



**Northamptonshire
Health & Wellbeing Board**

JSNA Report 2013

Obesity

Delivering meaningful, healthier, longer lives for the people of Northamptonshire

Introduction

- Obesity occurs when excess body fat has accumulated to the extent that it reduces life expectancy or increases the risk of health problems.
- Obesity increases the risk of many serious diseases including coronary heart disease, stroke, diabetes and cancer.
- Obesity also leads to disability and social care needs, and mental health problems.
- Obesity is more common in poorer people and there are variations in obesity prevalence between and within ethnic minority groups.
- The costs of health and social care for people with obesity are large and growing, both nationally and in Northamptonshire.
- One of the priorities in *In Everyone's Interest*, Northamptonshire's Health and Wellbeing Strategy 2013-16, is to reduce levels of childhood obesity.
- Effective interventions to tackle obesity in children and adults are yet to be developed and implemented to scale and efficiently in the County.

Key Points

- Obesity is common. About a quarter of adults in Northamptonshire are obese, a similar proportion to England as a whole. Obesity is more prevalent in Wellingborough than elsewhere in England.
- Almost one in ten children in Northamptonshire is obese when they start school, and nearly a quarter are obese or overweight. This proportion has risen recently.
- By year 6, more than one in six Northamptonshire children is obese and a third are overweight or obese.
- The National Institute for Health and Care Excellence (NICE) has published guidance on tackling obesity at a local level.
- Northamptonshire's obesity strategy 2010 to 2014 [Healthy Weight, Healthy Lives](#) set out the County's approach to preventing obesity, providing support for those who already have weight problems and encouraging healthy lifestyles in the population as a whole. However, the strategy is yet to be fully implemented.
- Northamptonshire County Council spends £351,000 per year on weight management services, comprising £181,000 on services for adults and £170,000 on services for children.
- Several weight management services are in place, though one has recently been de-commissioned. They appear not to be fully co-ordinated and sometimes are not well targeted. Many people do not attend or quickly cease attending. The extent to which the services comply with national guidance about how to support weight loss is not clear, the weight loss is usually too little to make a substantial difference to health and there is no information on participants' subsequent weight loss or gain.
- There are no audits, inspection reports, surveys of the views of service users or service evaluations.
- A survey of public opinion in Northamptonshire was conducted in July 2013. The reported barriers to having a healthy weight were commitment, convenience, cost, motivation, time, education, opportunity, friends and family.
- Total spending on the prevention and treatment of obesity in Northamptonshire is not known.

Recommendations

1. The Northamptonshire Health and Wellbeing Board should oversee the development of a coherent, community-wide, multi-agency approach to address obesity prevention and management addressing both adults and for children. The approach should include
 - raising awareness of the health problems caused by obesity and the benefits of being a normal weight
 - training to meet the needs of staff and volunteers, prioritising those who are working directly with local communities
 - influencing the wider determinants of health and healthy weight. This will include ensuring access to affordable, healthier food and drinks, and green space and built environments that encourage physical activity.
 - encouraging activities for both adults and children in a broad range of settings
 - providing lifestyle weight management services for adults, children and families
 - providing clinical services for treating obesity. This should include education for individuals who liaise with children and adults, so that every contact counts.

Health improvement partners are listed in Appendix 1 of [the Northamptonshire obesity strategy](#). They should

- integrate this work within the joint health and wellbeing strategy and broader regeneration and environmental strategies.
- provide funding and other resources for activities that make it as easy as possible for people to achieve and maintain a normal healthy weight. This includes, for example, activities to improve local recreation opportunities, community safety or access to food that can contribute to a healthier diet.
- look for opportunities firmly to engage a wider range of staff in tackling the obesity epidemic, for example health visitors, environmental health officers and community pharmacists
- involve the local community through Local Healthwatch, community involvement teams and community leaders. This provides a means to make clear the connections between obesity and other local concerns, such as crime, the siting of hot-food takeaways and alcohol outlets, the lack of well-maintained green space and pavement parking.
- ensure funding and resources beyond one financial or political cycle and have clear plans for sustainability
- optimise the positive impact and mitigate any adverse impacts of local policies on obesity levels. This includes strategies and policies that may have an indirect impact, for example, those favouring car use over other modes of transport, or decisions to remove park wardens that affect people's use of parks.
- assess regularly local partners' work to tackle obesity, taking account of any relevant evidence from monitoring and evaluation. In particular, they should ensure clinical commissioning groups' operational plans support the obesity agenda within the health and wellbeing strategy.

Local government and NHS employers in Northamptonshire should act as exemplars in developing internal policies to help staff, service users and the wider community achieve and maintain a healthy weight.

[NICE guidance](#) will be of value in this work.

2. The existing pattern of weight management service provision needs a review, which addresses the following questions:

- Who is the target population for each service?
- What data and information are required about service users? Specific information on disability, ethnicity, gender and age are needed to ensure that services are accessible.
- What do existing and potential service users want? What are their views of the existing service?
- How can the service be developed with input from the local community?
- How can the service be made attractive enough to secure adequate uptake and completion? What pattern of venues, times and interventions best achieves high uptake and maximum impact?
- How can more men be engaged by the services?
- Which packages of interventions are most effective and cost effective?
- What is the most appropriate intensity of programmes? How many interventions make up an effective programme? What percentage of the population should be reached?
- How does the commissioner ensure and confirm the service complies with national guidance?
- What is an acceptable weight loss target? How can the provider be incentivised to achieve it? Is there a place for payment by results, whereby the providers' revenue depends in part of participants achieving and maintaining weight loss?
- Should these services be commissioned separately, or as part of a wider lifestyle improvement service which also tackles smoking, physical activity, mental health and resilience and other community development priorities?

