

**SUBJECT: WEST NORFOLK NEIGHBOURHOOD PLAN – HEALTH PLAN**

**REPORT OF: DR JOHN REES, CONSULTANT IN PUBLIC HEALTH (WEST), NORFOLK PRIMARY CARE TRUST**

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## **1 SUMMARY**

- 1.1 This paper sets out the background and context upon which health improvement can take place within West Norfolk. It aims to use a community development approach to population based health improvement and to focus this initially on the problem of obesity.
- 1.2 West Norfolk is a “locality” of the new (from 1 October 2006) Norfolk Primary Care Trust (NPCT) and this locality is coterminous with the boundaries of the Borough Council of King’s Lynn & West Norfolk (BCKLWN).
- 1.3 This western locality is now divided into nine “neighbourhoods” and it is each of these that will be the focus for health improvement activities.
- 1.4 The combined work in localities will be overseen by the West Norfolk Partnership (WNP) which is the Local Strategic Partnership (LSP) for West Norfolk. There is a WNP Board which oversees the strategic and performance elements and 6 theme groups, one of which is a health group (West Norfolk Health Partnership). “Health” is the third major agenda item for the WNP, the other two being “skills and training” and “children and young people”.
- 1.5 “Health” underpins all that we do: it is “a resource for everyday life”. To change health status at population level means that whole communities have to change behaviour. Community members have to be involved in the change process to reduce the inequalities and increase the equity (fairness) in society.
- 1.6 Obesity is a major population and “societal” problem in the western world. It is a major factor in itself for direct and indirect associations with a wide range of diseases especially cardiovascular and is an “amplifier” for a range of risk factors (e.g. smoking) that contributes to heart and other diseases such as the cancers.

- 1.7 A major preventable disease is type II diabetes which is largely associated with obesity whose prevalence can be reduced with moderate weight loss. Our aim is to reduce the incidence of type II diabetes by a minimum of 50% in the next 10 years.
- 1.8 By reducing population weight, fat and salt consumption and by enabling people to increase their physical activity using a variety of means we aim to decrease premature mortality and achieve the target to reduce diabetes type II.

## **2 INTRODUCTION**

### **2.1 Health**

Health is a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity.

...Health is a resource for every day life, not the object of living. It is a positive concept....  
WHO 1986

## **3 HEALTH IMPROVEMENT**

### **3.1 Background**

Health is being seen increasingly in socio-ecological terms i.e. the link between wealth and conditions in economic, physical, social and cultural environments (Blane 1996).

e.g. Family experience

Self esteem

Employment

Socio economic status

Education / training

Social supports

Sense of control

Environment

Public Policy

Access to services

Recreation

Marginalisation (gender, language, age, poverty, race, sexual orientation)

It is highly likely that continued failure to acknowledge these factors accounts for our persistent failure to substantially improve population health despite the increased central investment. (Authors supporting this: Harrison 1998; Syme 1996; Wilkinson 1996; Marmot 1996). Syme (1996) suggests that we need to change our thinking to recognise that most health risk and most determinants of health are systemic and located within complex dynamic and interactive social relationships determined by social institutions and organisations including families, communities and workplaces. Determinants of population health are mediated through social systems but are determined by social relationships within those systems.

### 3.2 Core Values / Principles

#### 3.2.1 WHO document “Health 21” (WHO European Region)

- Health as a Human Right
- Equity and Solidarity
- Participation and accountability

#### 3.2.2 Hoffman and Dupont (1992) wished for a community development approach to be based on a set of values such as a belief: -

- In the absolute worth of the individual
- Individuals can learn and change
- Individuals and communities can identify problems and act together to find solutions
- An individual by positively changing aspect of his/her life may benefit and improve their health
- Community participation is health enhancing
- Individuals are interested in participating in their own health

## 4 COMMUNITY

### 4.1 Community and Community Development

#### 4.1.1 Communities are difficult to define.

“...a group of people linked in some way through residence, interest, demographic characteristic, profession, age, membership of an organisation...” (Ref. Raeburn & Rootman 1994)

#### 4.1.2 Community organisation

This is distinct from community activities and can be defined as: -

...the process of organising people around problems or issues that are larger than group member's own immediate concerns (Labonte 1993)

or Ross' (1967) view: -

- A process by which a community identifies its needs or objectives,
- Ranks these,
- Works at these objectives,
- Finds the resources necessary (internal or external)
- Thereby extends and develops co-operative and collaborative attitudes and practices in the community
- Enables many tasks to be accomplished and problems solved.

#### 4.1.3 Community Development in Health

...enables the active involvement of people especially those most oppressed and marginalised in issues, decision making and organisation which affect their health and lives in general. It is based on people identifying their own needs and how those can best be met, by enabling people to come together to share experience, knowledge and skill. Integral is a commitment to equal opportunities and confronting inequality and discrimination. (Sheffield Support Team 1993)

#### 4.1.4 Quality of Life

Public Health professionals have used statistical evidence of reduced mortality, and sometimes morbidity as indications of population health improvement.

However it is the subjective experiences of people which provide the main focus of community development. Health improvement and community development are linked to quality of life.

"...Individuals perceptions of their position in life in the context of culture and value systems where they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept incorporating in a complex way a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features of the environment..." (WHO QOL 1994)

We need to acknowledge that individuals and population “experiences” are admissible as “community evidence” and considered equally with “harder” quantitative evidence drawn from “data”.

If we are to reorient ourselves towards community approaches then all “agencies” must learn to listen, value and accept the language of communities.

We must, to succeed, remove the “we/they” gap between the “community” and the “professionals”: we are all in it together with a joined and common purpose.

