Commissioning: - learning from Sheffield and Rotherham'

The Rotherham Case Study

Prepared for: NICE Programme Development Group
Contact Details: Carol Weir, Public Health Specialist, Email: Carol.weir@rotherham.nhs.uk
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Problem Identification – Agenda Setting

In 2007 an estimated 60% of the adult population and one in three children in Rotherham were classified as overweight or obese, a statistic similar to the national figures, although higher than the average in England and continuing to rise (Health Survey for England, 2007; Information Centre, 2010). The Foresight Report (2007) predicted that unless there was clear action, these figures would rise to almost nine in ten adults and two thirds of children by 2050 (further child and adult obesity data in appendix 1). With this information in mind, Rotherham PCT, through their 5 year strategy (Better Lives, Better Health, NHS Rotherham, 2008) set key measures for improvement, that within the next five years NHS Rotherham (as it had now become known) would halt the rise in both childhood and adult obesity to achieve the Government ambition Public Service Agreement (PSA) target, by delivering a radical, far reaching and long-term strategy based on community wide prevention and the procurement of new, tiered weight management services, through a Healthy Weight Commissioning Framework.

Policy Formulation

As this was a new issue for Rotherham a new group was established with clear Terms of Reference and reporting and accountability structures. The strategy group undertook the following process to review the problem and action locally. The group reviewed: the current position, key issues/context, the 5 year plan, the health impact and impact on services of implementing the plan and doing nothing, how to achieve the goals of the activity, how to ensure initiatives impact on those who need it most, the current and additional spend required, timeline/milestones, procurement routes, process/outcome measures, and, risk.

The group, using the information they had sourced, employed the World Class Commissioning process and competencies (DH, 2007) to develop their strategy as follows:

- Locally lead the NHS - NHSR prioritised this investment based on need, acting on feedback from the public and set ambitious outcome based targets for services. They used national and local media to communicate their actions to garner local support.
- Work with community partners - The PCT is coterminous with the LA in Rotherham. The strategy group formed helped build and develop relationships and ensured effective communication across all partners. The multiagency, multisectoral partnership strategy group was established in July 2007 which included PCT commissioners, contracting specialists, information analysts, public health specialists (children, physical activity), Hospital staff, GPs, leisure services providers, private/commercial sector providers of weight management services, potential/new providers, voluntary and community sector representatives, Local Medical Council representatives, dietitians and clinical services leads, service users, as well as Local Authority and Local Strategic Partnership representatives. The strategy group developed clinically and commercially viable quality and outcome measures.
- Engage public and patients - The lead public health specialist undertook surveys, used patient panels and forums, held public events, focus groups, got regular feedback from service users, and ensured users were involved in setting quality and outcome measures.
- Collaborate with clinicians - A full range of clinicians were involved in the development of services and specifications and clinically and commercially viable quality and outcome measures. Stakeholder engagement was undertaken through discussions at a series of high level meetings and events.
- Manage knowledge/assess needs - All available national, regional and local data, evidence, and local experience was used, alongside data from surveys, patient, public and stakeholder engagement, and Health Equity Audit work, to inform the strategy.
- Prioritise investment - From papers submitted to high level meetings this was prioritised based on need.
- Stimulate market - The strategy group stimulated the market through co operation, choice and competition encouraging new providers into the market to tender for this activity, and building new relationships.
- Promote improvement/innovation – This was new and innovative activity aiming to promote improvement through services centred on quality and outcomes.
- Procurement - All services were fully tendered and procurement was robust and transparent, using an OJEU process. Good working relationships were fostered with the new providers. Contracts were agreed which included regular performance monitoring and incentives.
- Manage the local health system - This was done through service specifications and regular and robust performance management of the services.
- Make sound financial investments - The strategy group ensured services were commercially viable, value for money, and based on robust decision making, therefore through 'Investing To Save' NHS Rotherham was hoping to see a return on their investment, based on reduced ill health and clinical need and use of services in the future.

Strategy for change

The Rotherham obesity model and Healthy Weight Commissioning Framework was developed, as outlined in Appendix 2. This brings together strategies to both prevent and treat obesity in the population. Due to the high number of overweight and obese people across Rotherham there is a need to provide several services with different levels of intervention. Patients move up and down through the tiers of service to offer long term support for this relapsing remitting condition.

NHS Rotherham invested in a range of services with measurable health outcomes agreed in the service specifications (a timeline of key events is presented in Appendix 3):

- For Children, Young People and Families these included Community-based Carnegie Weight Management Clubs (delivered by DC Leisure (local leisure service provider) trained and supported by Carnegie Weight Management), a Multi Disciplinary Team (MDT) of health professionals (delivered by a local GP practice) to provide more specialist and individualised advice for families, and Carnegie Residential Camps.
- For adults, these included community weight management programmes (delivered by the Rotherham Dietetic Department), a Multi Disciplinary Team of health professionals (delivered by a local GP practice) to provide more specialist and individualised advice for adults who require more specific one-to-one support, and, bariatric surgery (further detail of the different tiers of service is provided in Appendix 4).

Evaluation of Process

<u>Successes</u>

- Political will, strong leadership and vision was key to the success of this programme and helped the partnership envisage the change and how they could deliver a change on the desired scale, to make a real difference to the people of Rotherham. Support and leadership from the PCT Board, Professional Executive and Directors to invest in this programme-essentially 'Investing To Save' was considered crucial.
- The tiered model of care and pathways for both adult and childhood obesity, ensuring individuals move up and down through the tiers, allows clients to receive a significant amount of support, which will hopefully lead to them feeling empowered to self-manage.
- It was necessary to stimulate the market, helping new entrants into the market and potential providers to see how this could be delivered within the financial envelope agreed.
- The procurement process led to NHS Rotherham awarding ambitious contracts to a plurality of providers, including new entrants to the market and private providers.
- Relationship building with providers and between providers sharing the care of patients on the pathway was crucial, alongside one single referral form for all services, enabling a 'single conversation'.
- All services are outcome based on successful weight loss to ensure service delivery is high quality and value for money, with robust contracts based on measurable health outcomes which involve monitoring impact against cost.
- Performance management frameworks aim to ensure the service is delivered with a focus on both quality and health outcomes. There is a comprehensive programme of monitoring and evaluation, both qualitatively and quantitatively, to ensure continuous service improvement which is user driven and which can be measured and reported. NHS Rotherham have and continue to monitor, evaluate, disseminate and, where appropriate, publish results to share the learning and experience.
- NHS Rotherham were the National Winners of the Health and Social Care Award for Excellence in Commissioning in 2009 for the obesity work described here and have shared outcomes, learning and experiences through a briefing paper sent to all PCTs and Local Authorities in England, presenting at national conferences and through the NICE shared learning database. The National Obesity Forum adopted the Rotherham Model as the NOF Obesity Strategy in 2009 after peer review. This profile and consequent media opportunities have garnered support for the programme across services and the public.

