Presentation reference paper:

Obesity working with local communities: Expert testimony witness – NICE programme development group, 5th October, 2011 RCPCH

Gareth Dix - Senior Public Health practitioner, Cornwall and Isles of Scilly PCT.

Tackling obesity in a rural county – a work in progress

1. Introduction:

This paper seeks to draw on personal experiences in addressing obesity within a rural environment. It follows the submission of a summary of the 'keep it in the family' project in Cornwall, to NICE, as an example of collaborative working. The paper further attempts to respond to specific questions posed by NICE-PDG as part of a 15minute presentation brief. To maximise the presentation time and personal experience this reference paper considers 2 of the key questions (below) and will cover the remaining questions more indirectly.

a) What are the essential elements of a local, community wide approach to preventing / tackling obesity that is sustainable and cost effective.

b) What are the barriers or opportunities to working with local authorities.

Keep it in the family (KIITF) is a 4 phase, 9 month intensive, family weight management intervention commissioned by the NHS in Cornwall. It is delivered using a multi sector partnership model to include public health, Cornwall Council, Exhale community interest company, commercial sector, MEND, school nurses, GP's, peninsula medical school and children's workers.

2. Cornwall Context

Cornwall is one of the most rural counties in England, surrounded by sea on 3 sides. Cornwall is predominantly a rural area and 27% of it is designated as Area of Outstanding Natural Beauty (AONB).

It is distinct from many other rural counties because rather than having one, large central conurbation in an otherwise rural area, Cornwall shows a dispersed settlement pattern of numerous towns and villages and hamlets. It is recognised that there are strong links between the towns and their rural hinterlands. Towns have a role in providing health care to rural communities.

Cornwall and the Isles of Scilly is a rural and maritime area. Cornwall is the second largest county in the South West region in terms of area (355,000 hectares), but has the lowest population density. The average population density for Cornwall and the Isles of Scilly is 1.4 people per hectare compared to 2.1 people per hectare in the South West and 3.8 people per hectare in England.

Cornwall has a highly dispersed settlement pattern where approximately 27% of the population live in the strategic urban centres of Penzance, Camborne-Pool-Redruth, Falmouth-Penryn, Truro, Newquay, St. Austell and Bodmin. 29% live in towns and larger villages (over 3,000 in population), and 44% live elsewhere.

The population of Cornwall is 535,000. The distribution of people is an issue for accessibility for rural areas to healthcare, transport, employment, ICT, training, community facilities and services such as shops, schools, childcare, sports and cultural activities.

Cornwall and the Isles of Scilly have unique and high quality environments with over 697 km of coastline. The natural environment also provides a number of opportunities for active lifestyles, such as surfing, cycling and walking. Many people depend on private vehicles to access services. Over a quarter (27%) of Cornwall's carbon emissions are caused by transport, with car associated emissions accounting for 63% of this.

Cornwall became a unitary authority in 2007 moving from 6 district councils and one county council into a single organisation. The NHS in Cornwall is in a current state of major transition with Cornwall and IoS PCT moving towards a new social enterprise and public health integrating with the new unitary authority.

3. Childhood obesity in Cornwall

The table below (taken from 09/10 National Child Measurement Programme) and highlights Cornwall's reception year obesity prevalence as higher than both regional and national average and year 6 obesity prevalence as higher than regional average and just below national average.

Obesity	**Reception %**	**Year 6 %**
Cornwall	10.8	18.1
Regional (sw)	9.2	16.1
National	9.8	18.7

In Cornwall, approximately one in four children in reception is either overweight or obese and approximately one in three children are either obese or overweight.

Obesity prevalence is more common in deprived centres of population. However, there are notable rurally deprived pockets of Cornwall with overweight and obese children.

Cornwall and IoS PCT deliver a range of low level prevention programmes through their health promotion service and specifically invest into tier 2 community family weight intervention which will compliment a new paediatric consultant-led, multi disciplinary team children's weight management clinic for January 2012.

4. (a) Essential elements of a local, community wide approach to preventing / tackling obesity that is sustainable and cost effective

1. From Strategy to 'Stevie'

Stevie is a local child who is obese and has been referred to KIITF with his family in 2011. In 2009 Cornwall and the Isles of Scilly initiated a Healthy weight strategy (09-13). A successful working strategy is one that unlocks a real tangible positive outcome for whom it is intended. Stevie's family have a different approach to food and physical activity because outcome 5 of the strategy recognised Stevie's need, personalised family support.

2. Embrace, support and value the community sector

The community sector has a huge role to play. CIOSPCT commissioning from outcome 5 embraced community sector Exhale CiC to deliver and drive forward KIITF in partnership with in-house health promotion team. The rationale for community sector; make quick decisions, generate further resources through other funding avenues, initiate effective collaborations, have a high energy level and passion for subject matter, achieve a sense of community engagement quickly, suits a commission orientated local authority, is clinically credible, uses standard evaluation and the work is more than a simple vocation to the community sector leads.

