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Report of the Director of Public Health and the Interim Strategic Director of Adult and Community Services CBMDC; and the Clinical Chair Bradford Districts Clinical Commissioning Group to the meeting of the Health and Wellbeing Board to be held on 26th July 2016

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Subject:

A Whole System Approach to achieving Healthy Weight for the population of Bradford District

Summary statement:

A discussion paper to outline the challenges posed by overweight and obesity to health outcomes and to facilitate discussion of how to achieve healthy weight for the population of the District

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Portfolio:

Health and Wellbeing

Overview & Scrutiny Area:

Health and Social Care

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

1. SUMMARY

1.1 This report considers what we can do to address the high level of overweight and obesity amongst the population of Bradford District - one of the major barriers to achieving good health and wellbeing in our local population. The report focuses on what the evidence suggests we can and should do about it to prevent more people becoming overweight or obese, and to support people who are already overweight or obese to reach and maintain a healthy weight.

2. BACKGROUND

2.1 Relevant decisions. In March 2015 the Board received a report 'Improving health through physical activity and reducing physical inactivity'. The Board resolved

(1) That the Board members be requested to review policies and practices of their respective agencies that might impact physical activity and to work together to improve these practices and develop policies to increase daily physical activity in the district.
(2) That the Board considered the key factors set out in Section 3.6 of Document "U" to increase physical activity in the whole population through joint work across all relevant sectors.
(3) That the Director of Public Health and the Strategic Director of Environment and Sport be requested to develop a vision of how a more active district will look in the future and an integrated overarching strategy to achieving this vision.

Action: Director of Public Health and the Strategic Director, Environment and Sport

2.2 Healthy life expectancy in the District is below the national average for men and women and below the regional average for women. Life expectancy overall is also lower than national and regional averages and there is a significant difference in life expectancy between the most deprived and least deprived parts of the district. Here, as elsewhere in the country, more and more people are becoming overweight and in some cases obese.

2.3 Causes:

Obesity/overweight occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the accumulation of excess body fat. However there are many complex behavioural and societal factors that combine to contribute to the causes of obesity. The Foresight report (2007) referred to a "complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain". The report presented an obesity system map with energy balance at its centre. Around this, over 100 variables directly or indirectly influence energy balance.

The Foresight map is divided into 7 cross-cutting predominant themes:

- Biology: an individuals starting point - the influence of genetics and ill health;
- Activity environment: the influence of the environment on an individual's activity behaviour, for example a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and showers;
- Physical Activity: the type, frequency and intensity of activities an individual carries out, such as cycling vigorously to work every day;
- Societal influences: the impact of society, for example the influence of the media, education, peer pressure or culture;
- Individual psychology: for example a person's individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences;
- Food environment: the influence of the food environment on an individual's food choices, for example a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables near home;
- Food consumption: the quality, quantity (portion sizes) and frequency (snacking patterns) of an individual's diet.

2.4 Health Risks:

<u>Adults</u>

- Musculoskeletal system
- Circulatory system
- Metabolic and endocrine systems
- Cancers
- Reproductive and urological problems
- Respiratory problems
- Non-alcoholic fatty liver disease
- Gastrointestinal disease
- Psychological and social problems

<u>Children</u>

Being overweight or obese in childhood has consequences for health in both the short term and the longer term. Once established, obesity is notoriously difficult to treat, so prevention and early intervention are very important.

The emotional and psychological effects of being overweight are often seen as the most immediate and serious by children themselves. They include teasing and discrimination by peers; low self-esteem; anxiety and depression. Obese children may also suffer disturbed sleep and fatigue.

Obese children and young people are more likely to become obese adults and have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity – for example, raised blood pressure, fatty changes to the arterial linings and hormonal and chemical changes such as raised cholesterol and metabolic syndrome – can be identified in obese children and adolescents.

Some obesity-related conditions can develop during childhood. Type 2 diabetes, previously

considered an adult disease, has increased dramatically in overweight children as young as five. Other health risks include early puberty, eating disorders such as anorexia and bulimia, skin infections, asthma and other respiratory problems.

2.5 Prevalence:

Adults

In adults, overweight is defined as a BMI 25-30 and obesity is commonly defined as a body mass index (BMI) of 30 or more.

Data on overweight and obesity among adults (defined as people aged 16 and over) are mainly from the Health Survey for England (HSE). Results for 2014 showed that 61.7% of adults were overweight or obese (65.3% of men and 58.1% of women). The prevalence of obesity is similar among men and women, but men are more likely to be overweight.

In England, the prevalence of obesity among adults rose from 14.9% to 25.6% between 1993 and 2014. The rate of increase has slowed down since 2001, although the trend is still upwards. The prevalence of overweight has remained broadly stable during this period at 36–39%.

The rapid increase in the prevalence of overweight and obesity has meant that the proportion of adults in England with a healthy BMI (18.5 - 24.9) decreased between 1993 and 2014 from 41.0% to 32.7% among men, and 49.5% to 40.4% among women. In England, currently 25.6% of adults (aged 16 years and over) are obese (HSE 2014).

By 2050 obesity is predicted to affect 60% of adult men, 50% of adult women and 25% of children (Foresight 2007).

Children

For children in the UK, the British 1990 growth reference charts are used to define weight status, using height, weight, age and sex (Cole, 1990).