<u>Challenges</u>

There were a number of challenges that had to be overcome to get the issue on the agenda, ensure prioritisation and funding and implement the programme. The key issues identified were:

- Partner and potential provider engagement/re-engagement and relationship building was sometimes challenging although the strategy group make-up and structure helped with effective and efficient communication which ensured all partners felt fully engaged.
- Helping the partnership believe they could deliver change and change on this scale was a significant challenge due to previous experience of programmes which have not met expectations.
- Developing robust, clinically and commercially viable yet ambitious service specifications based on outcomes and getting these agreed by all the partners and potential providers was key to the success of this programme, yet a challenge to get agreement on a new programme with ambitious outcome targets on this scale, based on little evidence of provision in the 'real world'.

- Stimulating the market and helping potential providers see how this could be delivered within the financial envelope agreed.
- To date, there is very little published evidence to support the effectiveness of any weight management interventions. However, these services are based on the NICE Guidance CG43 (NICE, 2006) and PH 27 (NICE, 2010), the Standard Evaluation Framework (NOO, 2009), the recommendations outlined in Healthy Weight, Health Lives (DH, 2008), the lessons learned from similar frameworks delivered elsewhere and the Rotherham experience.
- The measures of success (NCMP and service specification targets) set for these new services were challenging, with little available benchmarking data and a lack of evidence of costs and effectiveness of delivery in a real world setting, therefore we may be assessing effectiveness against unrealistic and unachievable outcomes and success may be ill-defined.
- Further benchmarking activity is on-going, however, there is an issue regarding other areas apparent unwillingness to share outcomes. Due to our 'early adopter' approach, little comparable data is available.
- From an economic perspective we are more interested in estimating cost-effectiveness and return on investment, measured in terms of cost per quality-adjusted life year (QALY) or cost per life year saved, or cost per hospital admission avoided. There are lots of such analyses for drugs (such as orlistat (NICE, 2006)) but less available for public health interventions to address obesity.

Evaluation

Evaluation is difficult due to the timescales imposed on this programme, that is: set up, implement and evaluate effectiveness of services all within three years. This timescale may be too limited to ascertain success and may lead to the cessation of activities in Rotherham, deemed unsuccessful, perhaps due to an unrealistic evaluation timeframe or unrealistic targets rather than actual failure. However, many obesity policies are either not evaluated or the expectations are too great in the timescales given, as it is recognised that for many public health interventions a change in behaviour that will lead to an improvement in a lifestyle factor such as reduction in obesity will take many years to observe (OECD, 2010).

Rotherham Evaluation

The outcomes from the Rotherham obesity activity will be known in 2012 and will inform local decisions regarding reinvestment in this area and what services are provided for the local population. In terms of measuring the success of commissioned weight management services and in terms of providing data to re-orientate strategy and services; the following outcome measures have been used: performance against service specification targets (see Table 1 below) and progress towards halting the rise in childhood obesity, as measured and reported through the NCMP (Table and Figures in Appendix 5), however, these measures are debated in terms of appropriateness. Performance is difficult to assess given that at any one time there will be numbers in the service who have yet to complete 12 weeks of activity, therefore indicating more activity than success. However, Table 1 (below) indicates the level of activity to date.

The costs per service are incremental with the tiers of the Healthy Weight Management Framework, as it is recognised that the greater levels of obesity required more intervention to treat as obesity and the choices that have lead to obesity become more entrenched, as outlined in Appendix 6.

Table 1: Performance Measured Against Service Specification Criteria

Tier	Target	Success Rate (activity to date/ 21 month target)	Rating (RAG) Costs & Activity	Success Defined as:	Indicative Unit Cost per success	Cost to date	Total 3 year cost
Adult Tier 2	60%, 667 people pa 2000 successes over 3 yr	538/1167 46%	A	Min 3% body weight loss	£165	£358 (538 successes, investment £192.5K)	£330K
Adult Tier 3	600 successes pa 1800 successes over 3 yr	1141/1050 >100%	G	Min 3% body weight loss	£435	£399 (1141 successes, investment £455K)	£780K
Child Tier 2	60%, 293 people pa 879 successes over 3 yr	325/513 63%	A	Weight loss on BMI centile charts	£580	£915 (325 successes, investment £297.5K)	£510K
Child Tier 3	200 people pa 600 successes over 3 yr	85/350 24%	R	Weight loss on BMI centile charts	£1,285	£5,291 (85 successes, investment £449.75K)	£771K
Child Tier 4 NB 4 years	30 young people pa 120 successes over 4 yr	121/120 > 100%	G	Weight loss on BMI centile charts	£3,250	£3,250 per success	£390K

From the level of activity to date the following lose assumptions can be made:

- The Adult Tier 2 service does appear effective and when measured against the similar service offered by the commercial sector but not against target activity as set in the service specification (46% when measured against target). The provider recognises the need to address recruitment and retention rates.
- The Adult Tier 3 service appears successful to date overachieving on target.
- The Adult Tier 4 service has planned activity of 39 procedures for 11/12, commissioned through the SCG. The SCG estimated yearly referral number for bariatric surgery in Rotherham is higher than the numbers accessing surgery possibly due to the positive impact of the MDT service, representing a significant saving. Given the increasing prevalence of obesity predicted in the upcoming years, it is felt that this referral rate could significantly alter if more upstream services are not in place to stem the tide. However, this reduction reflects more appropriate access to surgery and not a withholding of services.
- The Children's Tier 2 service, although underperforming against specification, does appear effective for those who complete the programme with success of 60%.
- The Children's Tier 3 service does appear costly and ineffective when compared to the required outcomes, however, it was recognised that this new service would be challenging and that there is little to compare this with. Further work benchmarking activity needs to be undertaken to assess value for money. The provider recognises the need to address: engagement with GPs and referring agencies to increase referrals, engagement with young people and families once referred to improve retention rates, and, further work with the other tiers of services to improve access, support and on-going care.
- The Tier 4 service appears effective and value for money against specification requirements.

However, all of this needs to be read, understanding the caveats and challenges already listed above, especially around target setting, defining appropriate measures and levels of success and benchmarking.

