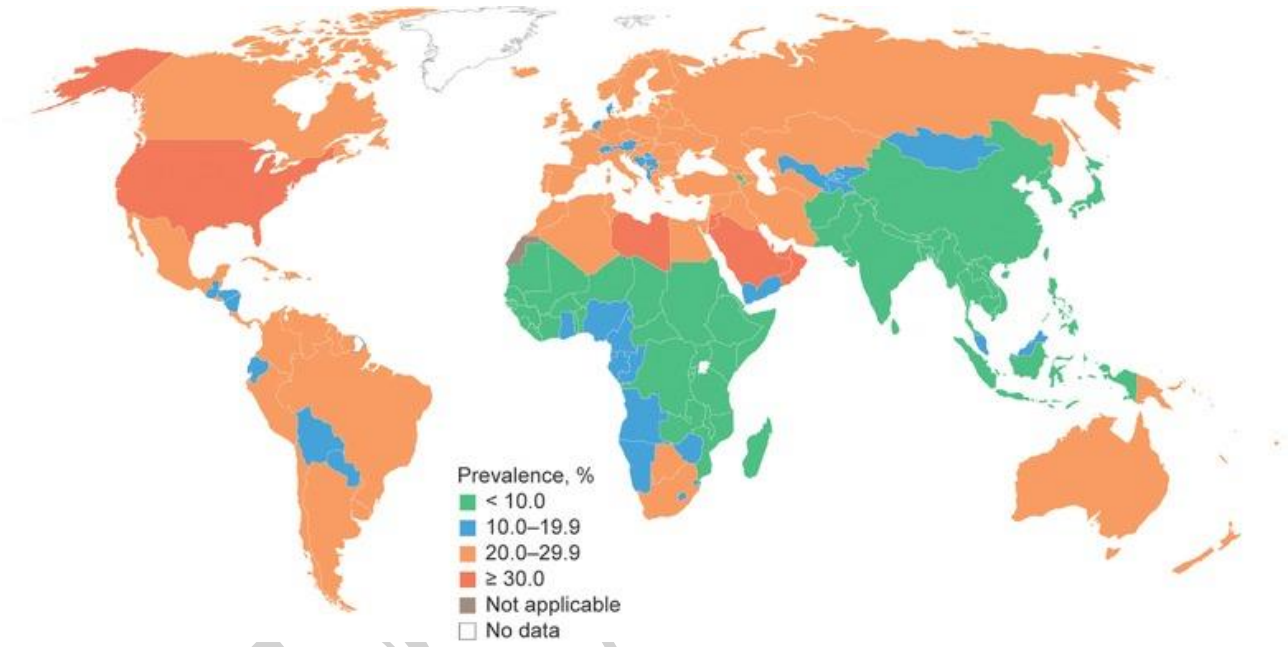
Priority 2: Create an environment that gives people the opportunities to be as healthy as they can be

Childhood and Adult Obesity

Fig. 1 Obesity – A National and International Epidemic



Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/obesity/data/prevalence-maps.html. 2015