The National Obesity Observatory has published [a standard evaluation framework for weight management interventions](#). It will be of help in Northamptonshire in

- commissioning services of high quality
- assessing their effectiveness
- identifying gaps in provision.

Key early priorities are:

- Reviewing the weight management service so it is correctly targeted and effective
- Taking action on areas within the control of statutory partners, such as promoting healthy eating and physical activity among local authority and NHS staff
- Beginning work on a comprehensive obesity strategy.

This needs assessment should be read in conjunction with the reports on diabetes, cardiovascular disease and cancer.

Why is obesity important in Northamptonshire?

Obesity occurs when excess body fat has accumulated to the extent that it reduces life expectancy or increases the risk of health problems. People are considered obese when their body mass index, a measurement obtained by dividing a person's weight in kilograms by the square of the person's height in metres, exceeds 30 kg/m². People with a body mass index of between 25 and 30 kg/m² are considered overweight.

Obesity increases the risk of many serious diseases, including:

- coronary heart disease
- stroke
- type 2 diabetes
- cancers of the oesophagus, breast, endometrium, colon, kidney, pancreas, thyroid and gallbladder
- hypertension (high blood pressure)
- high levels of cholesterol in the bloodstream
- gastrointestinal and liver disease
- musculoskeletal problems such as osteoarthritis and lower back pain
- reproductive and urological problems
- respiratory problems such as asthma and sleep apnoea
- psychological and emotional problems such as depression, anxiety and low self-esteem.

The risks of the most important diseases associated with obesity are shown in Table 1. [Compared with a non-obese man, an obese man is five times more likely to develop type 2 diabetes, three times more likely to develop cancer of the colon and more than two and a half times more likely to develop high blood pressure, a major risk factor for stroke and heart disease.](#)

[Compared with a non-obese woman, an obese woman is almost thirteen times more likely to develop type 2 diabetes, more than four times more likely to develop high blood pressure and more than three times more likely to have a heart attack.](#)

Table 1 Relative risks of obesity for selected diagnoses, by gender

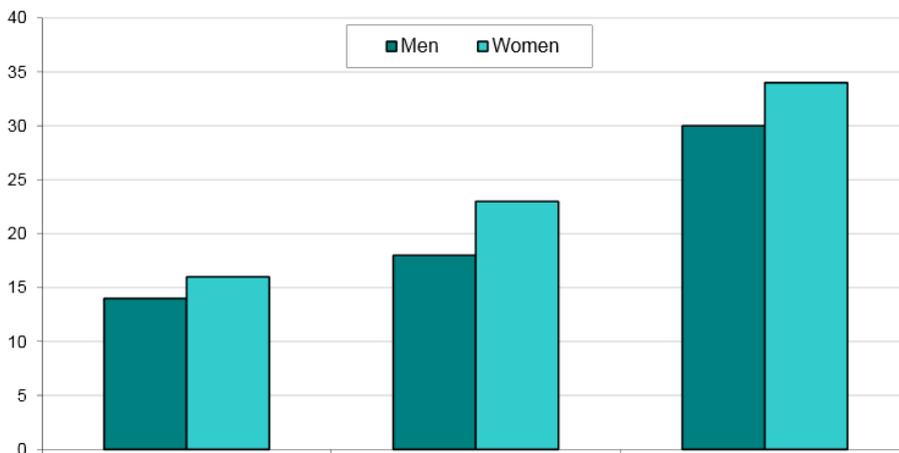
Diagnosis	Men	Women
Type 2 diabetes	5.2	12.7
Hypertension	2.6	4.2
Myocardial infarction	1.5	3.2
Cancer of the colon	3.0	2.7
Angina	1.8	1.8
Gall bladder disease	1.8	1.8

Ovarian cancer	–	1.7
Osteoarthritis	1.9	1.4
Stroke	1.3	1.3

Source: [National Audit Office](#)

These health risks in turn lead to long-term illness and disability. [Obese people are about twice as likely to have limiting long-standing illness than people of normal weight \(Figure 1\), overweight people having higher rates than people of normal weight.](#) This underlies the high impact of obesity on health and social care costs.

Figure 1: Limiting longstanding illness by body mass index and gender, England, 2011



Source: [Health Survey for England](#)

Obesity has complex causes, including excessive food energy intake, lack of physical activity and genetic susceptibility. Occasionally the cause is primarily a genetic abnormality, an endocrine disorder, medication or mental illness.