Performance Measured Against National Child Measurement Programme (NCMP) Targets

To date the children's obesity data has shown a slight dip or levelling off but alongside increasing coverage this seems promising. However, the relatively small number of children who have attended the services (approx 500 with some potentially attending all services therefore the number of unique children will be less) and the short timescales (less than 2 years delivery to date) may not be great enough to show an impact on the NCMP data. It should also be noted that services are delivered to children aged 7-18 years therefore a single measure of 3000–3300 children per annum in Yr 6 (of which approx 600 are obese) will have a limited relationship to the services outlined above (further detail in Appendix 5).

Conclusion

The obesity work in Rotherham has been replicated by many other areas trying to tackle this same issue. However, to date no evidence, either of effectiveness or failure, has been reported. This demand to deliver without evidence is reflective of the increasing prevalence of obesity in England and the need for action, based on expertise and experience, without evidence of effectiveness, which may take years.

However, to date this process and policy seem to exhibit some of the preconditions which may lead to success. The results of the Rotherham activity will soon be available and from this there may be some judgements made in terms of success, notwithstanding the need to define criteria for success and the lack of evidence on which these criteria are based.

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Appendix 1 – Relevant Obesity Data

Table 1: Rotherham Childhood Obesity Data

Year	2005/6	2006/7	2007/8
% height & weight measured	89.1% Target:80%	82.9% Target:80%	89% Target:85%
% in Reception Year obese	10	10.3	12
% in Reception Year overweight & obese	23	24	25
% in Year 6 obese	18	18.4	20.8
% in Yr 6 overweight & obese	33	34	37

Adult data

The numbers below illustrate the known extent of adult obesity in Rotherham (QUEST and QoF data) at that time:

- 45% of people with a recorded BMI were in a normal/healthy BMI category (compared to 39% in the 2005 Health Survey for England (HSE)
- 32% were overweight (37% in HSE) and 23% were obese (HSE 24%).
- 4,286 people were identified on GP practice registers with BMI over 40 (2.7% of the whole population, compared to the HSE 1.8%).
- 614 of these had a BMI over 50. This is 0.3% of the whole population, but it was recognised that there were presumably additional cases in the 22% with no recorded BMI.
- Predictions were that by 2050 there will be 142,000 obese people (BMI >30) in Rotherham, 50% of the population (based on population projections for 2050).

It was also known that obesity was not equally experienced across all sections of the population. The greater prevalence of obesity among poorer social groups implies that efforts to counter health inequalities must take account of obesity; conversely, action on obesity must take account of socio economic factors. Obesity is not exclusively a matter of social class and inequality. The suggestion that it is primarily a feature of lower-income groups would disguise the society-wide character of the epidemic. However, efforts to combat obesity in lower-income groups will have positive consequences for both health and inequality (NOO, 2009) therefore Rotherham took both a universal and targeted approach to the delivery of their obesity services across the local area.