The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults.

The National Child Measurement Programme (NCMP) measures the height and weight of around one million school children in England every year, providing a detailed picture of the prevalence of child obesity. The latest figures, for 2014/15, show that 19.1% of children in Year 6 (aged 10-11) were obese and a further 14.2% were overweight. Of children in Reception (aged 4-5), 9.1% were obese and another 12.8% were overweight. This means a third of 10-11 year olds and over a fifth of 4-5 year olds were overweight or obese.

Using National Child Measurement Programme data of primary school children, the Health and Social Care Information Centre states that:

- more than 1 in 5 children are overweight or obese when they begin school
- almost 1 in 3 children are overweight or obese by the time they leave primary school
- obesity rates are highest in the most deprived 10% of the population - approximately twice

that of the least deprived 10%

- obesity rates are higher in some ethnic minority groups of children (particularly Black African and Bangladeshi ethnicities) and for children with disabilities (particularly those with learning difficulties)

2.6 National context for policy and planning – Strategies and plans

- Healthy Lives, Health People – a call for action on obesity in England (2011)
- Everybody Active, everyday (Public Health England)
- Childhood Obesity: applying All Our Health
- Royal Society for Public Health - Child Obesity Strategy
- Five year forward view for the NHS – calls for prevention at scale of preventable disease

2.7 Economic Costs

In 2006/07, obesity and obesity-related illness was estimated to have cost £148 million in inpatient stays in England (Dr Foster, 2010). It is estimated that overweight and obesity overall costs the NHS £5.1 billion per year (Scarborough et al. 2011). However, if current trends continue, these costs will increase by an additional £1.9 billion per year by 2030 (Wang et al. 2011). In 2007, the cost to the wider economy was £16 billion – predicted to rise to £50 billion a year (at today's prices) by 2050 if left unchecked (Foresight 2007).

2.8 Health Inequalities:

In the UK, socioeconomic inequalities have increased since the 1960s and this has led to wider inequalities in both child and adult obesity, with rates increasing most among those from poorer backgrounds. This worsening of health inequalities in relation to obesity is more marked for women, and when socioeconomic position is measured by education, an indicator that captures the influence of childhood conditions as well as those in adulthood (Department of Health Public Health Research Consortium, 2007). In children, socioeconomic inequalities in obesity are stronger in girls than boys.

Other dimensions of inequality, which intersect with socioeconomic status in complex ways, also have important influences on health. There are major health challenges relating to specific 'equality groups' based on age, sex, ethnicity, sexuality, and disability (Strategic Review of Health Inequalities in England Post-2010, 2010).

<u>Deprivation - Adults</u>

Overall, for women, obesity prevalence increases with greater levels of deprivation, regardless of the measure used. For men, only occupation-based and qualification-based measures show differences in obesity rates by levels of deprivation.

Highest level of educational attainment can be used as an indicator of socioeconomic status. For both men and women obesity prevalence decreases with increasing levels of educational attainment.

Deprivation - Children

There is a strong relationship between deprivation and childhood obesity. Analysis of data from the National Child Measurement Programme (NCMP) shows that obesity prevalence among children in both Reception and Year 6 increases with increased socioeconomic deprivation (measured, for example, by the 2010 Index of Multiple Deprivation (IMD) score). Obesity prevalence of the most deprived 10% of the population is approximately twice that of the least deprived 10%.

2.9 Drivers:

Tackling obesity is a priority in the national Five Year Forward View for the NHS and in the Sustainability and Transformation Plan for the Bradford and Craven Health and Wellbeing System and contributes to 2 priorities in the Bradford and Airedale Joint Health and Wellbeing Strategy (see Appendix 1).

The public health outcomes framework identifies two specific indicators in relation to healthy weight; excess weight in adults and excess weight in 4-5 and 10-11 year olds. Excess weight combines data on overweight and obesity, but our local data allows these to be reported separately.

Data on excess weight in the district is based on weight and height measurements from 90-95% of Reception year and Year 6 children taken through the National Child Measurement Programme. As such it is an extremely robust data set which allows us to gain a comprehensive picture of children's weight across the district.

Data on adult overweight on PHOF is based on PHE Health profiles and as such is less robust. However data from the National Child Measurement Programme can be viewed as a reasonable indicator of adult overweight and obesity, once excess weight is established it tends to persist into adulthood.

2.10 Local data

Children - based on the National Child Measurement Programme

Chart 1: Proportion of pupils who are overweight by school year 2014-15

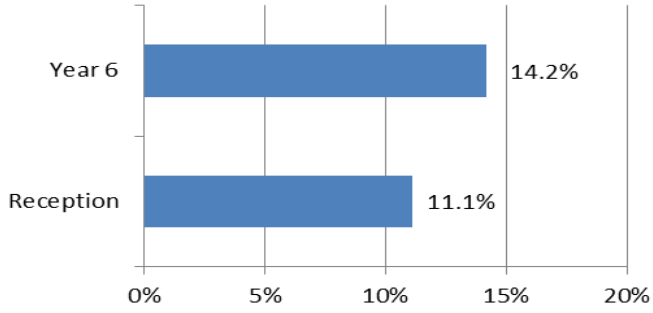
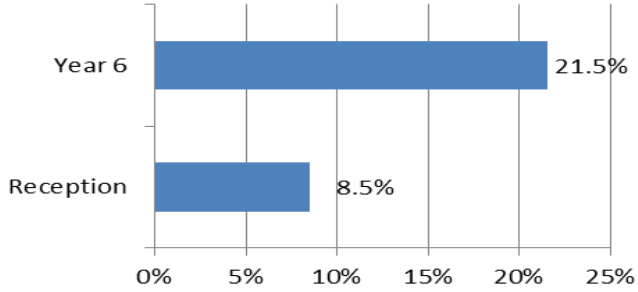