## **5 BRINGING ABOUT CHANGE IN COMMUNITIES**

5.1 Change from a community perspective involves multi-sectoral, multi-dimensional and diverse elements in contrast to the usual linear “predict and control” approach i.e. multiple factors operate concurrently.

5.2 Three models have been described by Rothman and Tropman (1982).

- Locality development  
e.g. getting a wider range of community people together to involve them in determining their felt needs and solving their own problems i.e. consensus, co-operation
- Social planning  
...Gather the relevant facts about the problem and decide on a rational and feasible course of action i.e. fact finding and analysis highly valued here.
- Social action  
... The organisation of mass action to bring pressure on selected targets e.g. individuals (lead of local authority) organisations (local council; PCT; Government) and so on.

*Example*

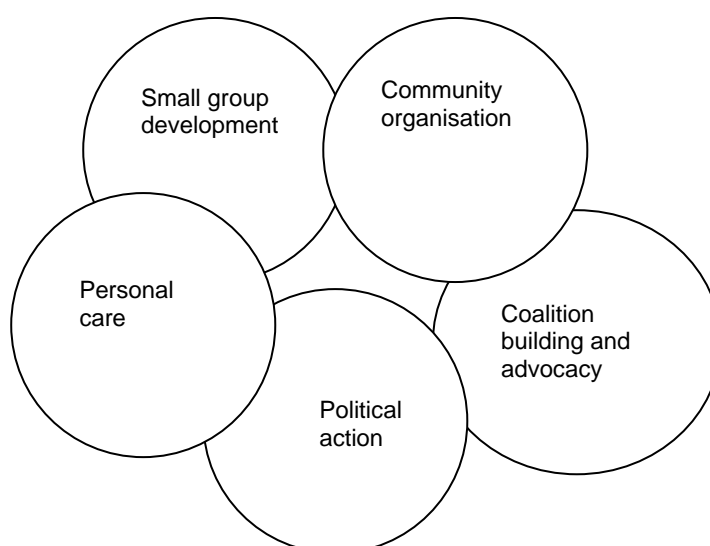
|   | Variable                                      | Locality Development   | Social Planning   | Social Action   |
|---|---|--|---|---|
| 1 | Goals of community action                     | Self help; community capacity and integration  | Problem solving with regard to substantive community problems                     | Shifting of power relationships and resources; basic institutional change.                |
| 2 | Basic change strategy                         | Broad cross section of people involved in determining and solving their own problems | Fact gathering about problems and decisions on the most rational course of action | Crystallisation of issues and organisation of people to take action against enemy targets |
| 3 | Characteristic change, actions and techniques | Consensus Communication among community groups and interests: group discussion       | Consensus or conflict   | Conflict or context: confrontation; direct action; negotiation                            |

- Behaviour

“Behaviour is influenced by the settings in which people live, work and play. Local values and norms significantly affect the attitudes and behaviour of the population”. (Thompson and Kinne 1990). They also believe that it is more appropriate to change community norms and values rather than measuring changes in the individuals as healthier settings are likely to reduce health risk behaviour. We all operate in a series of interlinked “systems” which depends on some degree of co-operation and consensus on societal goals, norms and values. The system is more than the sum of its parts and for desired change to occur takes the involvement of each of the systems parts.

- Empowerment

This process means essentially the empowerment of individuals and communities in comparison with elite classes dominating other classes by means of political and ideological leadership. Empowerment reduces the inequality and increases the equity (fairness) of access to the tools of power).

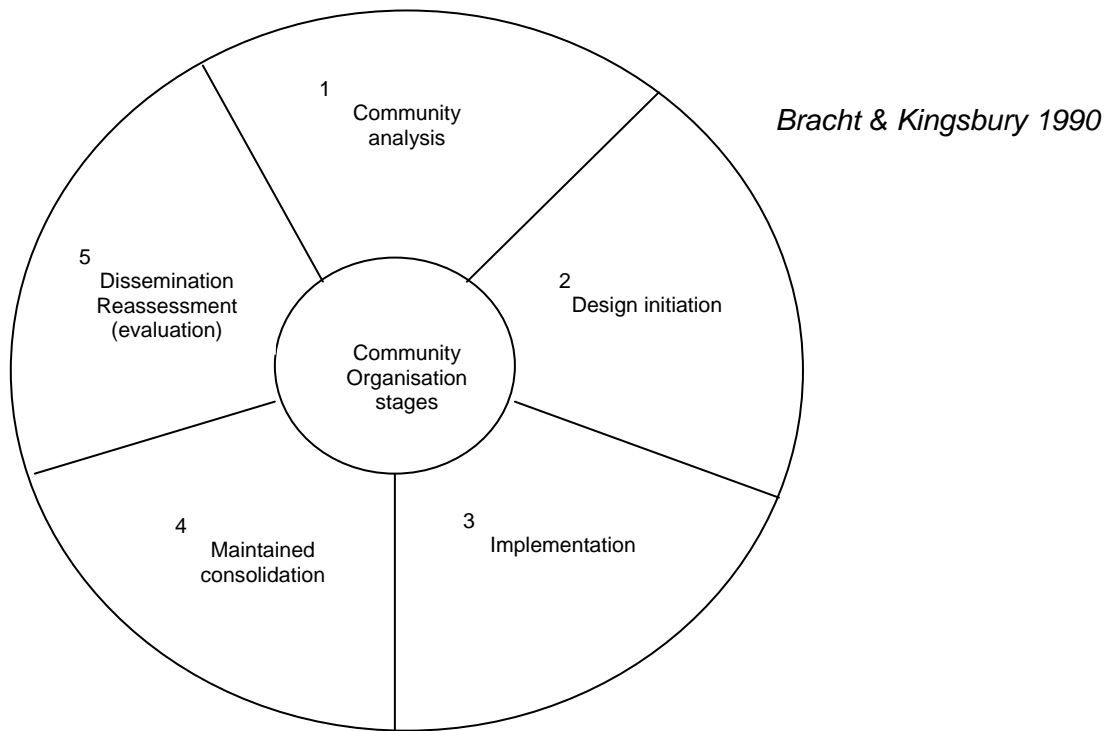


*Labonte 1993*

There is evidence of measurable health benefits in societies (e.g. infant mortality rates) which value public life; solidarity; civic participation and horizontal social and political networks (Putnam 1993). The converse approach yields negative health consequences. Authoritarian societies where democratic rights are prevented yields people who suffer from “learned helplessness” i.e. individuals internalising of powerlessness and resignation of their fate.