Appendix 2 – Rotherham Obesity Models – Adults and Children

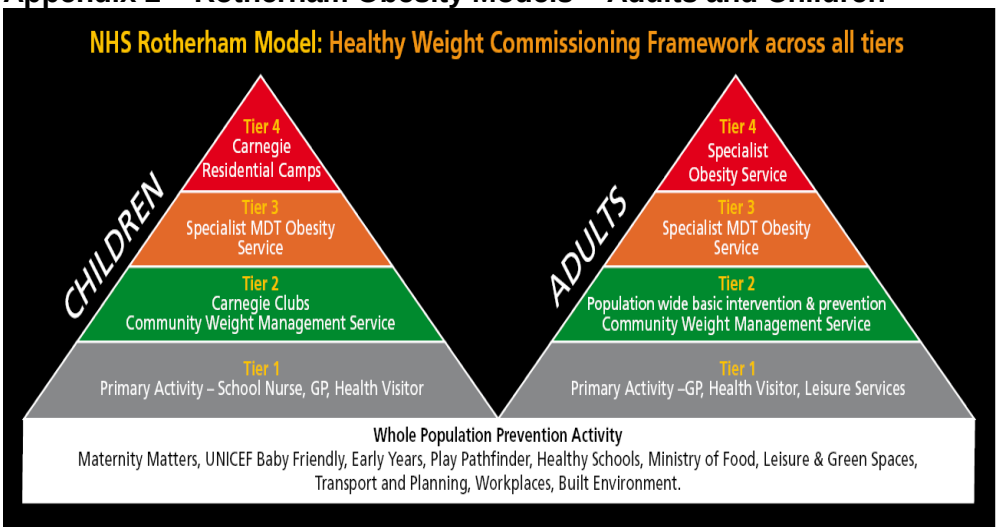


Figure a: Rotherham Obesity Model indicating referral criteria - Adults

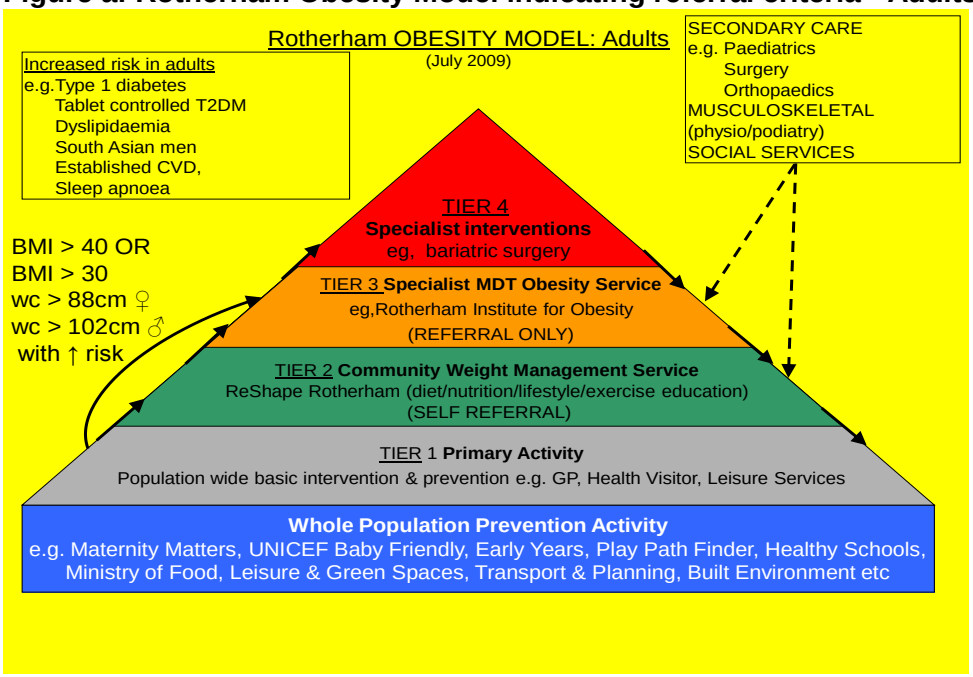
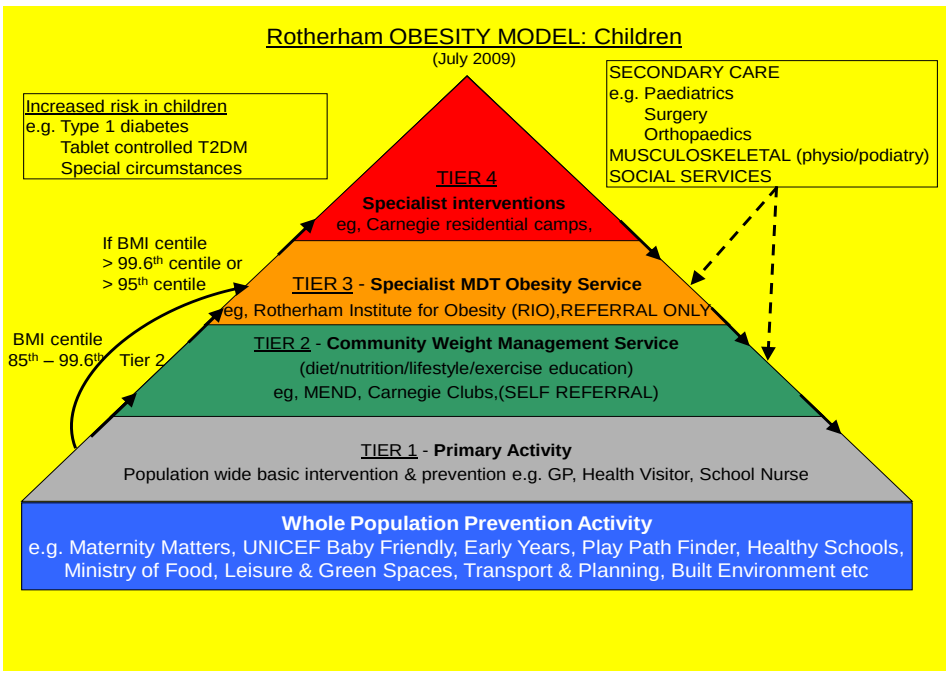


Figure b: Rotherham Obesity Model indicating referral criteria - Children



Appendix 3 - Timeline of Rotherham's Obesity Strategy Activity

Action	Timeframe
Public Health Specialist for Obesity in post	July 2007
Obesity strategy group formed to develop the model and service specifications	Sept–March 2008
Presentation to PCT Directors to seek support to pursue process	Dec 2007
Strategy and service specifications presented to PCT Directors, Professional Exec, PCT Board, Local Authority Corporate Management Team, Scrutiny, Cabinet and LSP	March 2008
Procurement process and Contract Awards	April-Dec 2008
Pilot Carnegie Camp and 15 week Rotherham Club	July-Dec 2008
Commencement of services Rotherham-wide Family Carnegie Clubs (Provider - DC Leisure) Adult Community Weight Management (Provider – Rotherham Foundation Trust) Community-based Adult and Children's MDT (Provider – local GP)	April 2009
Residential Camp (provider – Carnegie Weight Management)	July 2009

Appendix 4 – Services in detail

Adult Tier 2 service - Reshape Rotherham
Reshape Rotherham is a free service available to all local residents registered to a Rotherham GP. The course lasts 10 weeks, and consists of hour-long sessions designed to encourage a long-term approach to healthy diet and lifestyle. Any health professional can refer an individual to the service. Self-referral is also available. Criteria for referral include BMI 25-40 and waist circumference of >80cm in women or >94cm in men.

Adult Tier 3 service - Rotherham Institute for Obesity
RIO is a specialist centre for the management of obesity. It has a multidisciplinary team including obesity specialist nurses, healthcare assistants, dietetics, talking therapists for psychological issues, physical activity specialists, a General Practitioner with a special interest in obesity, as well as access to local bariatric surgeons. RIO provides all the necessary pre-operative assessment for adults who may be suitable for surgery. Those with a BMI>40 or with BMI>30 with risk factors (Diabetes, Dyslipidaemia, South Asian male, Established CVD) or with a waist circumference >88cm in women and >102cm in men are eligible. Referral is via GP, Consultant, Primary Care Team, Physiotherapist, Occupational Therapist and Pharmacist. Self-referral is not possible.

Adult Tier 4: Specialist Referral including Bariatric Surgery
Rotherham estimated yearly referral number for bariatric surgery stands at 67, yet only 34 people accessed surgery last year due to the positive impact of the MDT service. Given the increasing prevalence of obesity predicted in the upcoming years, it is felt that this referral rate could significantly alter if more upstream services are not in place.

Children Tier 2 service - Carnegie Clubs/DC Leisure
NHSR has developed a partnership with DC Leisure to provide Carnegie Clubs, which is a community based family weight management programme attended by both parent and child over a period of 12 weeks. Courses are conducted in groups, and last three and a half hours per week typically on a Saturday morning. Children with a BMI >85th centile for their age can be referred. Self-referral is also possible. There is at least a six month programme of follow-up.

Children Tier 3 service – RIO
The Rotherham Institute for Obesity also provides services to children who are referred by a healthcare professional. Referral criteria include a BMI>99.6th centile or >98th centile with co-morbidities. As with adults, failure of Tier 2 intervention is also a referral criterion.

Children Tier 4 service - Carnegie Camp
A specialist 6-week fully residential camp service is available to children with a BMI>95th centile. The programme involves parent workshops and support/follow-up is provided when the camp is complete by referral back to relevant tiers (e.g. Tier 2 or Tier 1 where appropriate).