Chart 2: Proportion of pupils who are obese by school year 2014-15



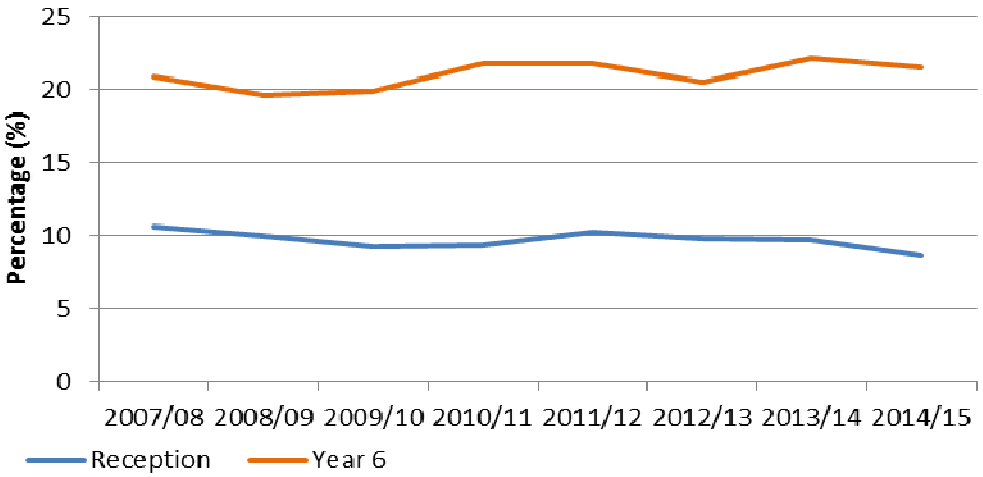
In the reception year of school 11.1% children were obese, with 19.7% overweight and obese; rates are higher among pupils in year 6 with 14.2% obese and 35.7% overweight and obese.

In the school reception year 8.5% of reception pupils are obese, lower than the National (9.1%) and Regional (8.8%) averages. However, obesity rates among year 6 pupils are considerably higher at 21.5%, higher than both National (19.1%) and Regional (19.2%) averages.

More males than females are obese in both reception and year 6, with 9.1% of males obese in reception compared to 7.9% of females, with 22.9% of males being obese compared to 20% of females in year 6.

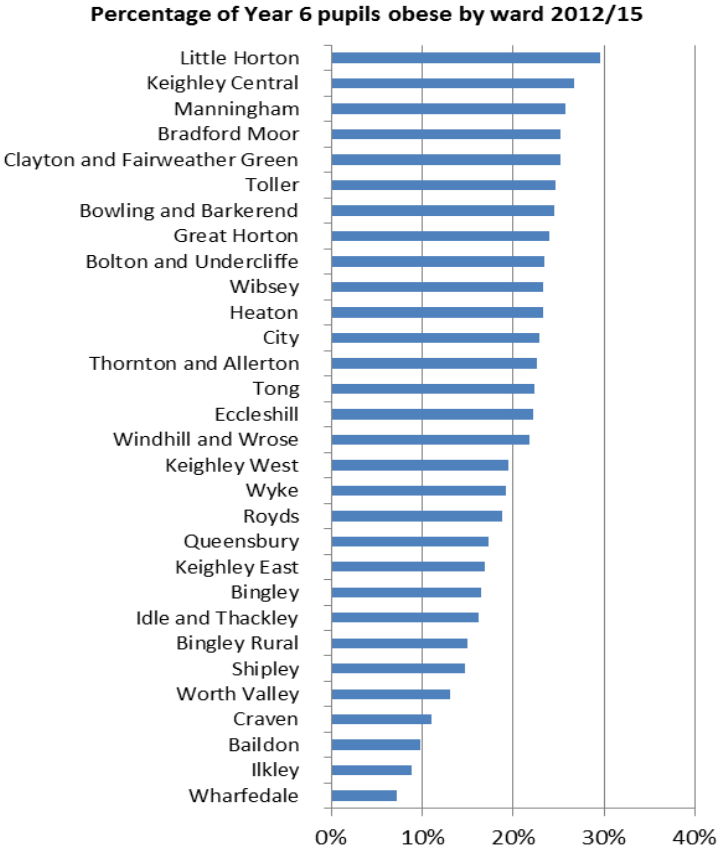
Obesity is related to social disadvantage with marked trends, especially in children, by area of residence (The Marmot Review 2010). There is also a close link to ethnicity. In Bradford District obesity is higher among Asian or Asian British pupils with 9.4% of Asian pupils obese in reception and 27.2% in year 6 compared to 16.8% of white or white British pupils in year 6.

