements and their potential impact on the patient’s motivation. When drug treatment is prescribed, arrangements should be made for appropriate health professionals to offer information, support and counselling on additional diet,
physical activity and behavioural strategies. Information about patient support programmes should also be provided.

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

- they have a BMI of 40 kg/m² or more, or between 35 kg/m² and 40 kg/m² and other significant disease (for example, type 2 diabetes or high blood pressure) that could be improved if they lost weight

- all appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least 6 months

- the person has been receiving or will receive intensive management in a specialist obesity service

- the person is generally fit for anaesthesia and surgery

- the person commits to the need for long-term follow-up

Bariatric surgery is also recommended as a first-line option (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m² in whom surgical intervention is considered appropriate.
APPENDIX 6 NATIONAL PROJECTS, LOCAL PRIORITIES

To be developed

Current national action programmes to be considered locally for inclusion in implementation plan:

Diet and nutrition:
- Sure Start – encouraging breast feeding
- Healthy Start – children in poverty have access to a better diet
- 5 A Day programme – increase access to and consumption of fruit and vegetables
- Food throughout the school day – Food in Schools programme
- National Healthy Schools Standard
- Amount of fat, salt and added sugar in diet
- Promotion and marketing of foods to children

Physical activity:
- Increasing physical activity levels in the community, learning from LEAP
- Pedometer and National Step-O-Meter Programme
- National PE, School Sport and Club Links Strategy
- National Healthy Schools Standard
- Children’s Play
- Green Gyms
- Walking the Way to health
- Well @ Work pilots
- Travel plans

Other national initiatives
- New GP contract – health promotion advice, QOF
- New pharmacy contract – public health role, weight reduction programmes
- New dental contract – relevant health promotion advice

Local priorities for action

Physical activity
- Increasing volunteering in sport
- Achieving a 1% increase in participation every year
- Opportunities for under represented groups – BME, over 60’s, 11-19’s
- Targeting difficult people/groups to reach
- 2012 dovetailing initiatives with Olympics
- Piggybacking successful initiatives eg Strictly Come Dancing, introducing dance classes

Food and nutrition
- Developing more community food projects
- Securing community food projects in deprived areas
- Rolling out Braunstone/FAB work
• Input to Childrens Centres, dietetic input

• Healthy eating campaign via pharmacies
• Sustaining public awareness work
• Food mapping
• Providing regular training sessions
• Utilising volunteers
• Consistent messages
APPENDIX 7 ACKNOWLEDGEMENTS, MEMBERSHIP, REFERENCES

To be inserted