Appendix 5 – Yr 6 Obesity Prevalence and Coverage

Table: Year 6 (age 10 and 11 years) NCMP Data

Variable	06/07(%)	Coverage(%)	07/08(%)	Coverage (%)	08/09(%)	Coverage (%)	09/10 (%)	Coverage (%)
Year	06/07	06/07	07/08	07/08	08/09	08/09	09/10	09/10
Statistical Neighbours Average	18.8	82	20.0	87.5	20.8	90.5	20.7	91.6
Rotherham	18.4	84	20.8	88	19	90.8	20.2	95
Y&H Average	17.2	82	18.9	90	18.6	88.9	18.8	88.8
England Average	17.5	80	18.3	87	18.3	89.1	18.7	89.9

Figure a: Prevalence of Obesity in Yr6

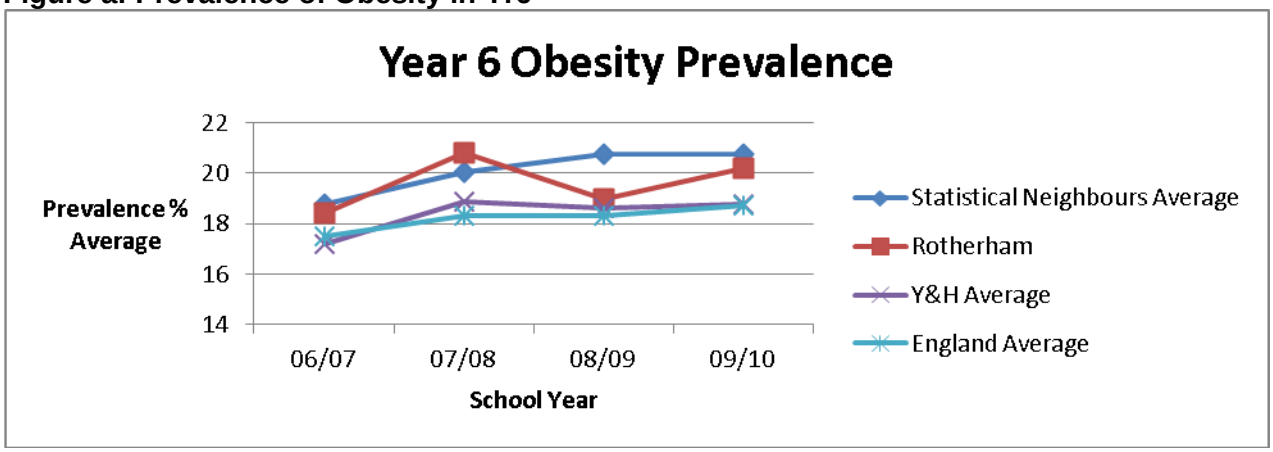
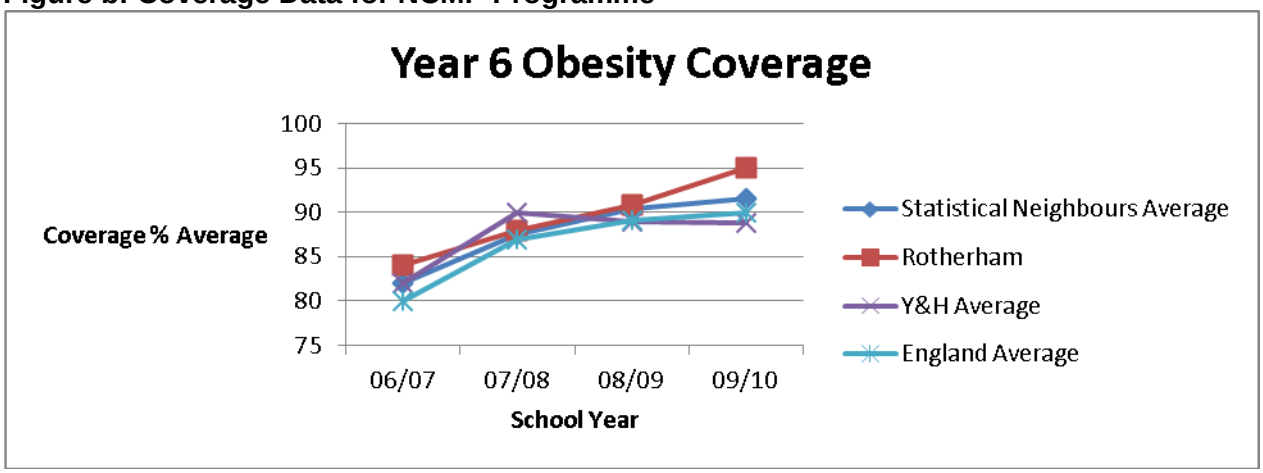
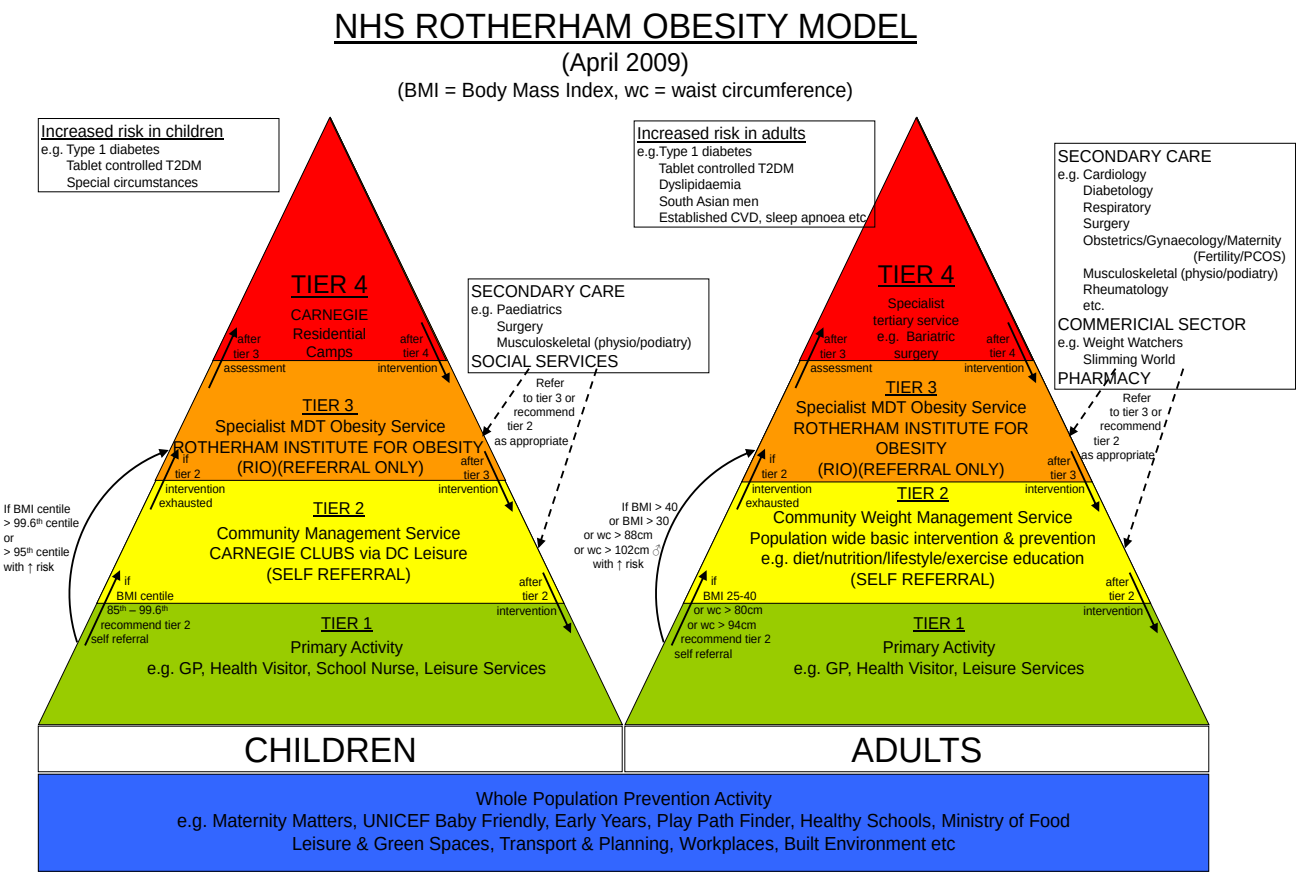