Chart 3: proportion of pupils obese over time by school year



The proportion of obese children in reception has reduced over the last 8 years, whereas for year 6 pupils there has been a slight increase with 21.5% obese in 2014/15 compared to 20.9% in 2007/08. Also the gap between those obese in reception and year 6 is increasing, so despite the fact that the number of pupils in reception who are obese is decreasing, more pupils are becoming obese by year 6.

Chart 4 Percentage of Year 6 pupils who are obese - by ward



For year 6 pupils, obesity rates are highest in; Little Horton, Keighley central, Manningham and Bradford Moor and lowest in; Wharfedale, Ilkley, Baildon and Craven.

Adults – based on Quality Outcomes Framework QOF data, registrations with GPs by condition

56,891 adults are registered as obese with their GP, this is equivalent to 12% of the District population aged 17plus

2.11 Local strategic picture

- Bradford and Airedale Joint Health and Wellbeing Strategy (JHWS)
    - Priority 5 'Reduce childhood obesity and increase levels of physical activity and healthy eating in children and young people';
    - Priority 17 'Reduce harm from preventable disease caused by tobacco, obesity, alcohol and substance abuse'. See Appendix A.
- Five Year Forward View for the Bradford and Craven health economy 2014-19
    - 'To create a sustainable health and care economy that supports people to be healthy, well and independent' - Reduce Potential Years of Life Lost by between 9% and 18% by 2018/19 by influencing five key areas including:
    - Reduction in rates of smoking, **obesity** and alcohol related conditions
    - Reduce mortality from CVD, respiratory disease and cancer

- City of Bradford's Sustainable Travel to School Strategy 2014-17

- Children's Healthy Weight Strategy 2013-17

- B-Active: A Strategy to get the people of Bradford moving (draft)

- Physical Activity and Sport Strategic Framework for Bradford District (draft)

- Bradford District Food strategy

- Self Care and Prevention Strategy

3. OTHER CONSIDERATIONS

3.1 A long-term, whole –system commitment

Successfully tackling obesity is a long term, large scale commitment. The evidence is very clear that policies aimed solely at individuals will be inadequate and that simply increasing the number or type of small scale interventions will not be sufficient to reverse this trend. Significant effective action is required to prevent obesity at a population level and acting on many of the factors that are driving obesity and overweight.

Tackling the issue across local health and wellbeing systems is complex and requires action at every level, from the individual to society, and across all sectors. Obesity cannot be effectively tackled by one discipline alone and local authorities, led by public health colleagues, are ideally

placed to develop co-ordinated action to tackle obesity across its various departments, services and partner organisations. Local authority departments and service areas can influence :

- Transport
- Planning and environment
- Leisure and culture
- Parks and green spaces
- Education and learning
- Health and social care
- Housing
- Workplaces

The Local Government Association has produced a briefing paper for councillors and officers, 'Tackling obesity - local government's new public health role'. The paper explains the challenges facing councils and the opportunities they have to tackle obesity and reduce health inequalities in local communities.The National Institute of Health and Care Excellence (NICE) has developed a series of local government public health briefings. See Appendix 2.

3.2 Interventions to support Healthy Weight

The four-tier diagram below explains the different levels of intervention that can be taken. It helps describe the need for the whole systems approach to the issue.

Tier 1 are universal services, available to the whole population, services that are not targeted or specialist but promote a healthy lifestyle and are underpinned by the principle of helping people make healthier choices. Tier 1 is also the built environment, our infrastructure and the issues that create the backdrop to our society and our communities. In order to prevent overweight and sustain behaviour change everyone can contribute to this tier; planning, transport, education, primary care, allied health professionals, social care colleagues, leisure, parks/green space, neighbourhoods, workplaces and the media.

Tier 2 are specialist services, generally time limited and offer an intervention/treatment when individuals are already overweight/obese. These interventions need to be evidence based, be easy to access and to facilitate behaviour change. They may be provided by the commercial sector e.g. Weight Watchers. These services also need to ensure that individuals are sign-posted and enabled to access Tier 1 services in order to sustain a healthy lifestyle. It may be the case also that by getting involved in Tier 1 services individuals become aware of Tier 2/specialist services and self-refer or seek referral to these.

Tier 3 is a specialist obesity service providing a medically led assessment and monitoring. This service is a 12-month intervention whereby a medical team check for underlying conditions and enable the individual to access weight management intervention; tier 2, medication and psychological support. This service is also for pre and post weight loss surgery (Tier 4). In order to qualify for surgery individuals need to have accessed at least 6 months of treatment (Tier 2 services), in particular psychological support in order to change their lifestyle behaviour and therefore manage their lifestyle after surgery.

Tier 4 is surgical intervention. It is essential that individuals have made lifestyle changes and access post-operative treatment.