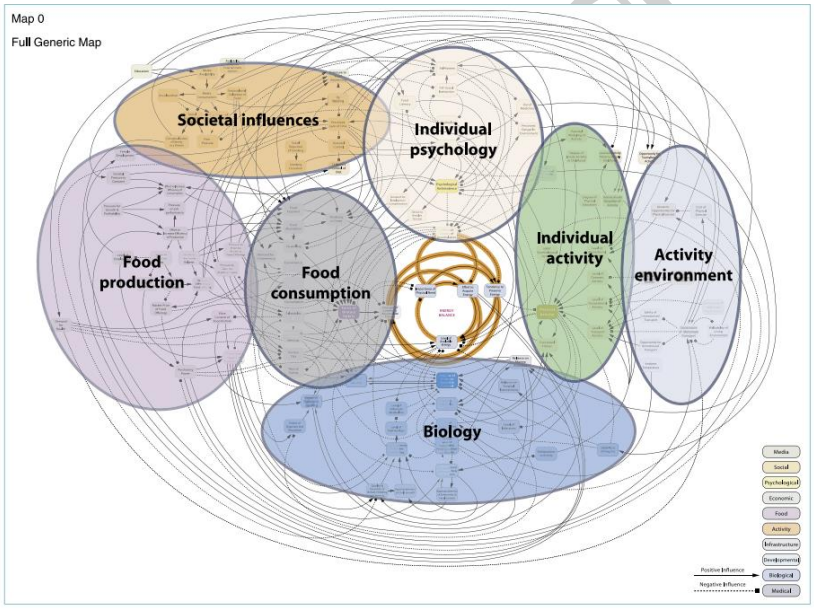
Contents

INTRODUCTION

Obesity is widely considered to be the most pressing public health challenge with national and global (WHO) increases for several decades. There is evidence that the COVID-19 pandemic and more recently the cost-of-living crisis have led to further increases in both childhood and adult obesity.

It is a system wide issue that is complex and requires the whole system to work together if there is to be any impact on what is termed the "obesity epidemic." The Foresight Report's system map in 2007 visualised the whole systems approach. Although complex it set the scene for a balanced perspective about the roles of the individual and the environment.

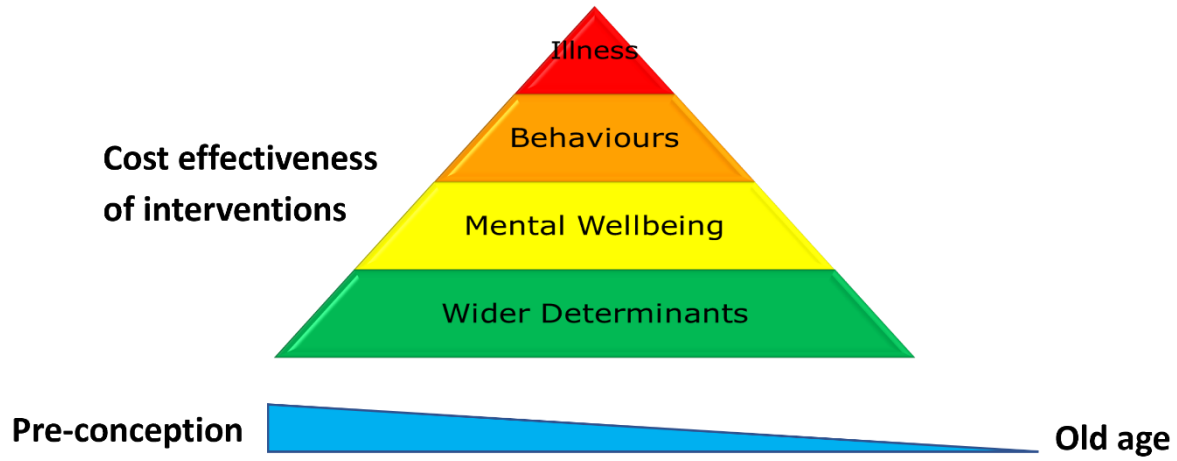
Fig 2: The Complex Obesity System



Foresight Report : Future Choices (2007)

Policymakers however still tend to focus on single initiatives, but our ambition is to use the opportunity afforded by the Joint Health and Well Being/Integrated Care System Strategy of incorporating 'systems thinking' into our effort to tackling obesity. This approach requires transformational evidence-based change that requires interventions to promote change across areas that we know have the greatest impact upon obesity. This is illustrated in Figure 2 which describes the key areas and where we can have greatest impact. Implicit in the model is that the earlier interventions are in childhood the greater the impact upon lifelong health.

Fig 3: A Transformational approach



Nationally we have nearly two thirds of the adult population either overweight or obese. This means that everyone is at risk, although we know there are higher rates amongst children and adults amongst certain groups and in deprived areas. Our interventions will be at a population level, they must affect everyone. Consequently, there is a focus upon creating environmental changes which affect everyone and address multiple settings, family, school, workplace, community, and the media.

However, we know people and communities respond differently to environmental and service level interventions which can exacerbate any inequalities. Our efforts therefore will reflect a "proportionate universalism" approach which will seek to understand the different needs and motivations that drive people and communities. This understanding will need to be embedded into how we plan and implement policy and other interventions

Historically locally and nationally there has been a plethora of interventions reflecting the complexity of obesity, but they have had varying levels of impact. It is important as we move forwards that we have a clear evidence-based approach that will lower rates and decease any inequalities.