Figure b: Coverage Data for NCMP Programme



Appendix 6: Rotherham Obesity Model indicating referral criteria



If criteria met for TIER 3 referral, use the proforma and complete the relevant boxes
Any TIER 3 patient requiring pharmacotherapy will be treated in TIER 3, and this will be reflected in the GP prescribing data for whom the patient is registered
NB If patients are considered unsuccessful at any given tier, they automatically progress to the next tier of intervention
After intervention, patients progress down through the tiers and back to primary activity (TIER 1) of monitoring and education (every 6-12 months)

Sheffield Let's Change 4 Life: A Whole Systems Approach to Tackling Childhood Obesity

Prepared for: NICE Programme Development Group

Contact: Carol Weir, (previous Director – Sheffield Let's Change4Life), Public Health Specialist, Email: Carol.weir@rotherham.nhs.uk

Date: 5th October 2011

Report prepared with Sheffield Hallam University: Dr Robert Copeland CPsychol, Max Moullin MSc, FORS, CQP, FCQI, Lindsey Reece MSc, Debra Gibson MSc

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Introduction

The Sheffield-Let's Change4Life Programme, funded through the 'Healthy Towns' approach identified in 'Healthy Weight, Healthy Lives (DH, 2008), is an ambitious initiative which aims to prevent obesity in children, young people and families through shifting attitudes and culture in the city at all levels and by delivering a range of universal and targeted prevention activities which focus on individuals, families, children's centres, schools and communities across Sheffield. The activities are underpinned by a social marketing campaign linked to Change4Life and a citywide drive to engage third and independent sector partners in this agenda, to make the prevention of obesity in the city everybody's business. The headline target is to achieve: NHS Vital Sign and Public Service Agreement targets (childhood obesity in YrR & Yr6), and, Local Area Agreement LAA targets - NI 55 & 56 (Childhood Obesity) and NI 53 (Increase the prevalence of breastfeeding at 6 - 8 weeks to 52.7% by 2010/11).
The SLC4L programme delivers activity across the following eight evidence based themes for obesity prevention (CDC, 2009): Breastfeeding friendly city, Parents as positive role models, Schools at the heart of healthy communities, Living Neighbourhoods, Healthy Open Spaces, Change4Life – social marketing campaigns, Community Health Champions, and, Cross-sector Innovation.

Figure 1.0 PSS Strategy Map

The Evaluation Method

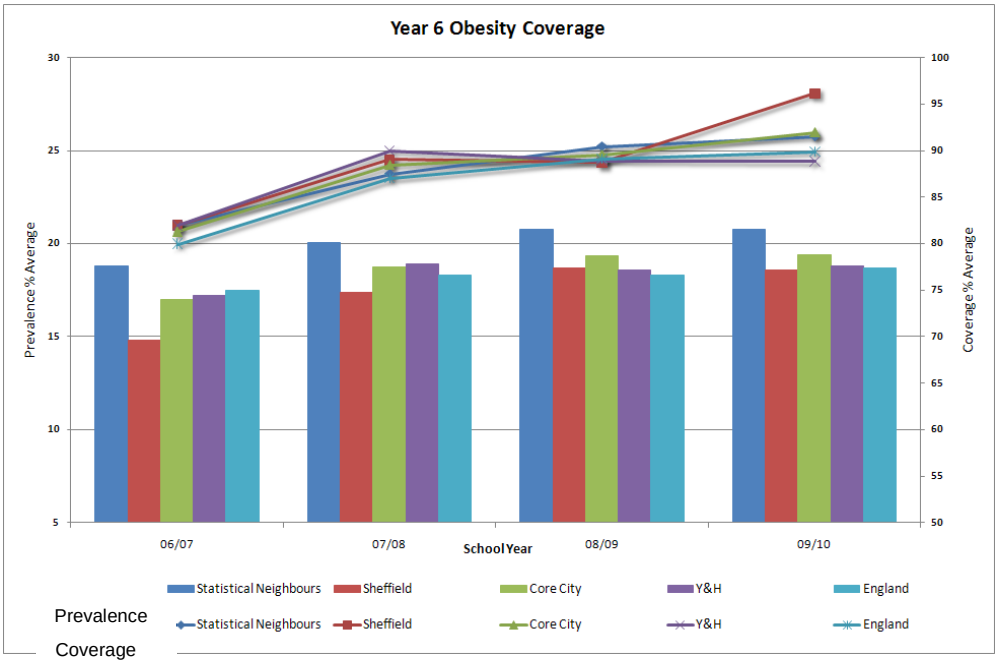
A number of theoretical models guided the evaluation approach in particular the Public Sector Score card (PSS) (Moullin, 2009) and the Theory of Planned Behaviour (Ajzen, 1991) summarised in the *SLC4L Strategy Map* (Figure 1). From the top down, the first two rows consider the main outcomes for the programme and represent an assessment of actual behaviour change and epidemiological benefit i.e. reduction in obesity prevalence. The third row represents the impact of the programme on people's attitudes and cognitions i.e. the Theory of Planned Behaviour. The elements in rows 4 and 5 represent the 8 different strands and the activities within strands. The final two rows, at the bottom, show the capability and capacity elements required to support the strands in achieving their outcomes. The programme was underpinned by effective leadership and support from the programme board.
The data presented needs to be read understanding the caveat that much of the data was collected in the absence of an experimental research design. Therefore, findings are descriptions, not statements of cause and effect, and, the majority of data is self-reported and should be considered in light of the inherent biases that exist with this form of data.