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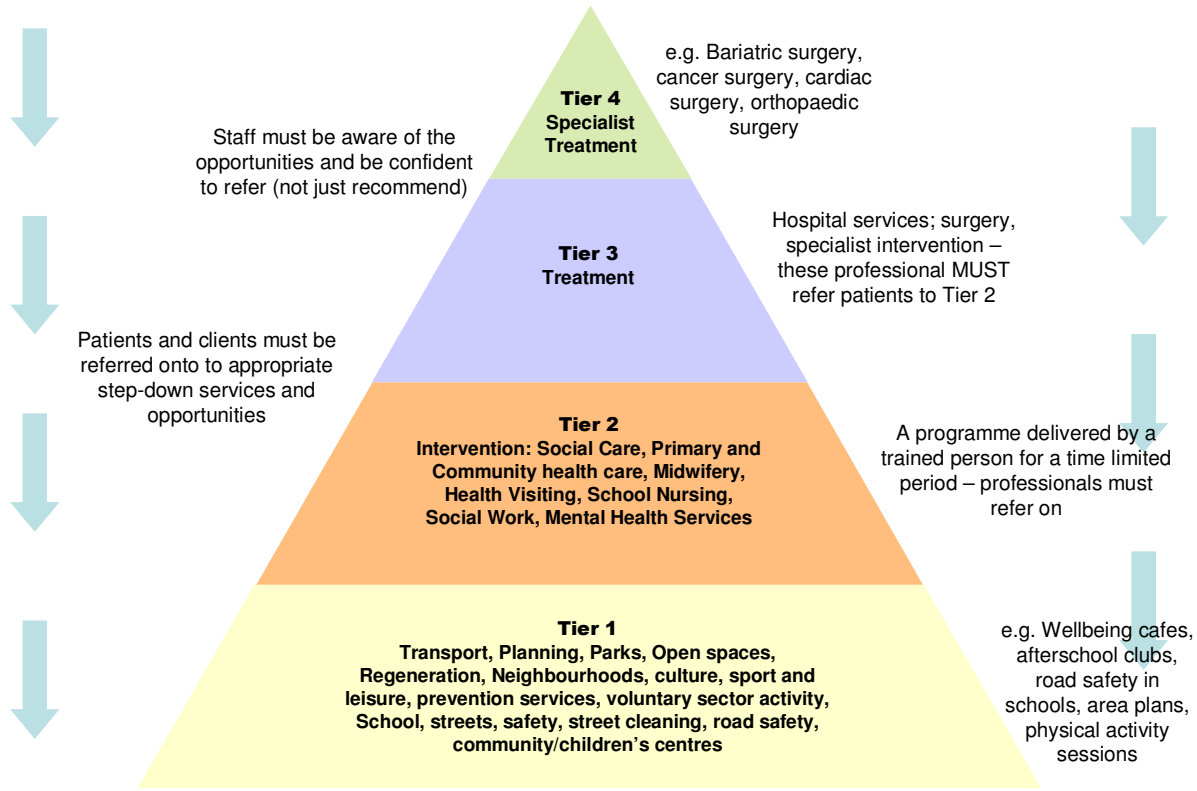

We must enable people to make healthy choices and facilitate the use of the opportunities available – on the streets, in open space, in leisure facilities, in their communities

Tier 1 is where we need to focus our efforts. There is a need to review our policies, strategies and practice and align our contributions, up-skill our workforce and develop a comprehensive plan of action. We have much of what's needed in Tier 1 but unfortunately its not linked together to create the impact that is necessary to make a difference. Many parts of the system do not see the importance of a whole-systems approach. We need to work across organisations, across the authority and to discuss the contributions that each sector can make. The voluntary and community sector provides varied activities including physical activity sessions, supervised exercise and gym sessions and promoting healthy lifestyles through learning and through sports. See Section 3.5 below.

With need some radical changes regarding the way we build our environment and encourage a healthier lifestyle, to enable people be to physically activity, and help people to eat a healthy diet. This needs broad, strategic thinking and most of all leadership and commitment.

Our commissioning needs to be health promoting and underpinned by the principle of enabling individuals to make healthy choices. We need to cross reference each others contribution to the agenda and our ambition to enable Bradford residents to live a healthy lifestyle.

Tier 2 services are available and currently underused. There is a need to promote and utilise the services available and a willingness to refer people identified through approaches such as NHS

Health Check and Making Every Contact Count.

Tier 3 and 4 are in place, although accessed by small numbers of people.

The NHS is delivering relevant schemes that cross both Tier 1 and 2 - targeting groups in the district with particular health risks:

The Bradford District CCG's *Healthy Hearts* promotes the best use of the cholesterol lowering drugs statins, increases awareness and detection of atrial fibrillation in primary care and uses physical activity to improve management outcomes in cardiovascular disease;

Bradford City CCG's *Beating Diabetes* scheme screens the at-risk population to identify undiagnosed diabetes needing treatment and deliver prevention or risk mitigation interventions to others according to their level of risk.

The development of an Accountable Care System for health and social is also addressing diabetes prevention.

3.4 Building a local whole system approach

The potential benefits of reducing the impact of excess weight on individuals and families and on demand for health and social care make a strong case for an overarching system-wide approach that supports healthier eating and a more active lifestyle at all levels.

Developing a whole system approach will allow us to ensure that we are using all the levers that we can to address overweight and obesity. It also allows us to harness the influence of a range of trusted professionals to help people to recognise and address the health risks they face through taking no action or continuing to gain weight, and to understand that help and support is available.

A system-wide approach to supporting people to be a Healthy Weight will be better equipped to identify and remove some of the barriers to making healthy choices the easier choices, and will increase the chance that interventions are not undermined by other factors that have not been taken into consideration.

Options – interventions that have demonstrated some success

Active Transport
Facilitating and encouraging walking, cycling, and public transport, which engender more physical activity.

Healthcare
Providing incentives or support to encourage healthy behaviour. These can include general financial incentives, such as premium rebates or reward points, or more targeted facilitating incentives such as free gym membership. Also deliver other interventions such as parental and weight-management programs.