Obesity is not just a health and health care issue. Long-term conditions such as diabetes and cardiovascular disease lead to disability and social care needs. Adults with severe obesity may have physical difficulties which inhibit activities of daily living. This can have resource implications for social care, including

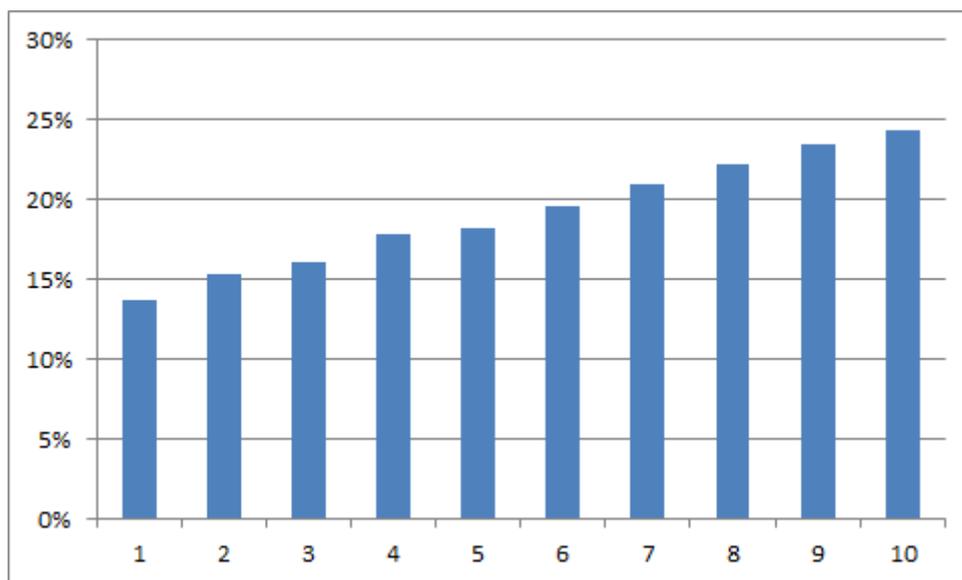
- housing adaptations such as specialist mattresses, doors, toilet frames, hoists and stair lifts
- the need for specialist carers trained in manual handling of severely obese people who are house-bound and have difficulties caring for themselves
- provision of appropriate transport and facilities, such as bariatric patient transport and specialist leisure services.

Obesity is higher in people affected by socioeconomic deprivation and there are variations in obesity prevalence between and within ethnic minority groups. Rising obesity rates can result in increased ill-health among disadvantaged communities and among [black and minority ethnic groups](#). This can lead to widening inequalities in health and social care. Obesity may also result in adverse social impacts such as [discrimination, social exclusion and reduced earnings](#).

Obesity also exacts a high economic price. [The direct NHS costs of treating overweight and obesity and the related morbidity in 2007 England were £4.2 billion, and the indirect costs of obesity are expected to reach £27 billion by 2015. By 2050, the NHS cost attributable to obesity and overweight may be £10 billion and the total costs £50 billion, at 2007 prices.](#)

There is a clear relationship between socioeconomic deprivation and obesity. For example, Figure 2 shows the prevalence of obesity in year 6 children, according to the deprivation of their school area. Obesity is more than 10% more common in schools in the most deprived areas than in those in the most affluent ones.

Figure 2: Prevalence of obesity by deprivation decile of school location, year 6 pupils, England, 2011/12



Source: [National Child Measurement Programme](#)
IMD decile - 1st decile (least deprived), 10th decile (most deprived).

There are also marked differences in rates of child obesity in different ethnic groups. For example, [the prevalence of obesity is highest in Black African and other Black children at Reception age. In Year 6, the prevalence varies between 17% in children of Chinese ethnicity to 28% in Black or Black British children. The figure for White children is 18%. Bangladeshi boys have a prevalence of obesity of 30% by Year 6.](#)

Northamptonshire's obesity strategy 2010 to 2014 [Healthy Weight, Healthy Lives](#) set out the County's approach to preventing obesity, providing support for those who already have weight problems and encouraging healthy lifestyles in the population as a whole. However, resource constraints made it impossible fully to implement the strategy.

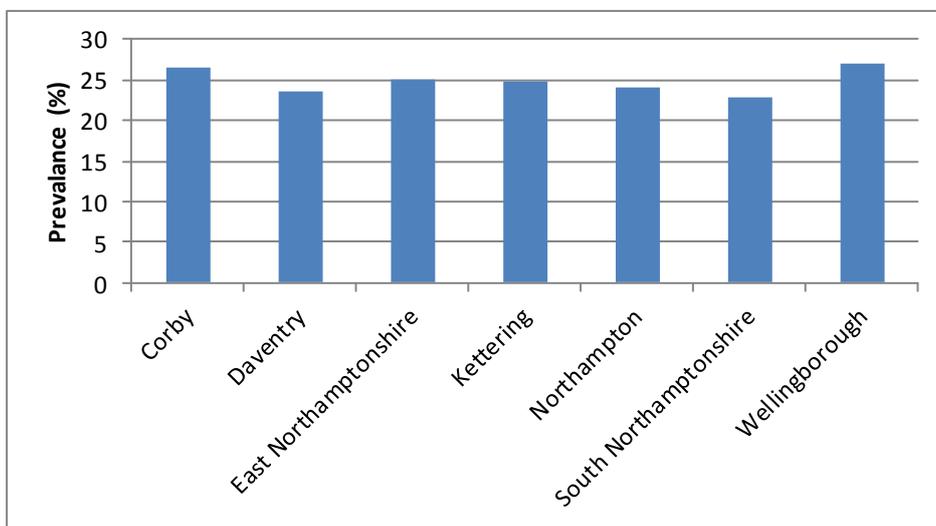
Reduction in levels of childhood obesity is a priority in *In Everyone's Interest*, Northamptonshire's Health and Wellbeing Strategy 2013-16. To tackle this, the parents of children who are classified as overweight or obese will be sent a letter informing them that a health professional will be in contact with them, unless they opt out. There are likely to be about 25,000 obese and overweight schoolchildren in Northamptonshire, so the implications of this approach are substantial. A service with the scale and reach to deliver this approach will be required to link with evidence-informed practice guidelines and necessary investment and is likely to be challenging to deliver.