## 6 PLANNING FOR CHANGE

6.1 The first step of a community approach to planning for empowerment is the creation of opportunities for people to name their own health issues.

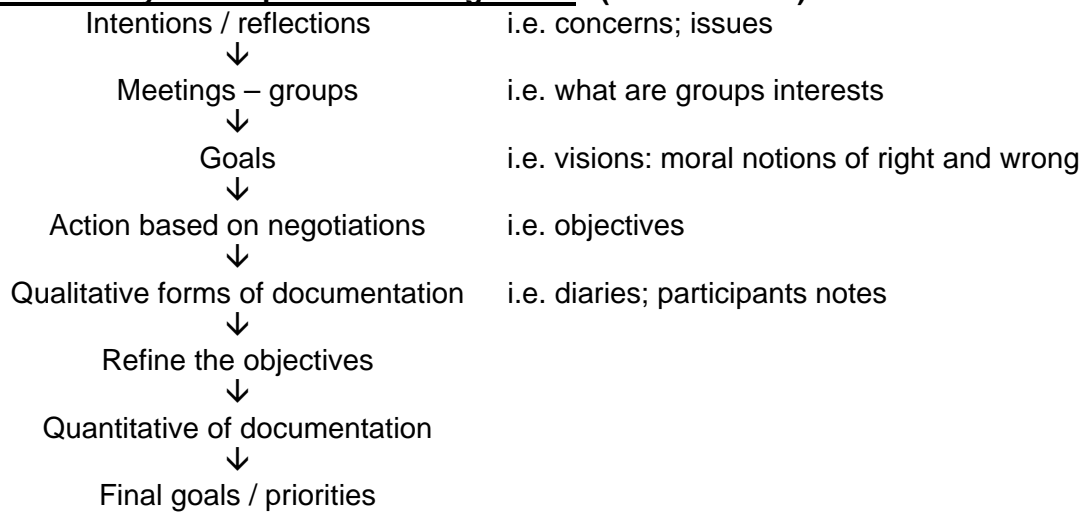


6.2 Neighbourhood Needs Map and Community Assets Map

It is important to focus on the positive strengths of a community. The traditional approach is to focus on the negative aspects e.g. reduced life expectancy; high deprivation; low numeracy and literacy and so on. We need to enable individuals within defined communities to realise their own and their communities potential. All communities have resources upon which to build. An understanding is essential of a community’s assets, capacities and abilities and to connect them with another that multiplies their effectiveness.

We therefore identify the mutually agreed community “needs” and the community assets with which to address the needs.

**Community Development Planning Model (Labonte 1993)**



6.3 Existing Strategies and Plans

There are a plethora of guidance and strategies from national down to county level. They all describe in detail what are the issues but are short on what action to take; even if action is described it tends to stop at a relatively large population level e.g. County. None describe how to tackle the issues among local population but when individuals are discussed then follows the usual “healthy” exhortations and then the focus switches to the NHS, usually the GP, to sort this out.

As obesity is an increasing problem then it is clear that these old health promotion approaches have failed hence why the advocacy of a new approach as described.

6.4 Acknowledgement is given here to the review of Linda Norheim from which much is quoted. (“Community Development for Health – a resource guide for health workers”- 1999).

**7 OBESITY**

7.1 Introduction

Obesity is an epidemic in western societies. It is the commonest cause of ill health in the UK.

It shortens life by an average of 9 years

It accounts for 6% of all deaths

More than 50% of adults are overweight

1:5 adults is obese (2-3 stones overweight)

Type II diabetes is almost entirely related to being overweight (diabetes can be translated as accelerated widespread arterial disease)

Obesity is associated with: -

- Cardio vascular disease
- Sleep apnoea
- Polycystic ovary syndrome (PCOS) and infertility
- Gallstones
- Venous stasis
- Depression
- Lower social achievement
- Lower educational progress
- Lower economic achievement