Locally, the Bradford Beating Diabetes and Bradford Healthy Heart initiatives are targeted, at scale initiatives that include referral to lifestyle change programmes to support people to reduce weight and increase physical activity.

Healthy Meals
Improving the health quality of meals in controlled settings such as schools and workplaces.

Calorie Food and Drink Availability
Reducing the ready availability of high-calorie foods to help control impulse consumption, including removing vending machines from schools and workplaces, high-calorie foods from supermarket checkouts, and fast-food retailers from locations outside schools.

Labelling
Providing calorie and other nutritional labelling so that consumers can understand the content of their food. Labels can be plain text or “engaging”— an easy-to-interpret assessment of the health of the product (for example, traffic lights).

Media Restrictions
Restricting high-calorie food advertising to reduce exposure to marketing that is proven to promote consumption.

Parental Education
Empowering and educating parents to promote a healthier lifestyle for their children through regular parental guidance sessions.

Pharmaceuticals
Intervening with drugs to reverse obesity rapidly in cases where it is creating immediate health risks.

Portion Control
Encouraging appropriate consumption through incremental (for example, 1 to 5 per cent) reductions in portion sizes and designing packaging to better delineate portion size to help moderate consumption.

Price Promotions
Restricting promotional activity in high-calorie impulse foods to decrease consumption.

Public Health Campaigns
Delivering a public health campaign through multiple media outlets to promote healthy eating and physical activity habits.

Reformulation
Incrementally reducing calories in food products to drive subconscious reduction in consumption; introducing new product ranges with improved nutritional profiles.

School Curriculum
Introducing additional hours of physical education and healthy nutrition in school curricula to encourage healthier habits.

Subsidies, Taxes, and Prices
Changing agricultural policy or regulatory policy to adjust consumer prices and the supply of select food and/or beverage categories.

Surgery
Scaling up delivery of bariatric surgery to reduce stomach capacity and deliver immediate change

in food consumption.

Urban Environment
Making changes to physical spaces and food access to facilitate and encourage healthy habits, such as increasing the walkability of cities and green space, furthering access to community sports facilities, and improving access to grocery stores.

Weight-Management Programs
Educating and empowering individuals to change key weight behaviour through counselling, physical activity programs, and education.

Workplace Wellness
Offering programs and engaging employees to encourage healthy behaviour, for example through financial and non-financial incentives, team competitions, and the provision of education and self-management tools such as personal tracking devices.

3.5 Building and connecting Tier 1 approaches – Harnessing the wider determinants of health

3.5.1 The built environment

In the context of busy lives where many people have the competing demands of work, family and caring responsibilities, the rate of physical activity has reduced and intake of calories has increased, fewer people walk or cycle even on short journeys and reliance on takeaway food and ready meals has grown over the last decades. Areas of the District with the poorest health and wellbeing are also characterised by higher than national rates of poverty, poor housing, poor physical health, low-paid and insecure work.

If healthy weight interventions (as already noted in the report) are predominately 'aimed' at the individual and are not as successful as we'd like we will need to consider wider determinant factors; the built environment, housing; physical activity; green spaces & safe play. The District's Core Strategy addresses these issues. However, to avoid a further widening of health inequalities between areas within the District, improvements to the design and development of the urban built environment, the development of active transport and the availability of green space and areas that are safe to walk and cycle must include the most deprived areas of the District.

3.5.2 Food and licensing

Food Strategy initiatives include healthy eating activities (cook and eat sessions and weight management classes), commissioned through VCS organisations and supported by the council. New responses are emerging to food poverty and affordability of healthy food, resulting in the reuse of food from Bradford's large commercial food businesses and organisations. Voluntary and faith based organisations across the district have built up food networks offering a range of crisis interventions; food parcels and hot food for householders struggling to access affordable food. Included in many of these are simple, nutritional recipes. The 'Good Food Award' is run by West Yorkshire Trading standards which helps educate, train and reward restaurateurs who address healthy eating.

Planning regulations have been amended in Bradford to reduce the number of hot food takeaway establishments located within 400 metres of schools. Of 16 applications in 2015-16, 7 were refused on these grounds and 4 were withdrawn. It is not possible to judge how many potential

applications were not put forward following advice from a Planning officer that such applications were likely to be refused.

3.5.3 Active transport

The Government target of 100% more trips by bicycle and ambition to reverse the decline in walking has been adopted in the recent draft Single Transport Plan for West Yorkshire with further targets to increase rail travel and to reverse the decline in bus patronage. However the same policy documents plans to maintain current car journeys to city centres and increase overall trips by 5%. From 2011 to present journeys by car and rail have increased, rates of cycling and walking have remained low while bus patronage has fallen.

Sustained efforts to promote cycling in primary schools are set to continue. However cycling rates in Bradford are the lowest in West Yorkshire and qualitative evidence suggests that poor perception of safety is the main barrier to cycling in primary age children. Similar engagement is planned with businesses close to City Connect route focussing on cycling facilities in the workplace. A number of employers have implemented sustainable travel policies, however there is limited evidence of change. Around 70% of journeys into Bradford City centre are by car, an increase in cheap all day parking is likely to maintain this rate.