Corby Clinical Commissioning Group's document *Shaping Healthcare Services in Corby 2013/14* lists as an aligned priority "children's welfare including managing childhood obesity". Nene Clinical Commissioning Group's *Top Priorities* does not mention obesity; the CCG's priorities should reflect the importance of obesity.

What is the local picture?

[An estimated 24.6% of adults in Northamptonshire are obese](#), about 134,000 people. This is similar to the England estimated obesity prevalence of 24.2%. Figure 3 shows the estimated prevalence of obesity in adults in each district in Northamptonshire. None of these rates differs significantly from the England average except Wellingborough, which has significantly higher prevalence of 26.9%.

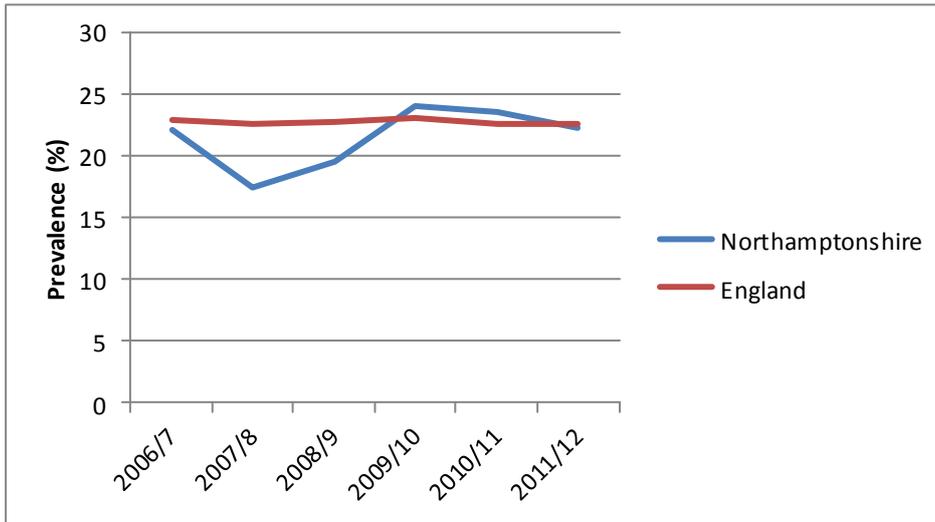
Figure 3: Estimated prevalence of obesity in adults, Northamptonshire, 2006-2008



Source: [Public Health England](#)

The prevalence of obesity in Northamptonshire reception year children in 2011/12 was 9.4%. Figure 4 shows the trend in obesity and overweight in reception-year children in Northamptonshire and in England. The local prevalence of obesity and overweight was significantly lower than in England in 2007/8 and 2008/9, but then rose and was significantly higher in 2010/11.

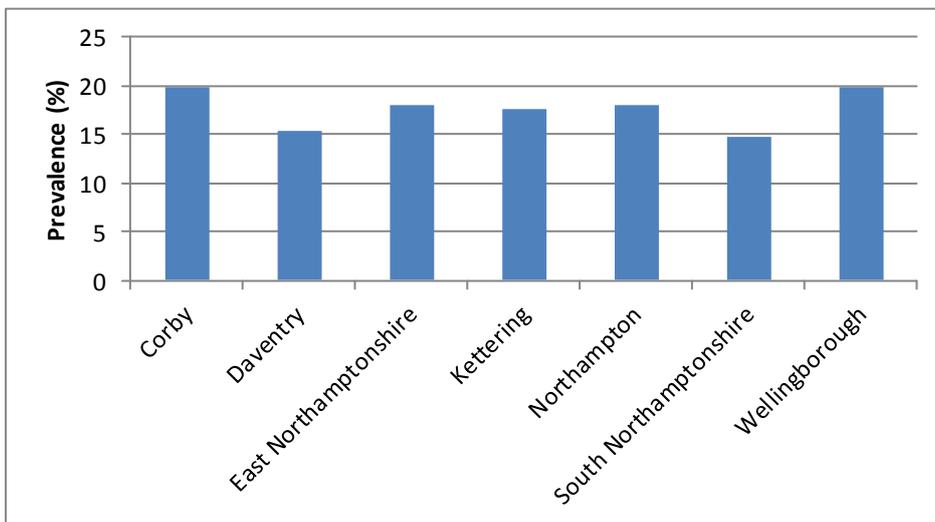
Figure 4: Prevalence of overweight and obesity, reception-year pupils, Northamptonshire and England, 2006/7 to 2011/12



Source: [National Child Measurement Programme](#)

Among Year 6 children in Northamptonshire, [the prevalence of obesity is high at 17.6%](#), but significantly lower than the England figure of 19.2%. Figure 5 shows the estimated prevalence of obesity in year 6 children in each district in Northamptonshire. None of these rates differs significantly from the England average except Daventry and South Northamptonshire, both of which are significantly lower.