The conceptual frameworks found in Figures 1 and 2 along with the adoption of a proportionate universalism approach provide a system wide framework at a strategic and operational level which will shape the delivery of our ambitions.

This conceptualisation clearly identifies synergies and areas of mutual benefit with the other three priorities being pursued in the Joint Health and Well Being Strategy Integrated Care Strategy. For example, the school environment can influence the diet and physical activity levels of children or the negative effects of easy access to fast food.

Although it is complex and challenging, we have set ourselves stretching ambitions for improving outcomes that will require ongoing development of interventions that will move us consistently along the path to achieving them.

CHILDHOOD AND ADULT OBESITY OUTCOMES

We have identified our outcome ambitions for childhood and adult obesity. They reflect that gaining traction on obesity is challenging due to its complexities, but we also know that we need to turn the tide if we are to secure better outcomes for our local population.

Achieve a 5% decrease in childhood overweight/obesity by 2030

Reduce childhood overweight/obesity to pre-pandemic levels by 2026

Reduce adult overweight/obesity levels to pre-COVID times by 2030

Every child in school will meet the physical activity recommendations

Achieve a 10% increase in number of adults who undertake 150 minutes of physical activity per week by 2030

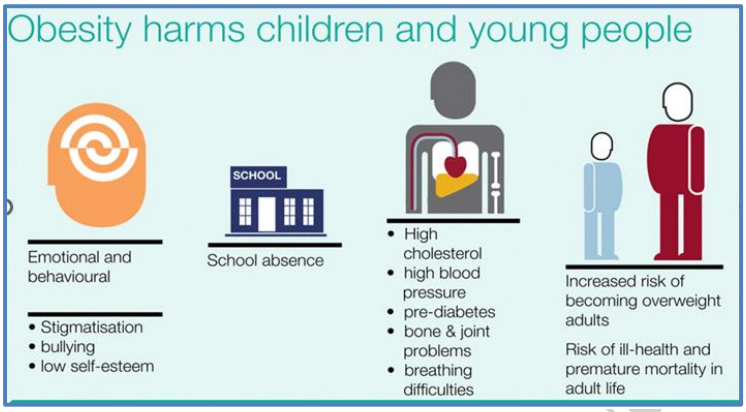
Reduce inequalities in overweight/obesity

THE CASE FOR CHANGE

Health Impacts and Outcomes

Obesity is one of or even our biggest threat to health and wellbeing of our population. It affects physical and mental health in both childhood and adulthood. The term overweight is when someone's weight exceeds what is a healthy weight, when the risks to health will start to build and for many people it leads to ongoing weight gain and being categorised as obese.

Figure 4: Impacts of obesity upon children

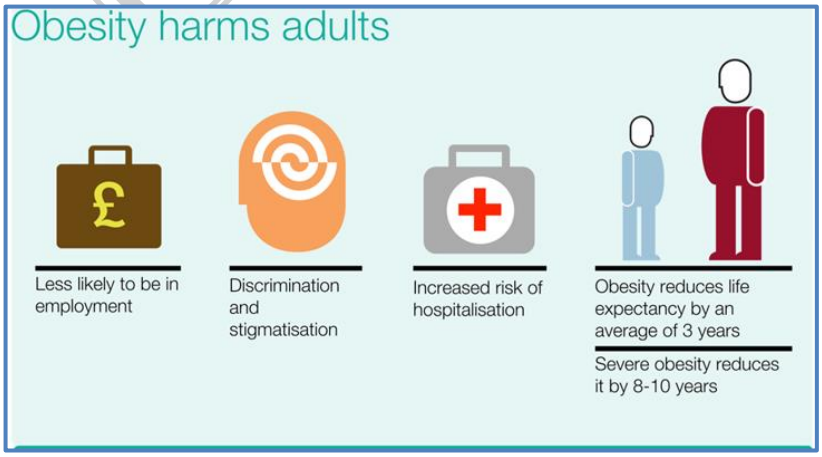


Office for Health Improvement and Disparities (OHID) 2022

The adverse impacts upon physical and mental health are well evidenced and conditions normally associated with adults are increasingly found amongst children with excess weight. Key health risks now being found in children are Type 2 diabetes and cardiovascular disease but also a range of other conditions including respiratory, neurological and kidney disorders. Children who have obesity may experience teasing or bullying by their peers. This can result in a loss of self-esteem and an increased risk of depression and anxiety. These health factors then manifest in school absences and lower attainment levels.