3.6 Initiating and supporting behaviour change

A whole system approach must not further medicalise these issues as that could undermine the message that people can act individually and together in their communities and that what is needed is a whole-system, population level approach. Everyday thousands of people within our communities come into contact with services – social care, education, healthcare, third sector –all sectors will need to be on board and the professionals within them will need to be engaged and to make every contact count in respect of this issue and broader health and wellbeing messages.

A system wide approach will need to consider how and when to engage people in potentially difficult conversations about their health and wellbeing. It will require that we learn from best practice in engaging and sustaining people to change entrenched behaviours.

We will need to ensure that public-facing staff and volunteers across all sectors have the right skills and deliver consistent messages to enable people, particularly those people with the worst health and wellbeing outcomes, to take steps back to healthy weight.

3.7 Acting at scale

The District has many initiatives in place; whilst some initiatives are taking place at scale, many appear to be applied piecemeal, others as in the example of travel into Bradford City Centre, can be undermined by other initiatives.

The challenges in taking a system wide approach will include: scaling up more of the effective initiatives; removing disincentives and managing conflicting interests, aiming for consistency of message across different settings and approaches; ensuring that initiatives are effective, well-linked together and supportive not undermining of each other; acting both at a broad community level and targeting initiatives where appropriate.

For example, to make a population level difference, being active every day needs to be embedded

across every community in every aspect of life. However, simply focusing on public health messages alone will not be sufficient to change the cultural and behavioural norms that have developed around physical inactivity and unhealthy eating. We will need to be more creative and effective in communicating with different audiences at different stages of understanding?

A system-wide approach means active environments, an active society and active schools, healthy eating embedded and supported across a wide range of organisations.There is a need, therefore, for everyone to play their part in creating a greater understanding of why healthy eating and physical activity are important, and what the consequences of poor diet and inactivity will be.

Robust governance will be needed and a task and finish approach may be required to get things moving.

4. FINANCIAL & RESOURCE APPRAISAL

A financial and resource appraisal will be undertaken against the decisions taken by the Board in relation to the issues raised by this paper. A comprehensive financial and resource appraisal has been undertaken in 2016 during the development of the Sustainability and Transformation Plan for Bradford District and Craven.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Governance and risk management operates through the established governance structure of the Health and Wellbeing Board and its sub-groups. The need for further development of governance for this issue will be raised as a matter for discussion.

6. LEGAL APPRAISAL

No legal implications.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

The association between overweight and obesity for some Black and Minority Ethnic communities should mean that improvement in health outcomes would result from any success in achieving healthy weight across the District. The association between overweight and obesity and deprivation would also indicate a potential reduction in health inequalities in relation to this non-protected characteristic.

7.2 SUSTAINABILITY IMPLICATIONS

Addressing obesity is a priority in the draft local Sustainability and Transformation Plan. The national Five Year Forward View for the NHS outlines the need to implement prevention at scale to reduce demand on the health and care economy related to preventable conditions (including those that are being driven by rates of obesity and overweight) in order to create a sustainable

health and social care economy.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

Adopting a whole system approach to healthy weight should include increasing the rate of active transport, particularly cycling and walking. Success in this area would contribute to reductions in greenhouse gas emissions.

7.4 COMMUNITY SAFETY IMPLICATIONS

Safety and perceptions of safety in respect of neighbourhoods and communities impact on willingness to use urban neighbourhoods and local green space for physical activity.

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

Ward level action may be needed to engage more people in becoming physically active and to eat healthily and to ensure that local green space and urban space is safe and accessible particularly in wards with higher levels of overweight and obesity amongst the local population.

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

None

10. RECOMMENDATIONS

10.1 The Health and Wellbeing Board endorses and adopts NICE Guidance to Health and Wellbeing Boards on working with communities to tackle overweight and obesity and to achieve healthy weight at a population level.

10.2 The Health and Wellbeing Board mandates the Local Authority to lead a system-wide approach to achieving healthy weight for the population of Bradford and Airedale to include:

Board members to ensure that the policies and practices of their respective agencies that might impact on healthy weight are reviewed; that these practices and policies are further improved and developed in line with a whole system approach and that the involvement and endorsement of their governing bodies is secured.

Appropriate governance is put in place and 6 monthly updates on progress are provided to

the Board.

Bradford Health and Care Commissioners to review their commissioning and to take action ensure that commissioned activity contributes to achieving Healthy Weight at a population level, with particular emphasis on prevention and early intervention.

10.3 The Chair to write to Bradford District Partnership seeking their endorsement and commitment to be involved in a system wide approach to achieving healthy weight.

11. APPENDICES

Appendix A – Extract from Bradford and Airedale Joint Health and Wellbeing Strategy
Appendix B – NICE Guidance to Health and Wellbeing Board on working with communities and briefings for local authorities

12. BACKGROUND DOCUMENTS

Foresight Report (2007) Tackling Obesities- Future Choices
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287937/07-1184x-tackling-obesities-future-choices-report.pdf

B-Active Strategy for Bradford District (in Draft)

Appendix A

Good Health and Wellbeing: Bradford and Airedale Joint Health and Wellbeing Strategy 2013-17

The District's Joint Health and Wellbeing Strategy considers:

Social factors - issues which affect the population as a whole, but do not necessarily affect everybody equally, government policies, the availability of work, general levels of wages, taxation and how much things cost – particularly the prices of essentials.
Living and working conditions - the important issues for people as they go about their lives, day in, day out: things like education, training and employment, housing, public transport and amenities, access to basic facilities - in this context, cooking facilities and equipment, affordable fuel and essential goods.
Social and community networks: A strong network of family and friends can help to ensure that an individual has a healthy lifestyle. Sometimes, individuals living alone may not have any "network"; sometimes the "network" can have an unsupportive effect.
Individual lifestyle factors: e.g. tobacco use, alcohol consumption, and drug use, whether people eat healthily and whether they take regular physical exercise. These choices are influenced by the environment in which the individual lives – how friends and family act, how products are advertised.
Personal factors – include some of the basic definitions of who people are: age, sex, ethnicity and genetic factors.

