

**An Overweight and Obesity Strategy
for
Newcastle upon Tyne**

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Without AP or appendices

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1.0 Executive Summary

The extent of the problem is well known – at least among professionals. The profile of the issues that contribute to the rise of obesity has never been higher amongst commentators, the national media and TV. The solutions are not straightforward. Dealing with overweight and obesity involves a complicated and multidisciplinary approach. The basic principles are very simple though; you will be overweight if you eat more calories than you burn. Therefore the action we should take revolve around diet, physical activity and the wider environment

This strategy recognises that the basic principles of a better diet and more physical activity require a sensitive and well thought through delivery plan if we are to reduce obesity levels and reduce health inequality in our most disadvantaged communities. The strategy is one of the components of the Health Improvement Strategy for the City. This strategy was based on a series of community engagement exercises carried out by Community Action on Health which concluded that the two priorities for the City were reducing obesity levels and improving mental health. The importance of the latter cannot be underestimated. People are more likely to drink, smoke and over eat or eat the wrong food and exercise less, if they don't feel good about where they live, or their personal circumstances.

Due to the mix of social, economic, clinical and environmental factors that influence obesity levels our response has to be through a joined up plan of action that brings together voluntary, community and government organisations. Hence the need for an Obesity Strategy.

This Strategy provides us with a framework for local action. It seeks to achieve the following:-

- Understanding the extend of the problem in Newcastle
- Provide Leadership by bringing together the resources of the voluntary and community sector with the Council and the PCT.
- Choosing the most effective interventions to deal with the priorities in our City.
- Monitor and evaluate performance
- Building up local capacity particularly in training volunteers and staff.

In accordance with government recommendations, there is a particular focus on childhood overweight and obesity.

The Strategy has been managed as a programme of interlinked projects. They are broadly categorised into different areas:-

- Preconception and early years
- 5-11 year olds – food and exercise at school and food and exercise in the community
- 11-18 year olds food and exercise at school and food and exercise in the community
- Adults – Food and Exercise in the community

The key goals are simple. Firstly, to increase the general awareness of the issue of obesity. This is of paramount importance as it then allows us to signpost individuals into care pathways; Secondly, to increase understanding of the need for a balanced diet and to increase the number of families whose diet approximates the Eatwell Plate; and thirdly to increase the number of people exercising and the frequency at which they exercise.

This strategy recognises the fundamental importance of the voluntary and community sectors in the city, who have a pivotal role to play in reducing overweight and obesity levels in the city.

2.0 Foreword

Danny Ruta

Gina Tiller

Brenda Hindmarsh

3.0 Newcastle’s Vision and Sustainable Community Strategy

“Our vision for 2021 is that Newcastle will be a vibrant and sustainable city with a healthy, diverse, growing population. The city’s transformation will be substantially achieved, and this will have built upon our distinctive and unique character but, more importantly, Newcastle’s residents will enjoy equal chances in employment, education, housing and health.....”

The Newcastle Partnership’s ambitious vision for the future of the city, extracted above, is at the heart of Newcastle’s Sustainable Community Strategy and Local Area Agreement document (SCS / LAA). The SCS outlines the five big long-term challenges facing the city as:

- Economic competitiveness;
- **Demographic change and health;**
- Climate change;
- Housing and communities;
- Child Poverty



These ‘five big challenges’ will be addressed in the coming years through the aims, objectives and priority objectives (LAA) contained in the six themes of the SCS / LAA. These are:



- 1: Strengthening the economy;
- 2: **Wellbeing, health and independence;**
- 3: Managing environmental impact;
- 4: Creating and sustaining quality places to live
- 5: Safe, inclusive, cohesive and empowered communities
- 6: **Improving outcomes for children and young people**



Overweight and Obesity Strategy for Newcastle

This document, *The Overweight and Obesity Strategy for Newcastle* has a critical role to play in helping to deliver on Newcastle’s vision as set out in the SCS. The *Strategy* sets out in detail how partners will work together to enhance **wellbeing, health and independence** and improve **outcomes for children and young people** through tackling obesity in the city. Of course, addressing overweight and obesity in Newcastle needs to be everyone’s business – not just the obvious public sector agencies such as the Primary Care Trust and Council leisure services. We need to better understand how other strategies and plans (such as the *Employability Action Plan*, *Transport Plan*, *Alcohol Strategy* and our *Land Use Planning Documents* for example) can all contribute to a healthier city.