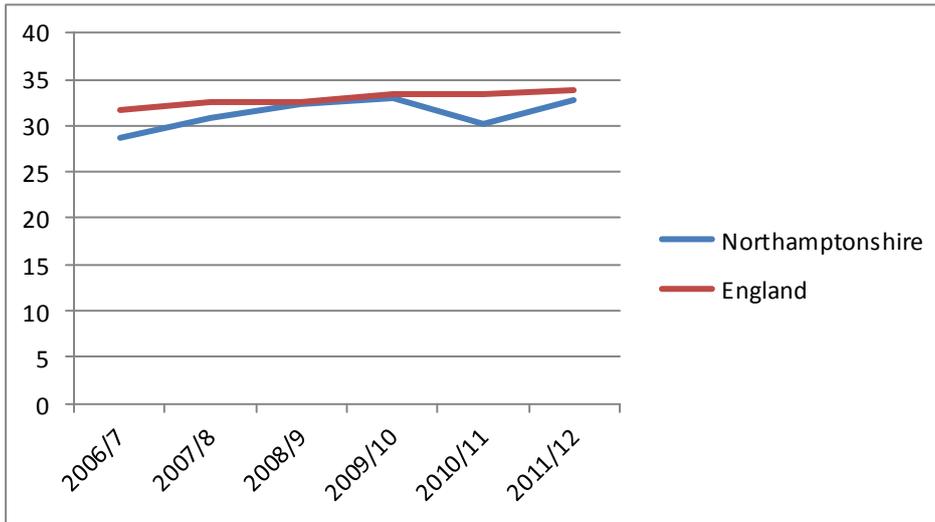
Figure 5: Prevalence of obesity in year 6 children, Northamptonshire, 2009/10 to 2011/12



Source: [Public Health England](#)

Figure 6 shows the trend in obesity and overweight in Year 6 children in Northamptonshire and in England. The local prevalence was significantly lower than in England in 2006/7 and 2007/8, but then rose. It was also significantly lower in 2010/11.

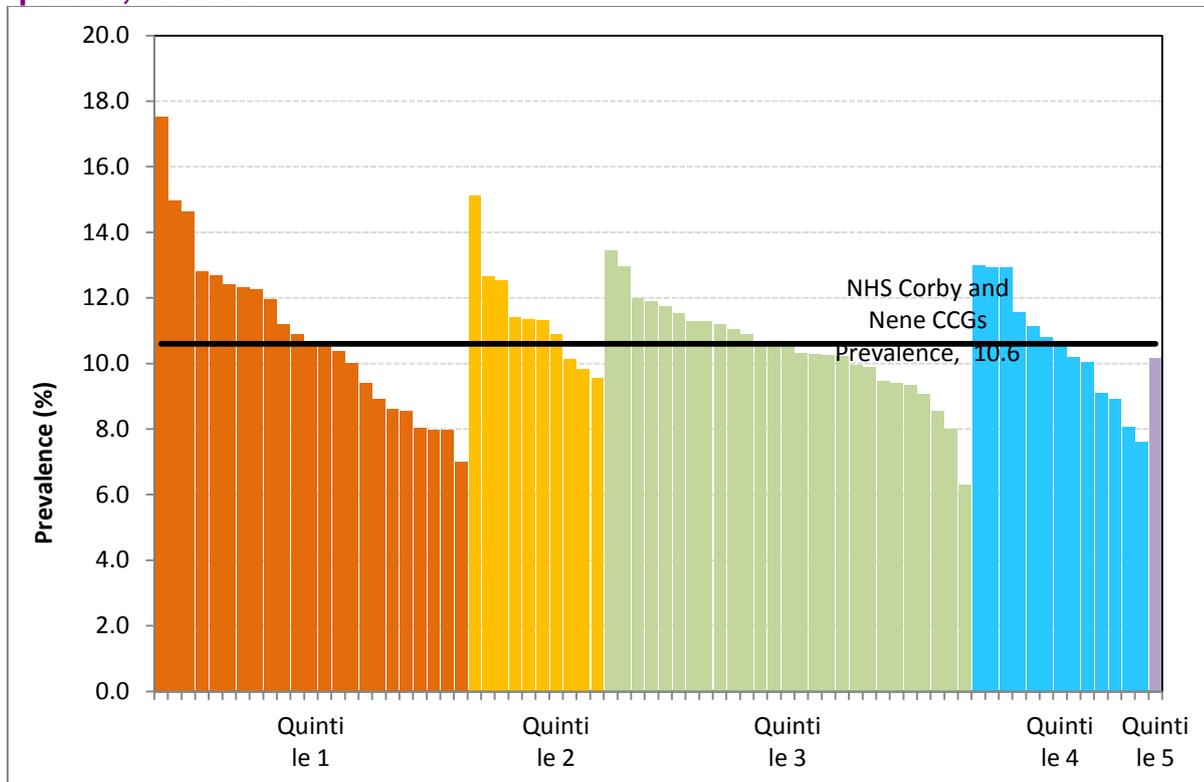
Figure 6: Prevalence of overweight and obesity, year 6 pupils, Northamptonshire and England, 2006/7 to 2011/12



Source: [National Child Measurement Programme](#)

There is wide variation between general practices in Northamptonshire in the proportion of registered patients recorded as obese (Figure 7). Although some differences will arise from variation in age, deprivation and ethnicity, it is likely that most practices are significantly under-diagnosing obesity in their registered patients. The overall recorded prevalence is 10.3%, less than half the true figure of 24.6%, confirming the existence of widespread under-diagnosis and under-recording.