Figure 1

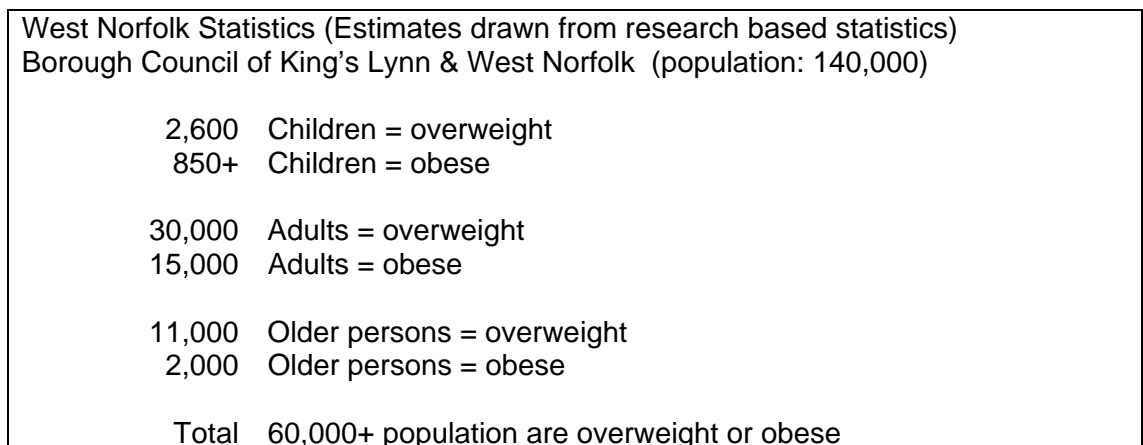
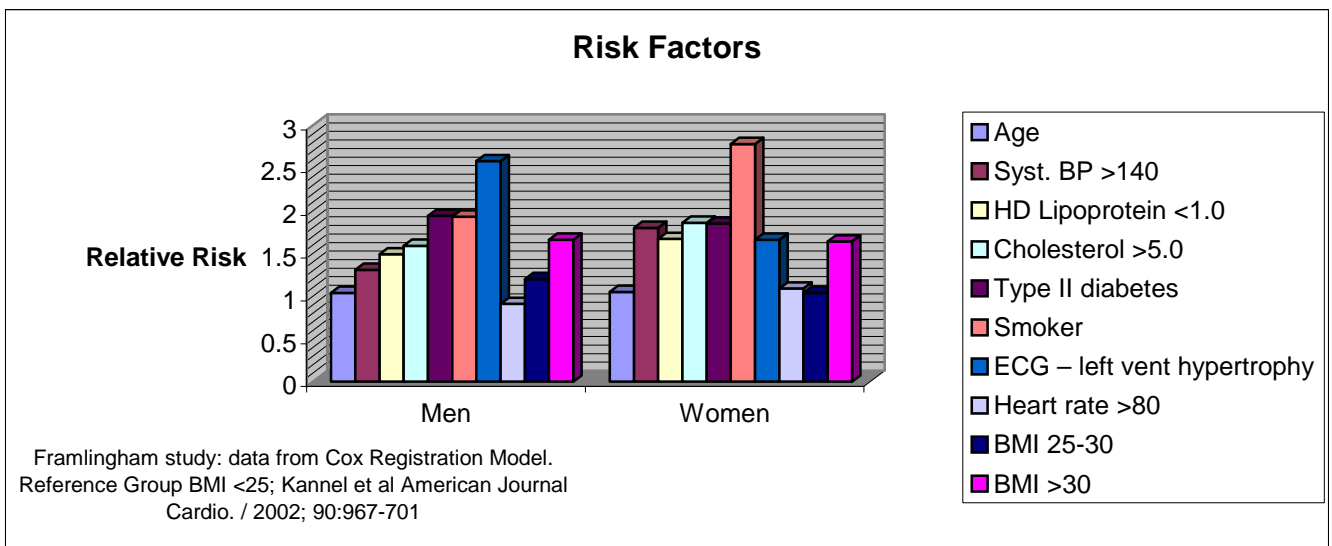


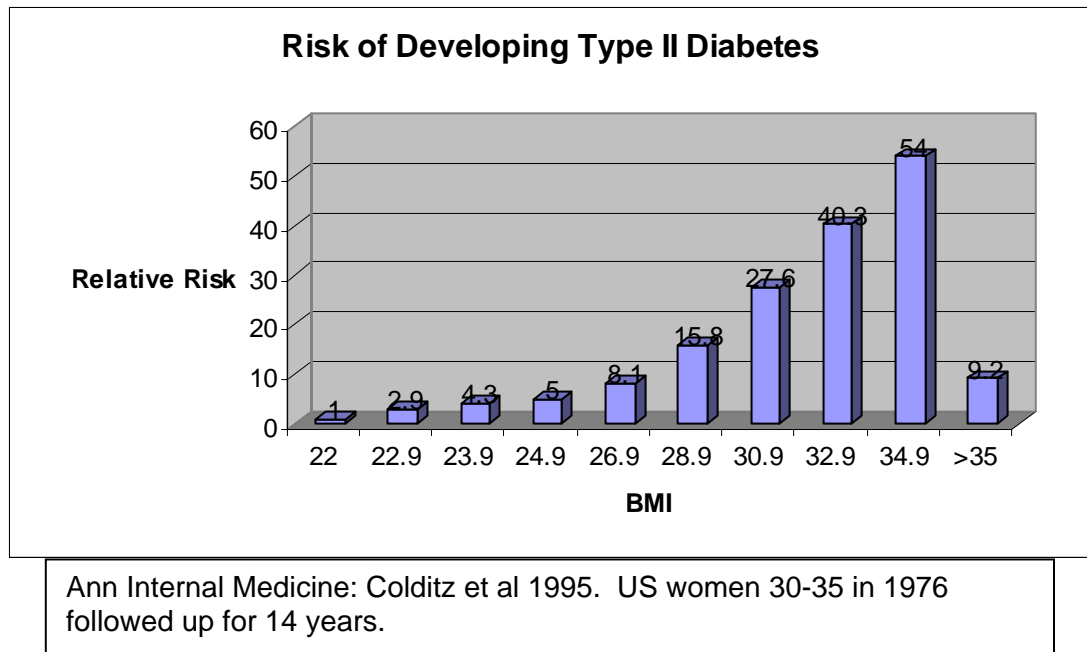
Figure 2



As can be seen both for men and women, obesity as an independent variable is expressed as a high relative risk factor.

If we could prevent the population from progressing to the next highest BMI category then the following percentage reductions in incidence of type 2 diabetes could occur.