Example – home visits by KIITF staff, part of a 3 month lead in to the 6 month programme.

3. Turn partnership into tangible collaboration

It is not always easy to turn 'paper partners' into 'practicing collaborators'. It can be argued that social enterprise or community driven initiatives have a stronger likelihood of initiating effective collaborations to achieve mutual outcomes and are less likely to work in isolation. Collaboration is common practice in Cornwall as a pre-requisite of European Social Funding. Collaboration can be used in achieving and measuring cost effectiveness.

Example is using Cornwall Volunteer bureau for driving isolated families.

4. Bring out the ‘style’ in healthy life-style

Utilize marketing and design skills in de-medicalising obesity without diluting the seriousness of the issue and use associations to well known brands to help putting style into lifestyle. The concept is using the same techniques for local people that are used to present Cornwall to visitors.

An example is surf’s up – surf school brand at polzeath beach.

5. Re-present and Re-introduce (giving back the land)

Cornwall is often termed ‘cool’ Cornwall for its healthy active environment and fresh produce (fish / crops). However there is an issue over local ownership and engagement to the natural environment and local produce by local people (it is perceived to be for visitors). This requires innovative ways of re-presenting the environment and re-introducing fresh produce. An example is the Blue gym initiative, part of Peninsula Medical Schools, European Centre for Environment and Human Health working with KIITF.

6. Communication to community requires clarity

A quality rural intervention can be built around simple and clear outcomes set as part of a robust specification or service level agreement within a commissioning framework. The essential element is to ensure what is expected is clear and includes community sector providers within the consultation phase in developing outcomes. In the case of KIITF, clarity is the opposite of complexity which can stifle creativity.

7. Breathing space – room to innovate

A smart and non-onerous agreement allows KIITF to be responsive to implement fresh approaches because of room to create. Allowing Exhale CiC to be the lead partner in KIITF provides a platform for creative and fluid approaches where required.

E.g. Sainsbury network introducing healthy produce, label reading to KIITF families or the Cornwall fire brigade running family activity sessions as part of the community programme.

5 (b) What are the barriers and opportunities to working with local authorities
Barriers

1. Paper partners? This is a question over the value placed on reducing childhood obesity by LA as the public health transition from NHS to local government begins. This could be based on a lack of understanding and a culture of strategy being NHS driven. A process of establishing a culture of valuing public health within a local authority framework would be a good starting point.

2. 5 to1 rule - There is always a danger of 5 years strategy (long term), 1 year funding (short term). Often a strategy is long term (good) but as the mechanisms for realising the vision roll out it can become noticeably short term and restrictive for delivery agents to plan. The commitment to a strategy requires a commitment to servicing it.

3. Political parochialism and priority - Political parochialism is common, particularly in larger councils. For instance a series of councillors may rationally view addressing childhood obesity as a far lower priority than a range of other local issues. A cultural change required for all and an important role for health and wellbeing boards.

4. Clinical input and evidence base. The culture of evidence based decision making and clinical input from specialist health practitioners is key to ensuring momentum is sustained in addressing childhood obesity. There is a risk this could be lost in transition to local authority whilst at the same time a huge opportunity that it could be better then ever.

5. Decision by committee – a unitary with almost 700 km of coastline, 3 technical zones and 21 network areas and an operating process with a culture of external inspection audit / Ofsted has to work hard to reduce decision making barriers. However if process is streamlined within a devolved locality approach such as Cornwall it could make for innovative and locally responsive thinking. Further to this, the risk and opportunities also exist for addressing health needs within a rapidly changing education environment such as academy status. The positive view is that the new education environment is ripe for radical locally grown good practice. The challenge is rolling out good practice and having a balanced offer where the local view may not be so responsive.

Opportunities

1. Whole new world – It is recognised that tackling obesity is far more than a problem for the NHS. By working closely with local authorities opportunities to locally influence e.g. planning policy, leisure service provision, open space management, trading standards, children centre programmes, school improvement, adult social care become a greater reality (examples in presentation). My view for tackling childhood obesity it that it will still come down to strong relationships at a local level between connectors, practitioners, community groups and public sector staff. It is common to find that one or two 'connector' individuals are at the heart of this even within a multi faceted setting, hence the advocacy for community sector / health interest organisations.

2. Local authorities have much experience in engaging communities. More recently they have had to work harder at sustaining a positive reputation in terms of community connection in times of austerity. Nonetheless capitalising on experience and robust community networks will become an essential ingredient in addressing obesity.

3. A local authority 'single subject' lead for addressing obesity with a strong connection to practice, application and strategy may be a worthwhile consideration.

End note:

Gareth Dix works on the childhood healthy weight programme for public health, Cornwall and Isles of Scilly NHS. Gareth has 12 years experience in local authority policy and delivery at district and unitary level, he holds under graduate and post-graduate degrees in recreation / exercise science and European resource management and is currently finishing REPS training to become a clinical exercise specialist weight management practitioner. Gareth is a co-founder of the social enterprise Exhale CiC providing local collaborative solutions to improving family health.