Figure 7: Recorded of obesity, Northamptonshire general practices, by deprivation quintile, 2012/13



Source: [Northamptonshire quality and outcomes framework](#)

What inequalities are there in health status and access to services?

There are no local data on the prevalence of obesity in different ethnic and socioeconomic groups in Northamptonshire. However, national trends noted above are likely also to apply in the County. They will exacerbate existing socio-economic variations by increasing the risk of obesity-related disease in people already affected by worse health.

The risk of chronic disease and mortality at a given level of obesity is higher for people of South Asian ancestry than in a European population. For many ethnic minority groups, the prevalence of obesity in adults is higher in women than in men. It would be useful to have more information on the prevalence of obesity in different communities in Northamptonshire. Tackling obesity in ethnic minorities requires overcoming potential barriers to accessing health provision, such as translation, advice and practical activities reflective of a broad range of dietary requirements.

There is a reciprocal relationship between obesity and disability among adults. Adults with disabilities appear to be at higher risk of obesity than those without disabilities, and obese adults may experience disabilities related to their weight. For adults who are disabled and obese, the disadvantages of both conditions may be compounded. Disabled people may face barriers to physical access to weight management courses and problems reading material about weight management, so addressing these problems is important in assisting them to reduce their weight.

What is the evidence base for interventions? What is best practice?

The National Institute for Health and Care Excellence (NICE) has published guidance on tackling obesity at local level. It includes [public health guidance on working with local communities](#) to prevent obesity, [public health guidance on managing overweight and obesity among children and young people](#) and [a clinical guideline on the prevention, identification, assessment and management of overweight and obesity in adults and children](#).

Lack of information on the interventions provided in Northamptonshire means that we cannot assess their quality against these standards.

What is the pattern of services in Northamptonshire at present?

At present, there is no document which describes the current approach to dealing with obesity in Northamptonshire. It is not at present clear what policies and processes are in place to prevent obesity and to promote healthy eating and physical activity on Northamptonshire.

Northamptonshire offers a weight management service, available on referral to adults over the age of 18. It is provided by Weight Watchers and Pink Lady Studios. Weight Watchers is available at more than sixty venues across Northamptonshire. Pink Lady Studios has one facility in Northampton. General practitioners refer patients with a BMI of at least 30 kg/m², or with a BMI of 28 kg/m² and co-morbidity; attendance is free for 12 weeks. We cannot tell whether take-up reflects the local prevalence of obesity.

Until October 2013, Northamptonshire County Council commissioned [the Mind, Exercise, Nutrition, Do it \(MEND\) programme](#) from Northamptonshire Healthcare Foundation Trust, working in partnership with borough and district councils and leisure centres. This was a

twelve-week programme in which parents were invited to a group session with their child. Rather than focusing on weight loss, MEND used a practical interactive learning approach to teach children and parents weight management skills. This included inspiring families to adopt a healthier lifestyle, to enjoy preparing and eating healthy foods and to reading food labels and healthy shopping on a budget. Particularly obese children were referred to the specialist obesity dietician.

MEND achieved its outcomes, but was not sustainable in view of the large numbers of overweight and obese children eligible to use it. The service was therefore de-commissioned in October 2013. Lessons from commissioning MEND will be used in identifying a future service.

There are no audits, inspection reports, surveys of user opinion or evaluations for these services. It is therefore not clear what interventions these services offer and the extent to which they comply with national guidance.

The dietetic service includes a specialist obesity dietician service which provides one-to-one and groupwork interventions for obese adults and children at three sites in Northamptonshire. All school nursing teams in Northamptonshire were offered a three-day training course on obesity.

What is the cost of current services?

The costs of current services are as follows:

- Weight management for adults, commissioned by Northamptonshire County Council: £181,000. Most of this is spent on the Weight Watchers service, with the remainder spent on Pink Lady Studios.
- Children weight management, commissioned by Northamptonshire County Council: £170,000
- Dietetic services, commissioned by Corby and Nene Clinical Commissioning Groups: £950,000, though only a small proportion of this is for obesity services
- Drugs used to treat obesity: £8189. This is £13 per resident, much less than the England average of £330 per resident because orlistat is not generally available on NHS prescription in Northamptonshire, on grounds of lack of clinical and cost-effectiveness.

Northamptonshire County Council therefore spends £351,000 per year on weight management services, comprising £181,000 on services for adults and £170,000 on services for children.

There is no available information on how much is spent on bariatric surgery.

What is the evidence of progress in developing these services?

A description of these services is given first; observations and commentary appears at the end of this section.

Weight management services

A report from the MEND programme for 2012/13 showed that of 104 attendees, a quarter (26 people) dropped out of the programme. Average body mass index was reduced from 24.5 to 24, though [body mass index may not be a reliable guide to obesity in children. Instead, obesity in children is measured by reference to thresholds that take into account age and sex.](#) Between April and September 2013, there were 29 attendees, with 12 (30%) dropping out. Average body mass index fell from 29.6 to 28.1.