Figure 3



A BMI increase from 26 → 27 causes a 13% increase in incidence of Type II diabetes.

Figure 4

|                               | BMI              |                |              |
|-------------------------------|------------------|----------------|--------------|
|                               | <25 to BMI 25-30 | 25-30 to 30-35 | 30-35 to >35 |
| Reduction in Type II Diabetes | 74%              | 61%            | 11%          |

Burke et al Diabetes Care 2003; 26:1999-2004. Non Hispanic whites in San Antonio Heart Study

Therefore in population terms we need to concentrate our activities on preventing normal weight persons becoming overweight and getting those that are already overweight to reduce to “normal weight” (BMI <25) especially as a BMI increase from 26-27 causes a 13% increase in incidence of Type II Diabetes. A study in Finland showed that a weight loss of 3.5kg (half a stone) could produce a reduction in type II diabetes incidence of 48% over 4 years (“diabetes prevention study”).

## Summary

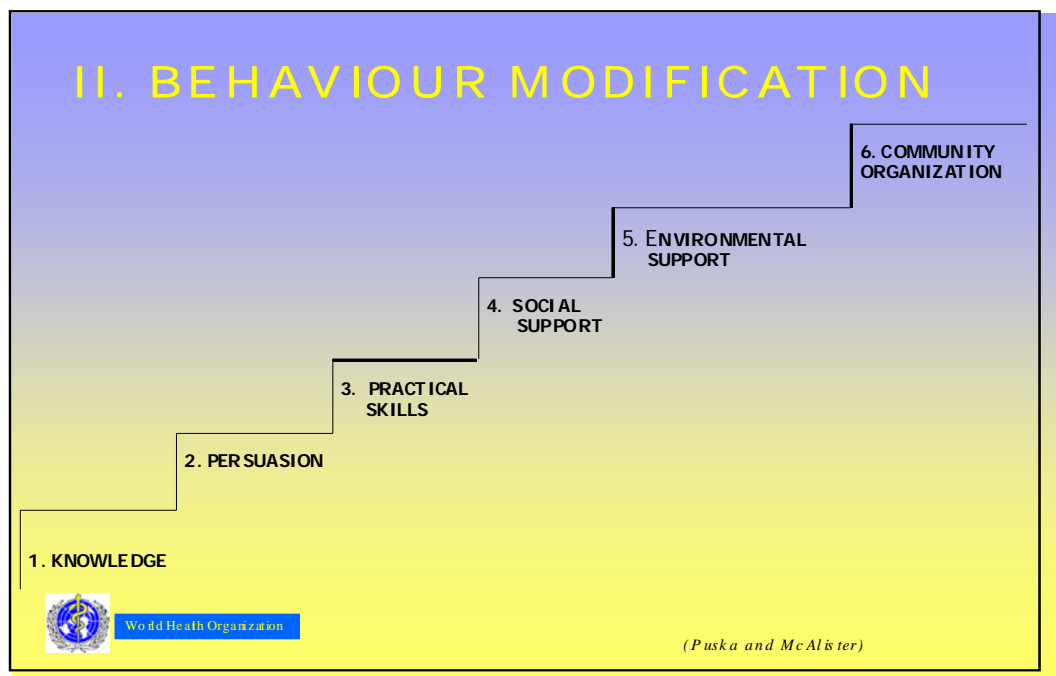
Obesity is a major population and “societal” problem. It is a major factor in itself for direct and indirect association with a range of diseases especially cardiovascular and is an “amplifier” for a range of risk factors (e.g. smoking) that contributes to heart disease. If we can, in the wider population replicate the Finnish Diabetes Prevention study then we could almost eradicate diabetes type II with a very modest population weight loss.

## 8 HOW?

This is a “societal” problem and “society” is required to solve it. It is not a problem of one group nor is it a problem that can be solved by one group. The NHS cannot alone solve this, neither can local authorities, voluntary groups and so on. All need to be involved in a planned and co-ordinated way and each has its “place of involvement”.

The Karelia Programme in Finland has demonstrated how the use of community involvement and development can reduce the mortality from heart disease and other negative contributing factors to health.

Figure 1



As can be seen from Figure 1 it is a co-ordinated community approach that is needed.

West Norfolk PCT, in collaboration with the BCKLWN, have agreed nine neighbourhoods on which to base community development work. The operational framework for health improvement will be “Choosing Health”, the Department of Health White Paper on improving the public health.

It is proposed that each neighbourhood will offer a “bespoke” plan to approach health improvement and within this the approach to alleviation of obesity. There will be an initial epidemiological “locality profile” drawn from a range of data and providing a basic “needs assessment” drawn on from routine data. This needs to be combined with information from the locality communities views of their needs, wishes and demands. This combination of information should then provide an initial needs analysis from which a set of priorities for action can be identified.

The focus for “societal” action is “primary prevention” i.e. prevention of ill health and promotion of health. “Secondary prevention” i.e. the early detection and then efficient and effective treatment falls more towards the services offered by the NHS.

8.1 Community Settings: The places and people who will be involved. Some examples are described here: -

8.1.1 The individual: The adult ultimately has a responsibility for their own health and also for that of their children.

8.1.2 The family: The home setting has a great influence on the whole behaviour of the individuals within it i.e. whole approach to life – exercise; sport; diet and being exemplars.

8.1.3 Schools: Schools have a profound ability to influence their pupils by the example and leadership set by the local head teacher and staff.

8.1.4 Further and higher education: Direct and indirect learning and the other experiences gained can influence present and future behaviour.

8.1.5 The workplace: People are at work about one third of their daily lives: work earns an income and better incomes generate more choice and control in relation to ones existence. Occupational health in terms of working conditions, canteens and diet, and exercise not only affect the individual working within that environment but the economic prosperity of the locality.