We are clear in our SCS that reducing obesity is a priority for the Newcastle Partnership. That is why our Local Area Agreement with Government contains

specific targets to tackle childhood obesity as well as encouraging more adults to participate in sport. This strategy provides the detail on how we will make that happen.

2.0

4.0 Our approach

This strategy uses “Healthy weight, healthy lives: a cross government strategy for England” as the basis for developing our approach in Newcastle. We have developed our own methodology, firmly based on a project management framework but essentially this strategy supports the five pronged approach advocated by Central government.

- Children: Health growth and healthy weight. There is growing evidence which points out that this is a fundamentally important aspect of a successful strategy. Preconception, breastfeeding and infant nutrition through to early years seem to pre programme future eating habits
- Promoting healthier food choices. Supporting government recommendations on a balanced diet.
- Building physical activity into our lives. In particular supporting active living throughout the lifecourse.
- Creating incentives for better health. Focussing on actions to maintain healthy weight in the workforce by the provision of healthy eating choices and opportunities for physical activity
- Personalised support for overweight and obese individuals. Providing pathways to manage overweight and obesity through weight management services.

4.1 A Life Course Approach

We have chosen to use a Life Course (see appendix 1) approach to identify project areas. We have agreed that we must ensure that there is adequate provision of universal preventative approaches through to targeted interventions for those that are already overweight or obese right across people’s life course. However, we have decided that we must also focus on preconception to early years interventions as these are the times in people’s lives where their biology is ‘programmed’ to be less obese in the future. There is a separate Newcastle Breastfeeding and Weaning Strategy dealing with some of these issues and our strategy fits with these.

5.0 Background

5.1 What is Obesity?

Overweight and obesity are terms used to describe increasing degrees of excess body fat which can lead to increasingly adverse effects on health and wellbeing. Potential problems include respiratory difficulties, chronic musculoskeletal problems, depression, relationship problems and infertility. The more life-threatening problems fall into four main areas: cardiovascular disease; conditions associated with insulin resistance such as type 2 diabetes; certain types of cancers, especially the hormonally related and large bowel cancers; and gallbladder disease. The likelihood of developing life-threatening conditions such as type 2 diabetes rises steeply with increasing body fat.

Overweight and obesity are commonly assessed by using Body Mass Index (BMI), which is defined as the person's weight in kilograms divided by the square of their height in metres (kg/m²). BMI is used because, for most people, it correlates with their proportion of body fat.

According to the World Health Organisation (WHO), in adults a BMI of 25 to 29.9kg/m² is defined as 'overweight', and a BMI of 30kg/m² or more is defined as 'obese'.

5.2 What is the Extent of the Problem?

Obesity is rising. Almost two-thirds of adults and a third of children are either overweight or obese, and work by the Government Office for Science's [Foresight](#) programme suggests that, without clear action, these figures will rise to almost nine in ten adults and two-thirds of children by 2050. Childhood obesity levels have risen dramatically, particularly in the last 20 years.

Severely obese individuals (BMI>45) are likely to die on average 11 years earlier (13 years for a severely obese man between 20 and 30 years of age) than those with a healthy weight¹. Obesity levels are related to socio-economic status with people from more deprived areas more likely to be obese.

5.3 The Size of the Problem in the UK

In Adults

- Almost two-thirds of all adults are either overweight or obese
- In both men and women, mean BMI generally increases with age
- A greater proportion of men are overweight than women and approximately three times as many women as men are severely obese
- Overweight and obesity are more common in lower socioeconomic and socially disadvantaged groups, particularly among women
- In women, the mean BMI is markedly higher in Black Caribbeans and Black Africans than in the general population, and markedly lower in Chinese. In men, the mean BMI of Chinese and Bangladeshis is significantly lower than that of the general population

In Children

- A greater percentage of boys than girls aged 2-10 years are overweight (including obese), and a greater percentage of boys are obese compared to girls
- Between the ages of 2 and 10, there is a steady increase in the proportion who are overweight (including obese) and obese only, in both sexes
- Obesity prevalence is lowest among children in managerial and professional households
- Obesity is almost four times more common in Asian children than in white children