The Strategy notes long standing issues related to obesity, diabetes, heart disease and infant mortality and that parts of the District continue to have big differences in health. Two priorities in particular address obesity: Priority 5 'Reduce childhood obesity and increase levels of physical activity and healthy eating in children and young people'; Priority 17 'Reduce harm from preventable disease caused by tobacco, obesity, alcohol and substance abuse'.

Priority 5: Reduce childhood obesity and increase levels of physical activity and healthy eating in children and young people

Key areas for action for Bradford District to reduce childhood obesity and increase levels of physical activity and healthy eating in children and young people:
Encourage and support the healthy growth and weight of children
Promote healthier food choices and improve the nutritional quality of food in schools
Increase everyday play and physical activity opportunities for children
Promote environments and practices that support children to eat healthier foods and to be active throughout each day
Provide personalised advice and support for children and their families through a child healthy weight pathway
Increase support and training for education and childcare staff to implement health improvement activity and increase availability and accessibility of evidence based children's lifestyle weight management services

Priority 17: Reduce harm from preventable disease caused by tobacco, obesity, alcohol and substance abuse

Key areas for action for Bradford District to reduce harm from preventable diseases caused by tobacco, obesity, alcohol and substance abuse:
Work with partners to promote an environment and culture that makes healthy lifestyles easier to achieve
Develop a tiered model of interventions so the most effective interventions get to the right people at the right time
Commission specialist services for those in greatest need
Provide brief interventions and referrals to effective preventative services, using the principles of 'Making Every Contact Count'
Increase access to targeted health checks

Appendix B

National Institute of Health and Clinical Excellence (NICE) recommendations to Health and Wellbeing Boards and their constituent members for working with local communities to address obesity: https://www.nice.org.uk/guidance/ph42/chapter/1-Recommendations

Ensure, through the health and wellbeing board, a coherent, community-wide, multi-agency approach is in place to address obesity prevention and management. Activities should be integrated within the joint health and wellbeing strategy and broader regeneration and environmental strategies. Action should also be aligned with other disease-specific prevention and health improvement strategies such as initiatives to prevent type 2 diabetes, cancers, and cardiovascular disease, as well as broader initiatives, such as those to promote good maternal and child nutrition or mental health or prevent harmful drinking. Specifically:

- Health and wellbeing boards, supported by directors of public health, should ensure joint strategic needs assessments (JSNAs) address the prevention and management of obesity.
- Health and wellbeing boards should ensure tackling obesity is one of the strategic priorities of the joint health and wellbeing strategy (based on needs identified in JSNAs).
- Health and wellbeing boards and local authority chief executive officers should encourage partners to provide funding and other resources for activities that make it as easy as possible for people to achieve and maintain a healthy weight. This includes, for example, activities to improve local recreation opportunities, community safety or access to food that can contribute to a healthier diet. Partners should be encouraged to provide funding and resources beyond one financial or political cycle and have clear plans for sustainability.
- Health and wellbeing boards should work in partnership with local clinical commissioning groups to ensure a coherent approach to tackling obesity that spans both prevention and treatment.
- Health and wellbeing boards should work with partners to optimise the positive impact (and mitigate any adverse impacts) of local policies on obesity levels. This includes strategies and policies that may have an indirect (negative) impact, for example, those favouring car use over other, more active, modes of transport, or decisions to remove park wardens, that affect people's use of parks.
- Health and wellbeing boards, through their performance infrastructure, should regularly (for example, annually) assess local partners' work to tackle obesity (taking account of any relevant evidence from monitoring and evaluation). In particular, they should ensure clinical commissioning group operational plans support the obesity agenda within the health and wellbeing strategy.

NICE Briefings to Local Authorities

- A briefing on the use of body mass index (BMI) as a signal for preventive action against long-term medical conditions. The focus is on people from black, Asian and other minority ethnic groups.
- A Physical Activity briefing summarises NICE recommendations for local authorities and partner organisations on how to encourage people to be physically active.
- Obesity – working with local communities sets out how local policy makers, commissioners, managers, practitioners and other professionals working in local authorities, the NHS and the wider public, private, voluntary and community sector can develop effective, sustainable and community-wide action to prevent obesity
- Walking and cycling sets out how commissioners, managers and practitioners involved in physical activity promotion or who work in the environment, parks and leisure or transport planning sectors can encourage people to increase the amount they walk or cycle for travel or recreation purposes.
- Behaviour change summarises NICE's recommendations for local authorities and partner organisations on the general principles that should be used when considering the commissioning, planning, content and evaluation of initiatives to support behaviour change at individual, community and population levels