### 8.1.6 Food Outlets

- a) Shopping: The pattern of food shopping is altering very rapidly. The “corner shop” is now rare and substituted by the large organisation based supermarkets. This monopolisation of food buying puts a great onus on these “food chains” to take a more responsible attitude and approach to how they influence the public – and influence the public they certainly do. They need to work with others to improve the health of their local populations and not stand alone and aloof from this.
- b) Eating: Better, more accurate and less misleading information on products needs to be a priority.

8.1.7 Sports facilities: Sport serves many purposes – fitness; team engagement; healthy competition and so on. Many are commercial organisations and expensive so cater to the relatively prosperous but not to lower socio economic groups, so there is inequity of access. We need to widen and equalise “access” to sports facilities across all the socio economic groups.

8.1.8 Commercial weight loss: The pharmaceutical industry promotes its drugs for weight loss. There is nervousness among professionals about involving them too closely because of the commercial factor.

Similarly with the varying weight loss / diet organisations. There is little interaction between the NHS and other statutory organisations with these weight loss clubs etc.

We do need a new approach to dialogue and involvement with all of these. Standing apart from them, whilst a significant proportion of the population attend them, is not a practical and realistic way to work in the 21<sup>st</sup> century.

8.1.9 Local Authorities: Local Authorities (LAs) (County, Borough, Parish) are the setting in which we have our elected representatives. LAs have a responsibility to lead the public health agenda – as they have done since the latter part of the 19<sup>th</sup> century. Pubs, restaurants, transport, education come under their responsibility. We are now “in the age of the car” and routine daily transport that facilitates exercise is next to non-existent. Local authorities need to look at how they can encourage safe cycling and walking as a routine, using other areas in the world as examples e.g. Gronigen in the Netherlands; Scandanavia.

8.1.10 Voluntary Groups: There are a huge range of voluntary groups some being small “special interest” based groups consisting of just a few people and others being large nationally based organisations. Between them they represent the varied interests of a large proportion of the grass roots population. This places them in a unique position from which they can view the problems and also identify potential solutions. As the main approach to the reduction in obesity will be by involving communities then voluntary groups will be crucially important in community development programmes.

## **9 OBESITY ACTION / PROJECT PLAN**

### 9.1 Outcomes

- 9.1.1 Decrease morbidity and mortality from a range of obesity linked diseases e.g. Diabetes Mellitus; CHD; Cancers etc...
- 9.1.2 To reduce BMI in children under 11 years of age.
- 9.1.3 Reduce population weight by at least 5% over 5 years.
- 9.1.4 Increase population physical activity by at least 1% per year, year on year.
- 9.1.5 Reduce the incidence of Type II Diabetes Mellitus in the population by at least 50% over 10 years.
- 9.1.6 Reduce the proportion of fat (to <35%) and salt (no more than 6 g/day; from 9.5) in the population’s diet.
- 9.1.7 Baseline estimation of the weight of a population sample and the observation of the effects of a range of interventions on weight and the other variable over a 5 year period.



## LIFE JOURNEY

| <b>1 Population within BCKLWN</b> |                                 |   |  |   |  |  |   |   |                      |                                      |
|-----------------------------------|---------------------------------|---|--|---|--|--|---|---|----------------------|--------------------------------------|
| <b>Aim/Outcome</b>                | <b>Problem/Issue</b>            | <b>Baseline evidence</b>  | <b>Brief description of action</b>                             | <b>By whom?</b>   | <b>How will this be resourced?</b>                           | <b>Milestones &amp; Dates</b>  | <b>Barriers &amp; Risks</b>                             | <b>High level target</b>  | <b>LAA Reference</b> | <b>Strategic framework reference</b> |
| Attain optimum weight             | Overweight and obese population | a) Estimations made from research evidence in literature<br>b) Baseline study on sample of local population | Multiple interventions based on a community development model. | Professionals and public industry; commercial sectors; local authorities; NHS; voluntary services | Human resources drawn from existing public and professionals | - 5% loss of weight 2007-2012 (1 <sup>st</sup> milestone)<br>- Increase in physical activity of 1% per year.<br>- Decrease in incidence of Type 2 DM | - Apathy<br>- Long timescales to achieve desired change | a) Reduced year on year rise in overweight and obesity in children<br>b) Nil specific for adults<br>c) ↓mortality<br>d) ↓BMI children | ?                    | EoE strategic plan for obesity       |

## 2 Preconception

| Aim/Outcome                       | Problem/Issue  | Baseline evidence              | Brief description of action  | By whom?  | How will this be resourced?   | Milestones & Dates                 | Barriers & Risks                                      | High level target   | LAA Reference               | Strategic framework reference |
|-----------------------------------|--|--------------------------------|--|---|---|------------------------------------|---|---|-----------------------------|-------------------------------|
| Achieve & maintain optimum weight | High levels of obesity in females can inhibit conception | Future local population survey | <p>Advice from and access to dieticians</p> <p>Promotion of exercise in several settings e.g. gyms; community settings; sports facilitators; dance</p> | <ul style="list-style-type: none"> <li>- Community areas</li> <li>- Schools</li> <li>- Work place</li> <li>- Teachers</li> <li>- Sports experts</li> <li>- Gyms</li> <li>- Local Authorities - cycling improvements &amp; walking routes</li> <li>- GPs / Primary Care</li> <li>- Dieticians</li> </ul> | <ul style="list-style-type: none"> <li>- Community action</li> <li>- Various professionals e.g. dieticians</li> <li>School teachers</li> <li>GPs/primary care</li> <li>LAs – e.g. cycling facilities</li> <li>- Diet : home/school/workplace</li> <li>- Exercise</li> <li>- Cooking skills</li> </ul> | Mid 2007 onwards in neighbourhoods | Population, disinterest, advertising by food industry | <p>Reduction in mortality</p> <p>↓weight</p> <p>↑physical activity</p> <p>↓Type 2 DM</p> <p>↓Fat &amp; salt</p> | <p>- ?</p> <p>- Obesity</p> |                               |