5.4 The Scale of the Problem in Newcastle

¹ Fontaine, K.R., Redden, D.T., Wang, C. et al (2003) Years of Life Lost Due to Obesity. *Journal of the American Medical Association*; 289:187-93

- The extent of the problem in Newcastle is summarised in Figure 1. It is estimated that there are about 3000 children in Newcastle aged 2-10 who are classified as obese (over the 95th centile), with a further 2600 classified as overweight (over 85th centile). It is estimated that there are over 45,000 adults in Newcastle who are classified as obese (Body Mass Index or BMI over 30) with a further 77,000 classified as overweight (BMI between 25 and 30). Measurements of Year 6 pupils show that schools in areas with higher deprivation are more likely to have higher levels of overweight and obesity. A map of estimates of levels of obesity in the adult population is shown in Figure 2. These estimates are produced by the Department of Health, based on applying national data to the demographics of the local population and are indicative only.

Figure 1: the scale of the Problem in Newcastle

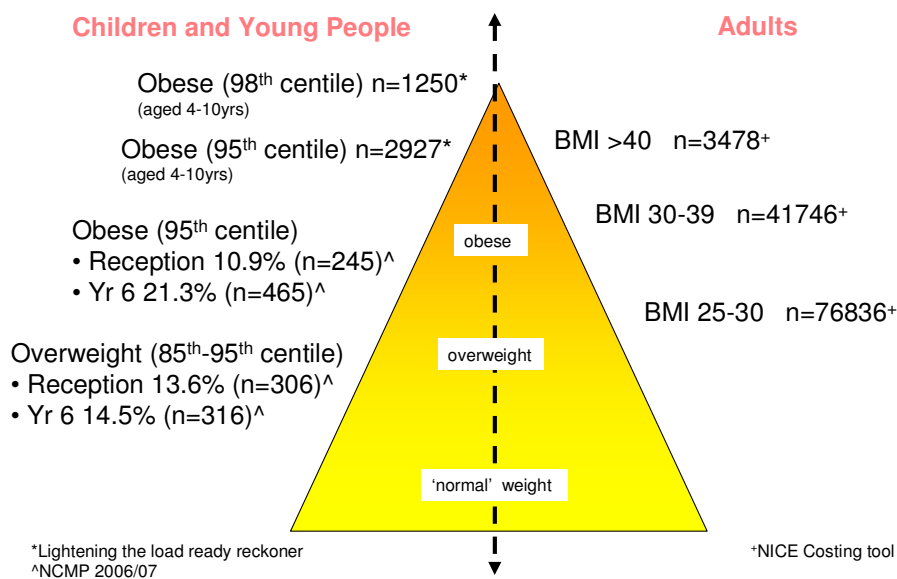
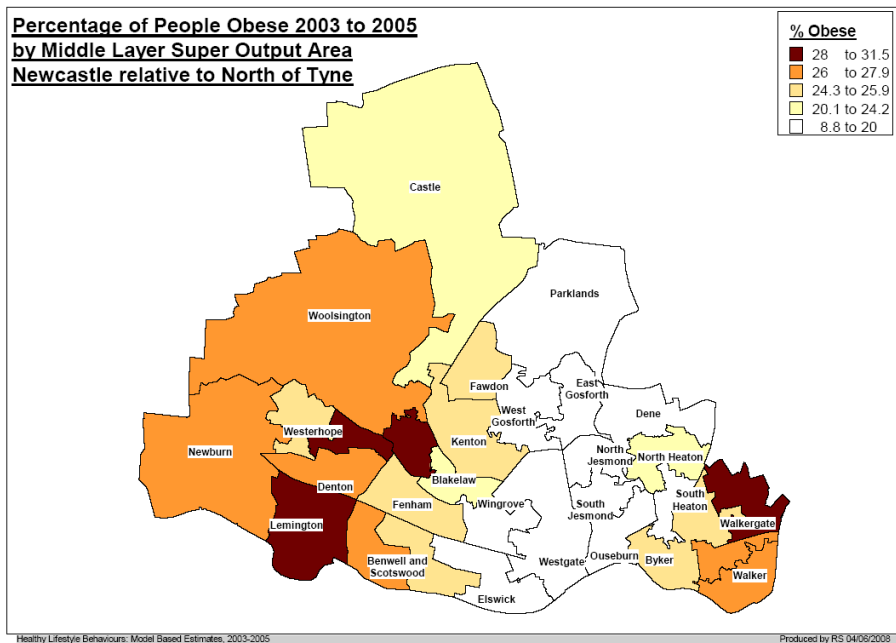