Headline Outcomes

Reducing overweight and obesity

The following observations can be made from the National Child Measurement Programme (NCMP) 2008-2010 data. The real impact of *SLC4L* is more likely to be reflected in the 2010/11 NCMP data which will be available in October 2011.

Obesity prevalence data - Year 6 - Figure 2: Year 6 obesity prevalence data



In Sheffield, a marginal fall in obesity prevalence between 2008/09 and 2009/10 (18.7% vs. 18.58%) has been observed. This should be compared to marginal increases in obesity rates in Core Cities, Yorkshire and Humber and England nationally. No change was observed in Statistical Neighbours obesity data. In comparing changes in obesity prevalence, it is important to note the large increase in coverage in Sheffield (88.7% to 96.6%), while those for the other comparators rose only slightly, which suggests progress is encouraging. The major point to consider here is that although obesity prevalence rates in Sheffield and indeed elsewhere appears to be slowing, the prevalence is still unacceptably high. It is crucial therefore that tackling obesity remains a priority for the City and momentum generated by *SLC4L* must not be lost.

Y6 Obesity data school level comparisons

There was no significant difference between matched (similar demographic profiles) schools with or without *SLC4L* interventions in terms of rates of obesity prevalence. In the most deprived areas of the city (IMD 2007) the rate of increase in obesity prevalence was slower in schools with *SLC4L* interventions compared to non-*SLC4L* schools. Obesity prevalence fell in schools with *SLC4L* physical activity interventions whereas a marginal increase was observed in matched non-*SLC4L* schools over the programme period. Given that schools were selected for physical activity interventions on the basis of obesity prevalence data, this outcome would appear to offer some encouragement, however, to robustly evaluate the impact of interventions in schools a longitudinal programme with a consistent cohort of children is required.

Satisfied stakeholders

Stakeholder response to *SLC4L* has been positive, particularly from participants in strand activities. 93% of strand leads positively rated their engagement in *SLC4L* and 97% of those attending *SLC4L* conferences indicated that the programme would have a positive impact on the obesity targets and priorities of the City.

Value for money & sustainability

A full cost-effectiveness study was outside the scope of this evaluation. A crude cost per head summary using data from strand activities (i.e. attendance at food festival, *SLC4L* Schools, training & awareness) and evaluation studies (i.e. cohort) suggested a total of 253,912 individuals and families engaged with *SLC4L* equating to a £34.96 per person per year cost for the programme.

In the longer term, maintaining political and senior leadership support and prioritising obesity in the City will be critical to the sustainability of the *SLC4L* programme vision. This could be achieved through prioritisation of obesity within the City's shared targets and policies. The development of a multi-stakeholder City wide obesity strategy could be an appropriate mechanism for translating the programme's vision and plans for sustainability into a commitment for action.

Strand Level Activity Headlines

Creating a Breastfeeding Friendly City - A programme of breastfeeding awareness & peer support has contributed to a city wide increase in: breastfeeding initiation rates (76.43% to 79.2%), breastfeeding prevalence at 6-8 weeks post birth (44% to 54.7%), and, confidence of mothers to breastfeed in public.

Although breastfeeding maintenance is increasing, the health inequality gap is widening. This suggests that a tailored approach to breastfeeding peer support might be beneficial

Parents as Positive Role Models

- A training and awareness programme contributed to a significant ($p<0.05$) improvement in health professional's intention and confidence to influence the management of obesity.
- The Healthy Early Years Award has been adopted as the 'gold standard' in promoting healthy lifestyles in children's centres and opportunities to access healthy options have increased with 150 outlets being awarded the Healthy Choices mark and 210 achieving baby friendly status.
- Sheffield Food Festival attracted 20,000 people to the City while Museums Sheffield Food Glorious Food exhibition had a positive impact on visitor's intention to make lifestyle changes. However, data also identified a need to provide more information about services in Sheffield that can help with lifestyle change at the point of decision.

Schools at the Heart of Healthy Communities

- Many benefits were reported as a result of participation in cooking clubs, targeted physical activity and growing clubs. A significant ($p<0.05$) improvement in physical activity and physical fitness, was observed for pupils accessing growing clubs and targeted physical activity respectively.
- Free school meal take up (as a percentage of children on the roll) in *SLC4L* schools has risen significantly with nearly 78% of those eligible claiming schools meals compared to 72.6% in Sheffield as a whole. Combined with changes to the school meal provider contract which emphasise the importance of healthy options data here is encouraging.
- Stay-on-site policies and changes to the school dining environment encouraged more pupils to dine in school, enhanced social interaction and improved the behaviour of the children. Engagement with kitchen staff and the pupils is key to implementing activities successfully.
- Systems such as bio-metric payment, pre-ordering food and having multiple food stations have been shown to drastically reduce queues and improve the lunchtime experience.
- Pupils and parents reported positive attitudes and intentions towards healthy lifestyles but this was not always manifested in actual behaviour change. Future interventions should focus on closing this intention-behaviour gap.

Living Neighbourhoods

- Street audits enhanced community dialogue and reduced barriers to activity. However, implementing capital projects is a challenge in such short timescales and should form part of a long term strategy.
- Significant ($p<0.05$) increases in cycling to school, reduction in sedentary travel to school and walking to school was observed in schools receiving Bike It! and 'Travel for Life'. The largest decrease was seen in bus use in Bike It Schools (5.7% reduction compared to 1.6% reduction in car use). There has been a significant increase in the proportion of children walking and cycling to school, with the proportion of children being driven to school falling from 22.9% to 20.7%.

Healthy Open Spaces

- Delays to match funding delayed the Play sites programme. Despite this, 11 sites were completed in Year 1 with a 15% reported increase in young people's satisfaction with Sheffield's Parks.
- Although the community garden programme has experienced implementation difficulties due to a change in site and land contamination, growing training is underway with Sheffield Wildlife Trust.

Social Marketing - Change4Life

- The *SLC4L* website has proven a consistent method of promoting the programme with an average of 512 unique visitors to the site each month. A significant ($p<0.01$) increase in knowledge and awareness of the *SLC4L* brand was also observed throughout the programme.
- Establishing shared ownership of project communications was difficult with a lack of consistency in understanding the importance and benefits of 'one brand' communications. Therefore, future programmes might wish to seek a communications agreement with all partners prior to commencement.