A separate report on all services included 665 referrals to the Weight Watchers service. Eighty-five percent were women. Initial body mass index measurements lay between 26.5 and 54.8, with an average of 38, again indicating the inclusion of people not obese and only slightly overweight. These people may have fitted the criteria for referral because of co-morbidity. At completion of the course, the average body mass index had reduced from 38.3 to 35.9, indicating a weight loss of about seven kg. Sixty-two percent of those who completed the course lost at least 5% of their body weight by the end of the course. This suggests that the course is of limited effectiveness, and its value should be reviewed.

Table 2 shows the recent results of the WeightWatchers service. There were 570 referrals in 2012/13, of whom 132 (23%) completed the course, with a further 57% still active at the end of the year. Average initial body mass index was 37.9. Forty-seven percent of those who began treatment achieved weight loss of at least 5%; because of non-attendance increasing the denominator, 66% of those who completed the course achieved this level of weight loss.

Table 2: Results from Weight Watchers, Northamptonshire, 2012/13 and 2013/14

	2012/13	April to September 2013
Referrals to date (number)	570	510
Completed course (number (%))	132 (23%)	75 (15%)*
Active (number (%))	325 (57%)	347 (68%)
Lapsed (number (%))	65 (11%)	36 (7%)
DNA (number (%))	17 (3%)	26 (5%)
Start weight to be confirmed (number (%))	31 (5%)	26 (5%)
5% weight loss (complete and lapsed) (%)	47%	58%
5% weight loss (complete only) (%)	66%	80%
Average BMI at start (kg)	37.9	38.2
Average weight loss (kg)	5.6	6.1
Weeks attended (complete and lapsed)	9.4	9.6
Weeks attended (complete)	11.8	11.9

Source: Northamptonshire County Council

* This figure is expected to rise as more participants progress through the course.

A report from the specialist obesity dietician service for 2012/13 records 1100 adult contacts and 516 referrals, less than a fifth of whom (103 people) joined the new patient group, and of these only 45 signed up for the education group. Forty percent of these people failed to attend or dropped out after the first session, leaving only 27 people (5% of all referrals) attending. The average body mass index of these people fell from 46.3 to 42.6. Some meetings were attended by as few as three people.

Finally, Pink Lady Studios received 76 referrals in 2012/13, of whom 72 started the courses. Most of these are still attending, and only a quarter (20 people) have so far completed them. Average body mass index at the start was 29.2, below the threshold for obesity, and only 12% achieved weight loss of at least 5%. The referral threshold was a BMI of at least 30, or of 28 and co-morbidity.

Manalive was piloted as a specific service for obese men. The pilot is now ended, but it has not yet been evaluated.

With the exception of Manalive, the services offered are universal, with no separate services targeted at ethnic minorities or others with special needs.

Several questions arise from these reports:

- How could the marketing and targeting of the service be improved?
- Could the size and location of the commissioned contracts better meet the needs of obese people?
- Are the services accessible to all who might benefit?
- Are they performing well enough? How do they compare with expectations and performance elsewhere?
- What is the quality of the process of care that they provide? To what extent does it comply with NICE recommendations?
- Why are default rates high in some cases?
- Is the weight loss achieved enough to make the courses worthwhile?
- How often is the weight loss sustained?
- Which of these services provide value for money?
- What is the role of each service? Do they form a co-ordinated set?

The information available does not at present allow us to answer these questions.

Bariatric surgery

Bariatric surgery aims to achieve weight reduction and maintain any loss by restriction of intake and/or malabsorption of food. In the East Midlands, surgery is only offered to patients with a body mass index of at least 50, or a body mass index of at least 45 and a serious co-morbidity which may be amenable to treatment if obesity is modified by surgery. About fifty such patients are expected each year in Northamptonshire. Surgery costs an average of £9000.

What do service users and carers say about their needs and the services that they receive?

No information is available about the views of service users.

A survey of public opinion in Northamptonshire was conducted in July 2013. The reported barriers to having a healthy weight were commitment, convenience, cost, motivation, time, education, opportunity, friends and family.

What additional information is needed?

Further information would be useful in these areas:

- Compliance of weight management service providers with NICE guidance
- The views of service users about the service received. This is of particular importance given the need for participants to complete the course and achieve substantial and sustainable loss of weight. A specific investigation of this could lead to the identification of ways of improving attendance and outcomes.

What are the recommendations to improve and support commissioning and forward planning to ensure quality of care and value for money?

There are three main conclusions that arise from our work:

1. Obesity is already a major problem in Northamptonshire. It prevents people carrying out a normal range of activities, it has implications for employment prospects and it causes disability, disease and premature death. Although no quantification of its impact on health and social care costs is available, these are already large. As existing obese people become older, gain further weight and develop complications of their obesity, and as the prevalence of obesity rises, these costs will become substantially larger. Obesity therefore merits high-level strategic attention.
2. Northamptonshire has no current public health strategy for obesity. The current approach is capable of improvement:
 - Northamptonshire should plan its approach to the prevention and management of obesity.
 - Reducing childhood obesity is recognised as a priority but it is not clear how this will be achieved. The focus on children who are already obese does not address the critically important public health issue of preventing the development of obesity in those not yet affected. There is no clarity yet about how to intervene with obese children and their families, which is the only specific action mentioned in *In Everyone's Interest*, Northamptonshire's Health and Wellbeing Strategy. The approach described in that document risks medicalising childhood obesity by involving a health care professional, rather than aiming for a more holistic public health approach. The MEND service appears to have adopted a broad and holistic approach, but was not sustainable in view of the large numbers of overweight and obese children eligible to use it, and was therefore de-commissioned in October 2013. Lessons from commissioning MEND will be used in identifying a future service.