Figure 2: Estimated levels of Adult Obesity across Newcastle



5.5 National Guidance

At a national level the following Public Service Agreement (PSA) Targets have been set up the government departments with responsibility for health, education and sport:

- To halt by 2010 (from the 2002-2004 baseline) the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole
- Further enhance access to culture and sport for children and give them the opportunity to develop their talents to the full and enjoy the full benefits of participation by:
 - Enhancing the take-up of sporting opportunities by 5 to 16 year olds by increasing the percentage of school children who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum from 25% in 2002 to 75% in 2006 and to 85% by 2008 in England, and at least 75% in each School Sport Partnership by 2008
- By 2008, increase the take up of cultural and sporting opportunities by adults and young people aged 16 and above from priority groups by:
 - Increasing the number who participate in active sports by at least 12 times a year by 3%
 - Increasing the number who engage in at least 30 minutes of moderate intensity level sport at least three times a week, by 3%

- Ensure people have decent places to live by improving the quality and sustainability of local environments and neighbourhoods, reviving brown field land and improving the quality of housing:
 - Leading the delivery of cleaner, safer, greener public spaces and improvements of the quality of the built environment in deprived areas and across the country.

The Government Office for Science has published the Foresight Tackling Obesity: Future Choices Report (2007). This report states that scientific and technological advances are outstripping human evolution which has left us with an 'obesogenic environment'. This means that lifestyle choices around less healthy eating and involvement in less physical activity are now easier and have led to 'passive obesity'. The report goes on to state that there is still a lack of evidence of what behaviour change initiatives are successful in tackling obesity, and conclude that

'Preventing obesity requires changes in the environment and organisational behaviour, as well as changes in group, family and individual behaviour'.

The report concludes that no single or isolated initiative will be successful in tackling obesity and that a shift in thinking at individual, family, groups and society needs to take place. Government intervention and wide ranging policies would be required.

The Foresight report estimates that, based on current trends, levels of obesity and overweight will rise to 60 per cent in men, 50 per cent in women, and 25 per cent in children by 2050, with a further 35 per cent of adults and nearly 40 per cent of children overweight.

The development of activities delivered by community or voluntary sector based organisations supports the Government Office for the North East's (GONE) recently produced draft health strategy for the region, 'Better Health, Fairer Health', which states:

- All parts of the region **should establish** comprehensive, integrated, community-based obesity treatment and support services. These should be established to a regionally agreed specification of best practice.
- An infrastructure across the region **should be established** to support family interventions for seriously obese children and families, together with a clear specification of best practice in delivering these.

6.0 Understanding the Problem

We have looked at the evidence of what works; what local data is telling us; what people have said in previous consultation exercises; and mapped current service provision. We have used two approaches to understand the problem:

- A pyramid approach where interventions are targeted at the top to people who are already overweight and obese through to preventative interventions which are universally applied to the general population at the bottom
- A life course approach where we have examined the different stages of peoples lives where there is evidence that targeting interventions can prevent or be successful in treating overweight and obesity.

6.1 What evidence is there for what works

We have used National Institute for Health and Clinical Excellence (NICE) guidance, [Lightening the Load](#), and [Healthy Weight, Healthy Lives](#) to examine what works. The following NICE guidelines have been published which are relevant to obesity:

- [Obesity](#): the prevention, identification, assessment and management of overweight and obesity in adults and children (NICE)
- [Promoting physical activity in the workplace](#): Intervention guidance on workplace health promotion with reference to physical activity (NICE)
- [Physical activity and the environment](#): Guidance on the promotion and creation of physical environments that support increased levels of physical activity.

We have taken the approach that there are four areas of evidence which are interlinked. Mental well being is important as improving mental health improves obesity and vice versa.

The guidance and recommendations are based on the best available evidence of effectiveness, including cost effectiveness. The recommendations in the guidance cover advice on the prevention of overweight and obesity that applies to local authority settings such as early years and schools as well as recommendations on the clinical management of overweight and obesity in the NHS.