The annual National Paediatrics Diabetes Audit 2020 to 2021 found that there was an increase of 14% in children being managed for Type 2 diabetes since its 2019 to 2020 Report. If the 2020/21 reports are compared with the 2015/16 Report an increase of 56% clearly shows the increase that this has been an ongoing increase. Consistent findings from the Reports in recent years are that there is higher risk of Type 2 diabetes in girls, those of non-white ethnicity, and those living in the most deprived areas.

Figure 5: Figure: Impacts of Obesity upon Adults



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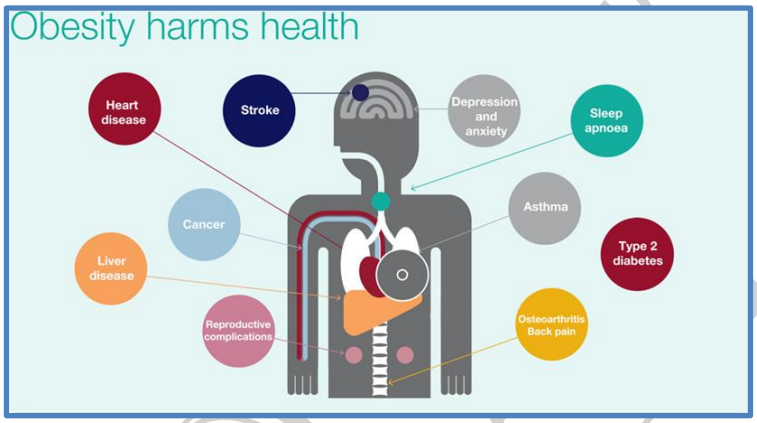
There is a high risk that childhood excess weight will persist into adulthood along with the associated risks to health and any conditions that have already presented. Living with excess weight in adulthood as in childhood is again linked to a wide range of diseases, most commonly Type 2 diabetes, cardiovascular disease (hypertension and strokes) some cancers and liver disease.

Excess weight has also been linked with a higher risk of severe illness and death from COVID-19. As with children excess weight in adults is associated with emotional and mental health issues. It has an impact on psychological and emotional health and again the stigma influences self-esteem and the ability to address their weight issues. Life expectancy is reduced by an average of three years and from severe obesity by eight to ten years.

Figure 6: Health Impacts



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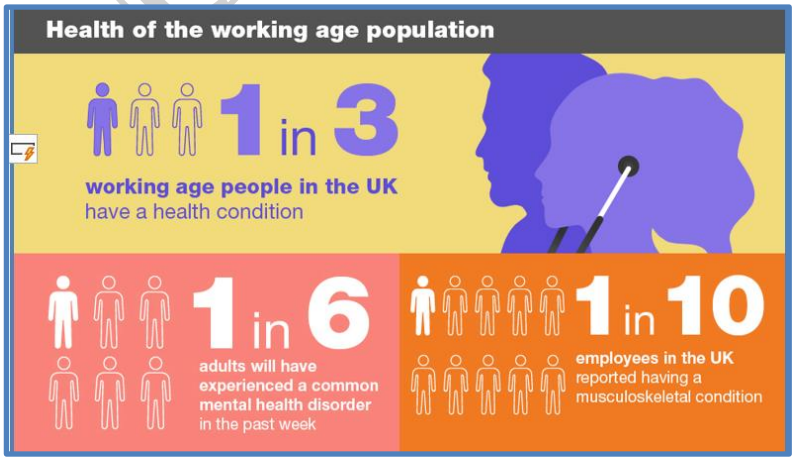
Moreover there are other socio-economic impacts experienced those living with excess weight that influence the prevention and management of obesity. There have been several studies that have found excess weight and associated health conditions can have negative impact on employment in terms of absenteeism, entering and maintaining employment. It has been described as a debilitating health condition that has an independent effect upon productivity and therefore employment along with being associated with discrimination.