- Childhood obesity is important, but an urgent task is to prevent and reduce obesity in adults, whose obesity will have adverse effects sooner. Northamptonshire should develop its strategy to include the prevention and treatment of adult obesity.
 - The lack of a strategy makes it hard to integrate the prevention of obesity with other local authority activities and responsibilities. These include leisure services, transport, the promotion of physical activity including walking and cycling, education, urban regeneration and the environment.
3. Services for obese people appear not to be part of a co-ordinated overall approach. They are sometimes not well targeted and may not appeal to the at-risk group. Many of those referred do not attend or quickly cease attending, those who do attend are often not obese (although they may qualify owing to the presence of co-morbidities) and few are male although this may change if the evaluation of the Manalive programme leads to its rollout. It is not clear how this compares with experience elsewhere and the extent to which the services comply with national guidance about how to support weight loss. The weight loss achieved is usually too little to make a substantial difference to health and there is no information on how often the weight loss is maintained, or continues to the point where weight becomes normal.

The following actions are recommended:

1. The Northamptonshire Health and Wellbeing Board should oversee the development of a coherent, community-wide, multi-agency approach to address obesity prevention and management addressing both adults and for children. The approach should include
 - raising awareness of the health problems caused by obesity and the benefits of being a normal weight
 - training to meet the needs of staff and volunteers, prioritising those who are working directly with local communities
 - influencing the wider determinants of health and healthy weight. This will include ensuring access to affordable, healthier food and drinks, and green space and built environments that encourage physical activity.
 - encouraging activities for both adults and children in a broad range of settings
 - providing lifestyle weight management services for adults, children and families
 - providing clinical services for treating obesity. This should include education for individuals who liaise with children and adults, so that every contact counts.

Health improvement partners are listed in Appendix 1 of [the Northamptonshire obesity strategy](#). They should

- integrate this work within the joint health and wellbeing strategy and broader regeneration and environmental strategies.
- provide funding and other resources for activities that make it as easy as possible for people to achieve and maintain a normal healthy weight. This includes, for example, activities to improve local recreation opportunities, community safety or access to food that can contribute to a healthier diet.
- look for opportunities firmly to engage a wider range of staff in tackling the obesity epidemic, for example health visitors, environmental health officers and community pharmacists
- involve the local community through Local Healthwatch, community involvement teams and community leaders. This provides a means to make clear the connections between obesity and other local concerns, such as crime, the siting of hot-food

takeaways and alcohol outlets, the lack of well-maintained green space and pavement parking.

- ensure funding and resources beyond one financial or political cycle and have clear plans for sustainability
- optimise the positive impact and mitigate any adverse impacts of local policies on obesity levels. This includes strategies and policies that may have an indirect impact, for example, those favouring car use over other modes of transport, or decisions to remove park wardens that affect people's use of parks.
- assess regularly local partners' work to tackle obesity, taking account of any relevant evidence from monitoring and evaluation. In particular, they should ensure clinical commissioning groups' operational plans support the obesity agenda within the health and wellbeing strategy.

Local government and NHS employers in Northamptonshire should act as exemplars in developing internal policies to help staff, service users and the wider community achieve and maintain a healthy weight.

[NICE guidance](#) will be of value in this work.

2. The existing pattern of weight management service provision needs a review, which addresses the following questions:

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- What data and information are required about service users? Specific information on disability, ethnicity, gender and age are needed to ensure that services are accessible.
- What do existing and potential service users want? What are their views of the existing service?
- How can the service be developed with input from the local community?
- How can the service be made attractive enough to secure adequate uptake and completion? What pattern of venues, times and interventions best achieves high uptake and maximum impact?
- How can more men be engaged by the services?
- Which packages of interventions are most effective and cost effective?
- What is the most appropriate intensity of programmes? How many interventions make up an effective programme? What percentage of the population should be reached?
- How does the commissioner ensure and confirm the service complies with national guidance?
- What is an acceptable weight loss target? How can the provider be incentivised to achieve it? Is there a place for payment by results, whereby the providers' revenue depends in part of participants achieving and maintaining weight loss?
- Should these services be commissioned separately, or as part of a wider lifestyle improvement service which also tackles smoking, physical activity, mental health and resilience and other community development priorities?

The National Obesity Observatory has published [a standard evaluation framework for weight management interventions](#). It will be of help in Northamptonshire in

- commissioning services of high quality

- assessing their effectiveness
- identifying gaps in provision.

Obesity provides an ideal opportunity to show the effectiveness of the Northamptonshire Health and Wellbeing Board in delivering health improvement, and of the County Council in leading this change. Obesity

- is a major threat to the health of local people
- is becoming more prevalent
- already contributes to health and social care costs through its impact on diabetes, cardiovascular disease, cancer, disability and mental health
- will substantially increase health and social care costs soon if not addressed successfully
- can only be successfully tackled through multi-agency, community-led approaches.