The guidelines key features include;

- long term investment
- partnership working across all agencies
- community involvement
- evidence-based solutions
- projects and programmes that provide the best opportunity for sustained actions
- interventions that address the needs of the local population

The Foresight report predicts that the costs of obesity are very likely to grow significantly in the next few decades. Apart from the personal and social costs such as morbidity, mortality, discrimination and social exclusion, there are significant health and social care costs associated with the treatment of obesity and its consequences, as well as costs to the wider economy arising from chronic ill health. The House of Commons Health Select Committee estimated that the total annual cost of obesity and overweight for England in 2002 was nearly £7 billion. This total includes direct costs of treatment, the cost of dependence on state benefits, and indirect costs such as loss of earnings and reduced productivity including an annual total of 45,000 lost working years.

If the current trend in rising obesity continues, the estimated NHS costs attributable to elevated BMI (overweight and obesity) for Newcastle² are set to grow from £24.9 million in 2007/08 to £37.4 million in 2015 and £57.5 million in 2050.

6.2. Choosing the Right Interventions

² using proportion of national estimates for Newcastle PCT 2006/07 allocations

The interventions we outline in the action plan have been selected based on local knowledge of what works best and what is sustainable. They represent a balance of preventative and reactive treatments, and are based on NICE guidelines.

Targeting the interventions and developing an approach which challenges behaviours is another degree of sophistication which requires local knowledge. The use of social marketing techniques in the “Lean East” project in the East of Newcastle indicates that this is an effective way of understanding and overcoming barriers.

The action plan for Newcastle fits into the “National Insight” social marketing research recently carried out by HM Government, which informs the “Change 4 Life” programme. The ‘National Insight’ research helps us understand the problem in Newcastle, make our intervention more sophisticated and build local capabilities. The research identified the following six market cluster types that relate to families:

- Pressured
- Inexperienced
- Treaters
- Engaged
- Traditional
- Active

A full description of each cluster is in appendix 3.

6.3 Equality & Diversity Issues

While there is considerable overlap between attitudes to diet and physical activity across all parts of the community, there are also significant differences. As a result, the research recommended that the following factors need to be taken into account:

- **Cultural appropriateness:** Families could be encouraged to be more active by providing opportunities to take part in culturally appropriate and acceptable activities, for example dancing walking, cricket and football. Adults may respond positively to opportunities to take part in activities with other people from the same ethnic background. Linking children’s physical activity to school (for example, by setting up more after-school clubs) could help parents – who tend to prioritise their children’s education over exercise – to see physical activity as more culturally acceptable.
- **Adapting existing eating habits:** Interventions should focus on ways of making traditional meals healthier, for example by using slow cookers or pressure cookers (rather than frying food) and swapping ghee, butter and palm oil for alternative such as olive oil. Guidelines should also be provided on ‘translating’ current health messages into specific changes to traditional meals, and on healthier snacks and treats for children.
- **Engaging community leaders and workers:** Getting key community influencers to promote the value of physical activity for both male and female children could help parents feel they have been given cultural and religious ‘licence’ to encourage their children to be more active. For Bangladeshi and Pakistani women brought up abroad, key influencers such as GPs, health visitors, community health promotion workers and practice nurses are also trusted sources of information.

- **Engaging the extended family:** Extended family members tend to have a significant influence over children’s food intake and family eating habits in general, especially in Bangladeshi and Pakistani families. Interventions must therefore target extended family members, in particular grandmothers. Engaging with these older members of the community could also be a step towards breaking down the widely held perception that an overweight child is a healthy child.
- **Using children to reach parents with limited English:** For Bangladeshi and Pakistani women brought up abroad, children are the most important source of Information about health issues and guidelines. Children are already feeding back to their parents about health issues covered during lessons and their school’s healthy eating policies.
- **Using one-to-one, community-based interventions:** These are crucial for those with limited English and whose engagement with mainstream media channels is therefore likely to be restricted. These interventions will need to be targeted at specific communities in order to overcome cultural and religious barriers.

6.4 Current Service Provision

Current services, programmes or interventions have been mapped against both the pyramid of need (see figures 3 and 4 **Error! Reference source not found.**) and the life course approach (see appendix 1) So that gaps can be identified and strengthened. Please note that the mapping has tried to capture the different types of intervention. It will not have captured all interventions and is therefore illustrative rather than comprehensive.