Figure 7: Obesity and Co-morbidities in the Workplace



Office for Health Improvement and Disparities 2019

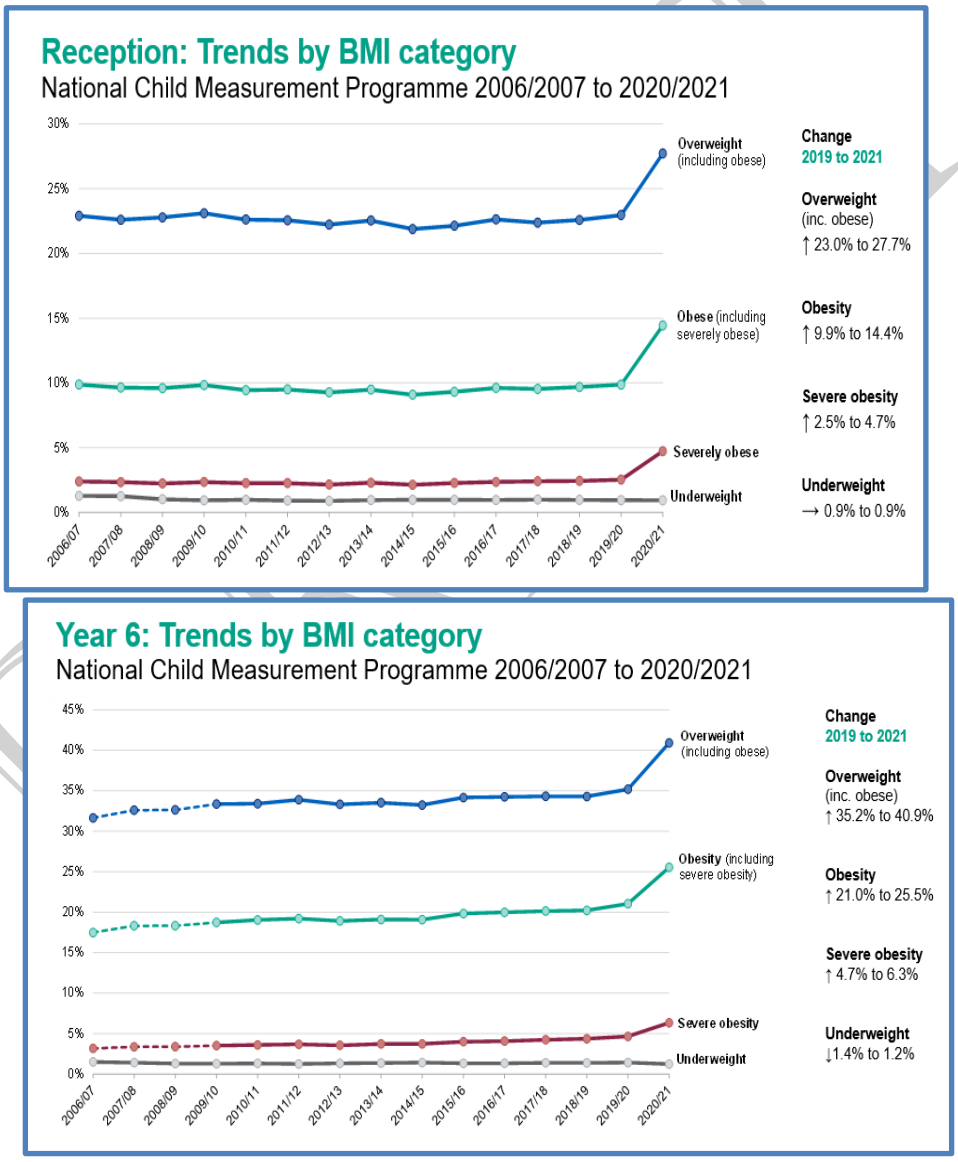
Clearly the impacts of excess weight have synergistic relationship between the prevention and management of excess weight.

THE OBESITY PROFILE

Childhood Obesity

In response to perceived increases in childhood obesity the National Child Measurement Programme (NCMP) was commenced in 2006. This annual measurement of children in Reception and Year 6 provides a robust annual picture of childhood obesity.

Figure 8: National trends in Childhood Obesity – Reception and Year 6



Rates of childhood obesity nationally plateaued from 2006 but increased during the COVID-19 pandemic The 2019/20 NCMP data collection stopped in March 2020 when schools were closed due to the Covid-19 pandemic.