| <b>3 - Antenatal</b>   |   |                              |   |   |   |   |                             |   |                      |                                      |
|--|---|------------------------------|---|---|---|---|-----------------------------|---|----------------------|--------------------------------------|
| <b>Aim/Outcome</b>   | <b>Problem/Issue</b>                      | <b>Baseline evidence</b>     | <b>Brief description of action</b>  | <b>By whom?</b>   | <b>How will this be resourced?</b>  | <b>Milestones &amp; Dates</b>   | <b>Barriers &amp; Risks</b> | <b>High level target</b>  | <b>LAA Reference</b> | <b>Strategic framework reference</b> |
| Maintain appropriate weight during pregnancy to maintain health of mother and foetus | Disproportionate weight gain in pregnancy | ?From future baseline survey | <ul style="list-style-type: none"> <li>- Diet</li> <li>- Exercise</li> <li>- Advice on benefits of breastfeeding</li> </ul> | <ul style="list-style-type: none"> <li>- Midwives</li> <li>- GPs</li> <li>- Family</li> <li>- Health promotion specialists</li> <li>- Locality groups</li> <li>- Dieticians</li> <li>- Antenatal clinics</li> <li>- Gyms</li> </ul> | <ul style="list-style-type: none"> <li>- NHS – PCT and Primary Care</li> <li>- Locality support groups</li> <li>- Antenatal classes</li> <li>- Midwives</li> <li>- GPs</li> <li>- Family</li> <li>- Health Promotion specialists</li> </ul> | 2007-2012<br><br>No easily obtainable data.<br><br>To obtain data via survey. | ?                           | <ul style="list-style-type: none"> <li>- Prevent gestational DM</li> <li>- Reduce future ↑BMI in children</li> <li>- Reduce fat and salt in diet</li> </ul> | Obesity reduction    | Strategic plan for obesity           |

| 4 Postnatal   |   |   |  |   |  |                    |                      |   |               |                               |
|---|---|---|--|---|--|--------------------|----------------------|---|---------------|-------------------------------|
| Aim/Outcome   | Problem/Issue   | Baseline evidence   | Brief description of action  | By whom?  | How will this be resourced?  | Milestones & Dates | Barriers & Risks     | High level target   | LAA Reference | Strategic framework reference |
| Return to optimum BMI weight for mother and "correct" weight for baby | - Difficulty losing weight gained during pregnancy and return to optimum weight<br>- Prevent obesity in infants | ?source of evidence of postnatal weight gain as predictor of future sustained weight gain | - Postnatal classes<br>- Community support groups, community based exercise groups<br>-Breast/feeding mothers diet<br>- Weaning advice<br>- Parenting skills | - Health visitors<br>- Midwives<br>- Primary Care<br>- Community Groups<br>- Dieticians | Existing NHS resources<br>- HVs<br>- Primary Care<br>- Community workers<br>- Midwives | 2007-2012          | Postnatal depression | ↓Mortality<br>↓Weight<br>↑Physical exercise<br>↓DM2<br>↓Fat, salt | ?             |                               |

| 5 Children & Young People   |  |   |   |  |  |                    |   |   |               |                               |
|---|--|---|---|--|--|--------------------|---|---|---------------|-------------------------------|
| Aim/Outcome   | Problem/Issue                          | Baseline evidence   | Brief description of action   | By whom?   | How will this be resourced?  | Milestones & Dates | Barriers & Risks  | High level target Objective   | LAA Reference | Strategic framework reference |
| Maintain optimum weight<br><br><b>Adele Godsmark to help complete this section please</b> | Maintenance of optimum growth velocity | a) Estimation of obesity in children from research literature.<br><br>b) National survey of weight in children at 5 years & 11 years.<br><br>c) Baseline survey of sample of population in BCKLWN area. | Dietary advice to parents<br><br>Various actions in schools, colleges, workplace<br><br><b>(Adele to expand on this please)</b> | - Crèches<br>- Nurseries<br>- Schools (as hub of community)<br>- Colleges<br>- Parents | - Community<br>- Voluntary groups<br>- Community/school groups<br>- LAs:<br>Cycling<br>Sports facilities<br>- Schools:<br>Meals<br>Vending<br>Machines & water availability<br>Sports / - PE<br>- Transforming school food:<br>Fruit /veg schemes in school<br>- Lunchbox advice<br>- Commercial:<br>Supermarkets<br>- Dietary advice to parents<br>- Exercise<br>play<br>sports –<br>increase variety)<br>walks<br>cycling<br>- ↓TV time<br>- Weigh children at 4-5 and 11 years<br>- School travel plans | 2007 – 2012 (2010) | ?Parental Adolescent resistance<br><br>Teachers time in schools | Halt year on year rise in obesity in children <11 by 2010<br><br>↓Fat, salt<br><br>↓DM2<br><br>↑Physical exercise | ?             | EoE Obesity Plan              |