Figure 3: Current Service Provision - Children

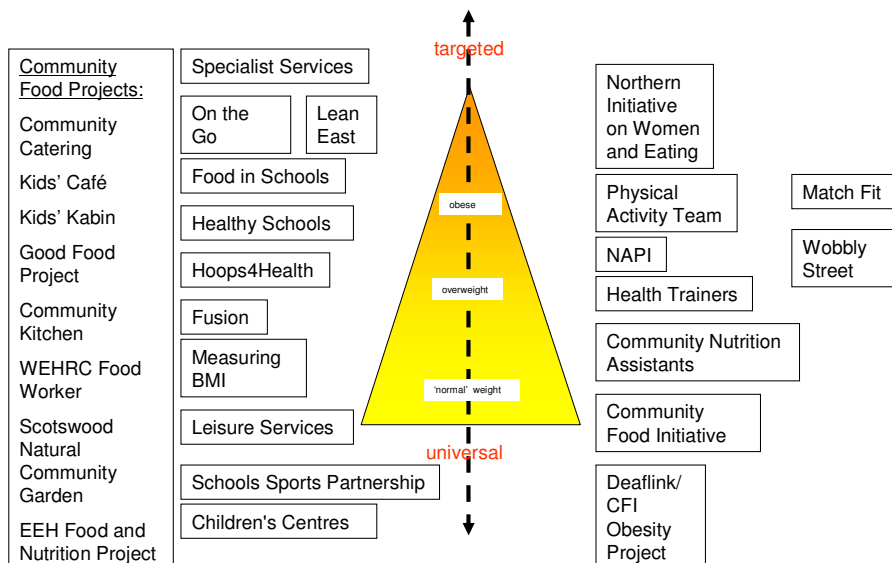
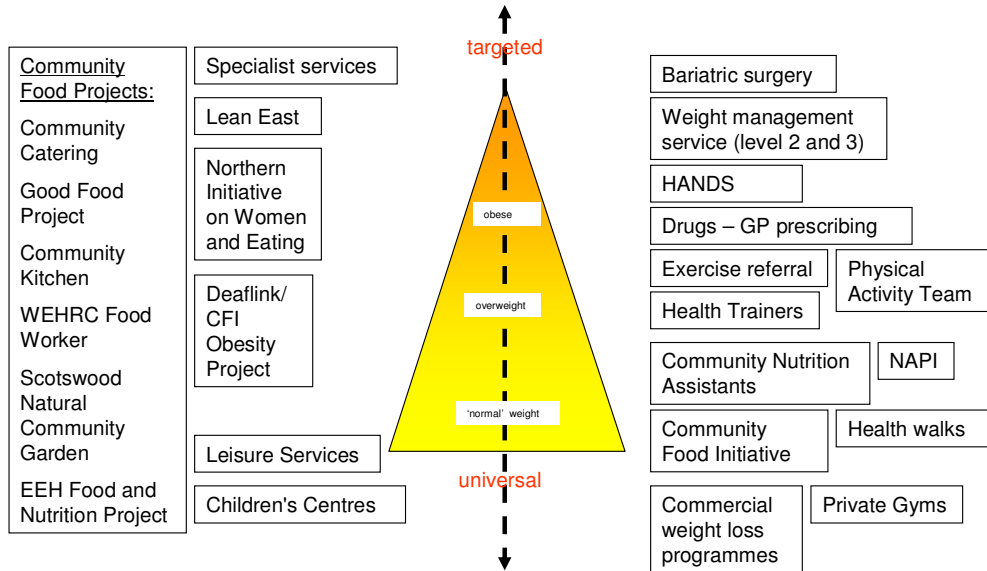


Figure 4: Current Service Provision - Adults



NB this is not intended to be a complete picture and it is recognised that there are many other projects that make a significant contribution. These diagrams are intended to illustrate the breadth of provision in the city

The level 3 specialist weight management programme

This programme was commissioned in May 2008 as an 18 month pilot project for adults with a BMI of either 35+ with 2 or more co-morbidities or for those considered to be morbidly obese with a BMI of > 40. Health outcomes include attendance for specialist assessment and intervention designed to inform and motivate individuals about their weight and behavioural lifestyle change interventions to promote weight loss, reduction in BMI and waist circumference. Other measures also include a walk test, blood pressure monitoring, blood biochemistry, anxiety and depression scores and mood and obesity related quality of life scores.