Community Health Champions

- A programme of 240 volunteer Community Health Champions has been of great benefit to those individuals who were champions themselves with 59 obtaining paid work and numerous social and wellbeing benefits.

Cross Sector Innovation

- Significant strides have been made to embed health and well-being in future planning policies including changes to the Sheffield Development Framework, the reference document for planning decisions until 2026, promoting active travel and access to healthy food and open spaces. However there is some way to go before these issues are seen by planners as part of their 'core business'.
- Awareness of the key messages of *SLC4L* in workplaces has been enhanced through the recruitment of Business (Health) Champions in 8 of the City's largest employers. However, there appeared to be limited progress on employer's 'owning the bottom-line' benefits of a healthy workforce and there is still work to be done to overcome cultural resistance to workplace health promotion in male-dominated organisations with mainly manual employees. However, the use of sport-based tournaments and festivals such as 5-a-side appear promising.

Capability and Capacity Elements

These are the key messages from the Capability and Capacity review of the programme:

- The *SLC4L* programme board has been successful in steering the project smoothly through a number of political and financial challenges with evidence of strong leadership from the Director of Public Health and Executive Director of Children and Young People's Services, with good support from the Cabinet Member for Children and Young People's Services.
- Expressing the vision of a complex programme like *SLC4L* appeared difficult, as a result, it was not articulated in the first instance loudly enough or broadly enough to enhance shared ownership. A '*vision sound bite'* that represents the essence of the programme is recommended for future complex and multi agency public health programmes.
- The operational focus of the board, although understandable given time constraints at implementation, potentially limited opportunities for strategic leadership.
- There was evidence of a shared agenda and a desire to overcome differences in organisational culture. However, the challenge remains for partners to extend and embed services beyond the short term timescales and funding of *SLC4L*.
- A long term vision and multi-agency obesity forum is therefore required to maintain the priority status of obesity across relevant stakeholders in the City and it will be important for senior leaders to set the culture of partnership for this forum.
- Programme away days helped to breakdown internal, historical and organisational barriers and improve communication and strengthen links between partners. They also facilitated a sense of contribution to the broader agenda of tackling obesity amongst strand leads.
- A systems approach greatly encouraged joint working between strands and has a positive impact on working practices.
- Community engagement and the development of external partnerships have been key strengths of this programme. These partnerships were formed between individuals, organisations and communities who would not have come together had it not been for the systems approach adopted here.
- The programme benefitted from strong project management.

Conclusion

There has been much to learn in terms of the process of taking a whole systems approach to tackling obesity in one local area. Mapping the activities to the Foresight Obesity Systems Map (Foresight, 2007) and the Marmot Review (Marmot, 2010. See Appendix 2) has helped to improve partnership action and local awareness of the complexity of obesity as well as the opportunity and impact addressing obesity across the life course would have on health inequalities. It is recognised that this approach will not produce outcomes in terms of reducing population prevalence of obesity in the short term but may impact on obesity in the longer term if activity and partnership action are sustained beyond the short-term funded 'Healthy Town' programme.

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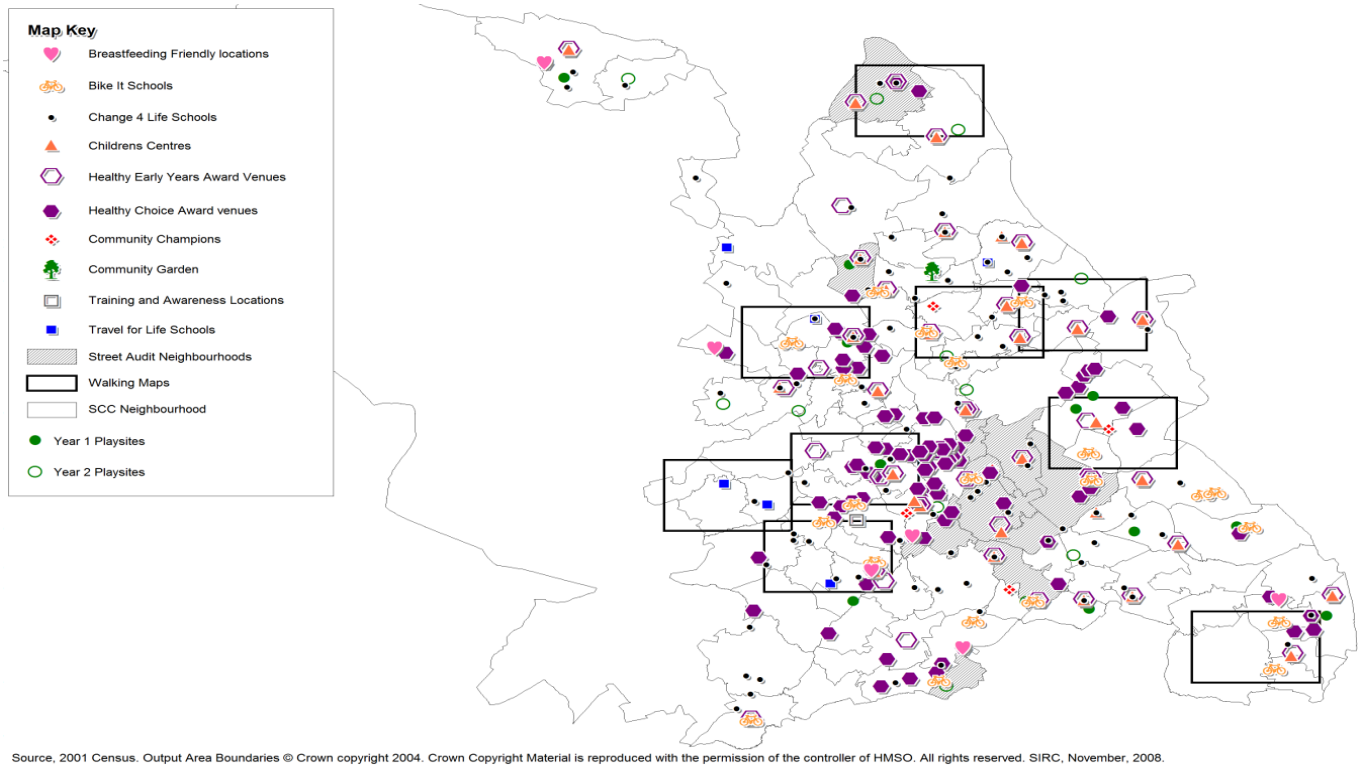
Appendix 1 - Sheffield - Let's Change 4 Life Activity Map



Appendix 2 – Sheffield – Let's Change4Life and Marmot – Areas of Action