| 7 Adults  |  |  |   |   |   |  |  |   |               |                               |
|---|--|--|---|---|---|--|--|---|---------------|-------------------------------|
| Aim/Outcome   | Problem/Issue  | Baseline evidence  | Brief description of action   | By whom?  | How will this be resourced?   | Milestones & Dates   | Barriers & Risks   | High level target Objective   | LAA Reference | Strategic framework reference |
| Maintain weight at BMI <25<br><br>Reduce complications of obesity:<br>- DM2↓<br>- Hypertension↓<br>- Mortality from CHD; Stroke;<br>Musculo skeletal disorders<br>- ↓sickness absences in industry and commerce | 50+% of population are overweight<br><br>1:5 adults are obese<br><br>Even small reductions in weight reduce risk of complications<br><br>Sickness absences in industry | a) Estimations from research literature and surveys<br><br>b) Future baseline measurement of weight in sample of population in BCKLWN area | <ul style="list-style-type: none"> <li>- Dietary advice</li> <li>Education re healthy diet</li> <li>Cooking skills</li> <li>- Workplace</li> <li>- Gardening/ allotments</li> <li>- Exercise</li> <li>Facilitated</li> <li>Travel to work</li> <li>Walking</li> <li>Cycling</li> <li>Subsidised exercise</li> <li>Neighbourhood based exercise programmes e.g. sports, dancing</li> <li>Clubs</li> <li>- Restaurant menus</li> <li>- Commercial sectors - Food outlets</li> <li>- Pharmaceutical companies</li> <li>- Weight loss organisations based in communities</li> <li>- Maximum claiming of "benefits"</li> </ul> | <ul style="list-style-type: none"> <li>- Professional NHS</li> <li>Non NHS</li> <li>LAs</li> <li>Employees</li> <li>- Primary Care: Weight management</li> <li>1:1 advice and help</li> <li>- Public in communities</li> <li>- Employers</li> <li>- The "family" working together</li> <li>- Dieticians advice</li> <li>- Local Authorities: Transport</li> <li>Walkways</li> <li>Safer cycling</li> <li>- Commercial organisations: Pharmaceutical</li> <li>Food industry</li> <li>Restaurants</li> <li>Cafes</li> <li>Food shops</li> <li>Food markets</li> <li>- Slimming organisations</li> </ul> | 2 <sup>nd</sup> homes funding via LSP<br><br>Community based cookery classes<br><br>Community based home economics (where needed)<br><br>Community based slimming clubs | 2012<br><br>Based on neighbourhood priorities identified in 2007 | Persuading large numbers of the population to change behaviour in relatively short time period | Reduce weight in population by at least 5% in 5 years<br><br>Reduce incidence of DM2 by at least 50% in 5 years (?) | ? outcome 2.2 | EoE strategic plan            |

| 8 Older People   |   |                                  |   |   |   |   |                                   |  |               |                               |
|--|---|----------------------------------|---|---|---|---|-----------------------------------|--|---------------|-------------------------------|
| Aim/Outcome  | Problem/Issue   | Baseline evidence                | Brief description of action   | By whom?  | How will this be resourced?                                     | Milestones & Dates                        | Barriers & Risks                  | High level target Objective  | LAA Reference | Strategic framework reference |
| <p>Reduce obesity and maintain weight in under weight</p> <p>Reduce mortality from obesity and its complications</p> | <p>Obesity leads to premature mortality from CHD, Stroke, DM and Cancers which are all more common in those &gt;65 yrs</p> <p>Increased hospital admissions</p> <p>Increased osteoporosis</p> <p>Increased mental health problems e.g. depression</p> <p>Hospital admissions</p> <p>Levels of osteoporosis</p> <p>Levels of depression which leads to ↓motivation</p> | <p>Research based literature</p> | <ul style="list-style-type: none"> <li>- Diet</li> <li>- Maintain appropriate diet and calorific levels</li> <li>- Allotments and vegetable growing</li> <li>- Maximise "benefits" claims</li> <li>- Use skills of older people to teach others</li> <li>- Exercise:               <ul style="list-style-type: none"> <li>Encourage continued exercise:                   <ul style="list-style-type: none"> <li>Walking</li> <li>Cycling</li> <li>Exercise clubs</li> <li>Dance clubs</li> </ul> </li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>- Community residents</li> <li>- Extended schools scheme</li> <li>- Voluntary groups</li> <li>- Older people as "teachers" e.g. cooking, gardening</li> <li>- Dieticians</li> <li>- Restaurants</li> <li>- Food industry (supermarkets)</li> <li>- LAs: walking and cycling</li> <li>- Older people to teach others where possible e.g. gardening, cooking</li> <li>- Benefits office</li> <li>- Primary Care</li> </ul> | <p>??<sup>nd</sup> homes funding</p> <p>Community resources</p> | <p>2012</p> <p>Mid 2007 in localities</p> | <p>Not what older people want</p> | <p>No specific targets apart from</p> <ul style="list-style-type: none"> <li>- 5%↓ in weight in population in 5 years</li> <li>- 50% reduction in DM2</li> </ul> | <p>? 2.2</p>  | <p>EoE obesity plan</p>       |

| <b>9 Disabled</b>  |                      |                          |                                    |                 |                                    |                               |                             |                                    |                      |                                      |
|--------------------|----------------------|--------------------------|------------------------------------|-----------------|------------------------------------|-------------------------------|-----------------------------|------------------------------------|----------------------|--------------------------------------|
| <b>Aim/Outcome</b> | <b>Problem/Issue</b> | <b>Baseline evidence</b> | <b>Brief description of action</b> | <b>By whom?</b> | <b>How will this be resourced?</b> | <b>Milestones &amp; Dates</b> | <b>Barriers &amp; Risks</b> | <b>High level target Objective</b> | <b>LAA Reference</b> | <b>Strategic framework reference</b> |
| Physical           |                      |                          |                                    |                 |                                    |                               |                             |                                    |                      |                                      |
| Disabled           |                      |                          |                                    |                 |                                    |                               |                             |                                    |                      |                                      |