Funding was provided with a target of engaging 200 individuals in weight management assessment and intervention including group programmes and drug treatment. In addition, there are 3 group programmes, including one evening session, running in 2 localities in venues in Benwell and Byker (negotiated at no extra cost). The programmes run once per week for 8 weeks with a maximum of 15 clients. Each session includes 3 components – education about nutrition, physical activity and behavioural lifestyle change, physical exercise and goal planning and monitoring. The aim is to help and support individuals establish a successful weight loss routine. A proportion of clients have continued to attend clinic sessions and have been prescribed anti-obesity medication with further weight loss. Monthly monitoring is offered for these clients and the uptake of this intervention continues to rise.

Evaluation of the health outcomes associated with the programmes is at an early stage but clients who fully engage with the programme have lost weight and/or reduced their weight circumference, some quite significantly.

Despite opt-in and reminder systems, a significant percentage of those referred either do not attend (DNA) for assessment, attend for assessment but DNA for the group programme or refuse the programme at partial booking stage. Although the programme is on target to meet the 200 assessments, the total number of assessment slots required to meet this needs to be much higher.

Between May 2008 - February 2009, the programme received 376 referrals from primary, secondary and tertiary services and the referral rate is impacting on waiting times for both for initial assessment and for group programmes. It has always been acknowledged by the professionals involved in both the level 2 and level 3 programmes that the potential demand for both levels would be much greater than their capacity.

Pressures on the Programme

Responding to over demand is a significant issue. The programme requires guidance about how to manage the over demand. Further, the programme has not had capacity to provide training and support for primary care and other referrers in providing first line help and advice to people identified as significantly overweight. This may be a factor contributing to the number of people who do not attend for assessment or intervention, and those who attend but who are not ready to commit to a weight loss programme. Readiness for change and motivational strategies are yet to be developed at level 1.

Current funding does not cover management, venue or equipment costs and retaining experienced staff has proved difficult given the part-time and short-term nature of the pilot. There is also a lack of clarity about realistic goals for health outcomes. Some other difficulties encountered with referrals include the lack of information regarding the clients such as being wheelchair users, blood tests being incomplete, and clients being referred to both the level 2 and level 3 programmes.

Requests have also been received for home based assessments but due to capacity issues it is not possible. Clients who have completed the 8 week programme but do not require pharmacological interventions are currently discharged back to primary care for follow up. These clients have also expressed a wish to continue to have longer term support from the programme and drop in clinics could meet this need. Provision of longer term support of clients will also be a capacity issue if 6 months follow up for those on medication is undertaken in primary care. NICE guidance also suggests the need for support for individuals awaiting and recovering from bariatric surgery. Informational systems including pathway tracking and health outcomes still require further development.

6.5 What Previous Consultations Told Us

Community Action on Health (CAOH) held events in August 2006 to identify community themes and issues for inclusion in the 10 year Health Improvement Strategy. Issues identified around obesity include:

Education / awareness issues

- more education around healthy food opinions and nutrition
- more education around benefits of being active
- more education within schools

- Health warnings on junk food

Culture issues:

- More home cooking
- Employers taking more interest in the health of employees
- Diet is key to health, encourage healthy eating
- Lifestyle education

Support issues:

- More supermarkets offering more fresh food
- Access to organic fresh food at local shops
- Improved access to activities
- More healthy living projects
- More healthy eating centres – breakfast clubs for children and older people
- More clean, green spaces
- Affordable leisure activities
- More support for people to produce their own healthy food
- Support information should be easy to understand

A number of outcomes and actions were identified during action planning events for the Health Improvement Strategy in December 2006:

To tackle the growing rate of obesity a number of **outcomes** were suggested:

- Obesity levels in children
- Physical activity levels in children
- Obesity levels in adults
- Physical activity levels in adults
- Levels of social isolation
- Levels of expectation about good diet and nutrition
- Access and utilization of green open spaces
- Consumption of good quality food products

The following specific **action points** were suggested:

- Deployment of community nutrition assistants
- Community cooking skills/courses
- More funding for green spaces
- Ensure facilities don't provide unhealthy snacks
- Proactive support for local shops
- Schools need to provide a range of options in addition to sport i.e. exercise options that are not competitive
- Free leisure facilities and public transport for young people
- Encourage activity as part of life- not as separate activity
- More lobbying about food marketing and the need to be able to compete to promote health messages
- Pricing policies that encourage healthy choices

7.0 The process

7.1 The project plan

We have used the Newcastle project planning framework to develop the Obesity Action Plan using the Life Course approach explained earlier (see Appendix 1). In the light of this the following project areas have been determined.

Early years (0-5 year old) interventions
 Children and young people (5-11 years)
 Children and young people (11-18 years)
 Adults (17+)
 Spatial planning
 Weight management

There is a large body of evidence which indicates that interventions in the preconception, maternity breast feeding and weaning stage have a fundamentally important effect in pre programming children to grow into a leaner adult. There is also some evidence that the way we plan our communities can have an important affect on the amount of physical activity a community undertakes. Ensuring that walking and cycling are the primary forms of transport can substantially increase physical activity. Consequently there are individual projects for early years and spatial planning.

Most of the individual projects are broken down into a nutrition and physical activity component. Underpinning these specific areas is a work stream that considers how we can improve the basic infrastructure which supports these projects, particularly training.

7.2. Targets and Performance Indicators

An extensive action plan was produced with the original strategy. It was felt that this needed to be streamlined and refocused using better performance management arrangements. It was also agreed that the plan should focus on new interventions whilst acknowledging all the good work which already happens. The new action plan is being project managed by Newcastle City Leisure Services on behalf of the Obesity Strategy Group.

The high level objectives can be seen in Project Plan Appendix. Each project will have agreed milestones and measures of success.

Overarching indicators for the strategy are shown in **Error! Reference source not found. (To Be agreed ?need to add other LAA indicators)**. We will set up a systematic process to report these to the Obesity Strategy Group.

Table 1: Overarching Strategy Indicators

	Indicator	Source	Timing
1	% children in Yr 6 who are obese	NCMP	Annually Feb (interim results available from PCT Public Health dept Sept)
2	% children in Yr 6 who are	NCMP	Annually Feb (interim results

	overweight or obese		available from PCT Public Health dept Sept)
3	% children in Reception who are obese	NCMP	Annually Feb (interim results available from PCT Public Health dept Sept)
4	% children in Reception who are overweight or obese	NCMP	Annually Feb (interim results available from PCT Public Health dept Sept)
5	Prevalence of BMI greater than or equal to 30 in adults over age of 16 years in the previous 15 months in GP registers	QoF	Available annually. Interim results are available from PCT Public Health dept from April)

The LAA and Vital Signs target for Yr 6 levels of obesity were set according to the DH guidance³ and can be seen in **Error! Reference source not found..**

Table 2: LAA and Vital Signs Indicators

Current performance	LAA and Vital Signs Targets		
2006/07	2008/09	2009/10	2010/11
21.3%	21.3%	21.3%	21.2%

7.3. Building Local Capacities

Each project area has been tasked with looking at workforce training and capacity issues. It is important that everyone working at a local level is clear about their role in promoting the benefits of a healthy weight and that appropriate training is available so that both health and non-health professionals feel confident in sensitively raising the issue of weight with those who are overweight or obese.

- We need to adopt a whole systems approach so that all agencies tasked with delivering the action plan understand the need to increase the understanding of the complexities associated with overweight and obesity, and have the ability to train their staff accordingly.
- This will entail consideration of the different needs of health and non health professionals. How we deal with the sensitivity around the issue is of particular importance if we are to bring about a behaviour change in our residents.
- We will use the 'Obesity Training Directory: www.domuk.org as a guide to training, but already have in place a training programme for a whole host of practitioners in the City.

7.4 Conclusions

For this obesity strategy we have already:

- Reviewed the ever improving body of evidence

³ How to set and monitor goals for prevalence of child obesity: guidance for Primary Care Trusts (PCTs) and local authorities, Department of Health, Feb 2008

- Reviewed new national guidance
- Reviewed current provision of universal and targeted services
- Outlined high level priorities for Newcastle
- Set up a project management structure

In order to lay the foundations of an effective obesity strategy and action plan we need to-

- Agree overarching indicators **(by April 2009)**
- Complete evidence based checklist **(by August 2008)**
- Agree objectives and indicators for each project area including workforce development **(by April 2009)**
- Set up a systematic process for monitoring indicators (both overarching and project specific) **(by April 2009)**
- Ensure that the priorities feed into commissioning processes for the PCT and LA **(by September 2008)**