In a usual NCMP collection year, national participation rates are around 95% (over a million) of all eligible children, however in 2019/20 the number of children measured was around 75% of previous years. Despite the lower than usual number of measurements, analysis by NHS Digital indicates that figures at national and regional level are directly comparable to previous years, for all breakdowns.

Although increases in childhood obesity occur across the whole population there are considerable disparities in the rates of childhood obesity related to ethnicity and deprivation. They are most marked when looking at deprived areas during the COVID-19 pandemic period, when the gap increased considerably more in deprived areas.

Figure 9: National disparity trends - childhood obesity and deprivation.

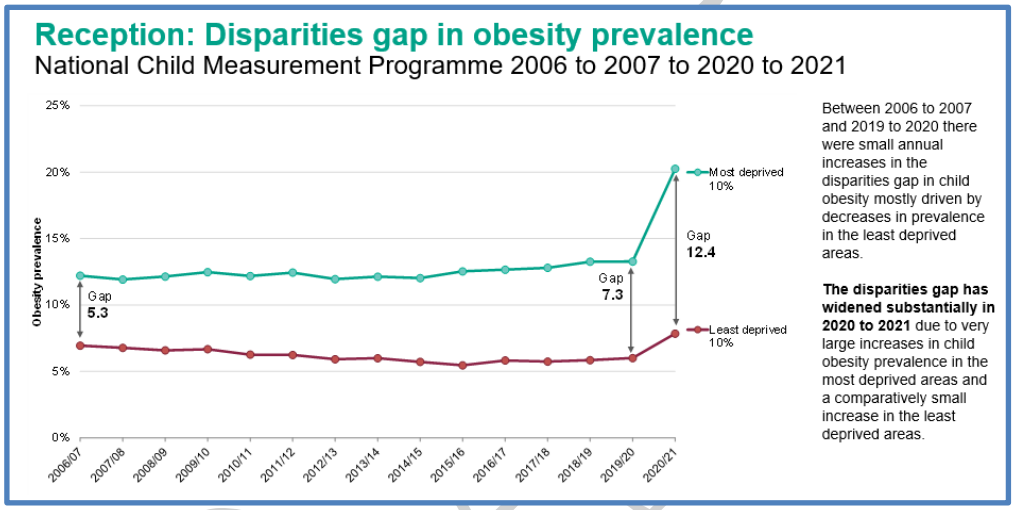
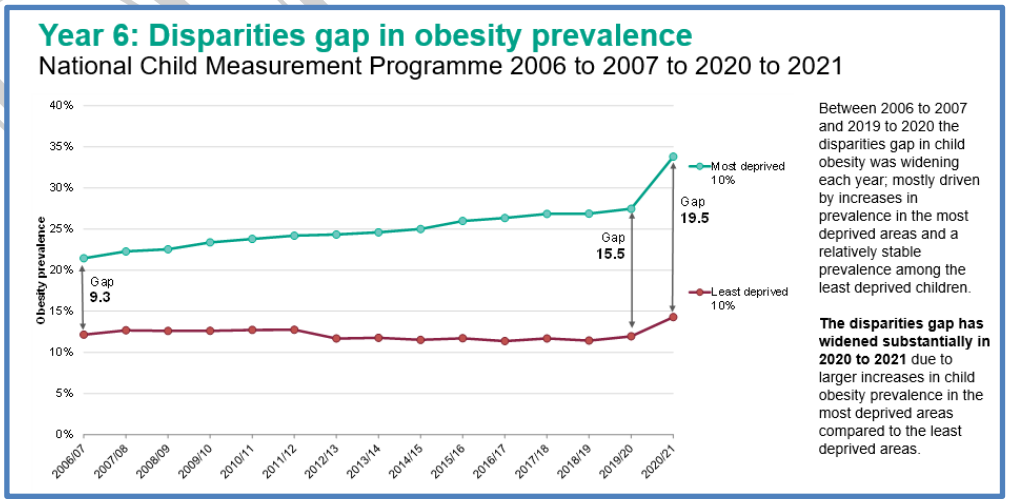


Figure 10: National disparity trends – Year 6

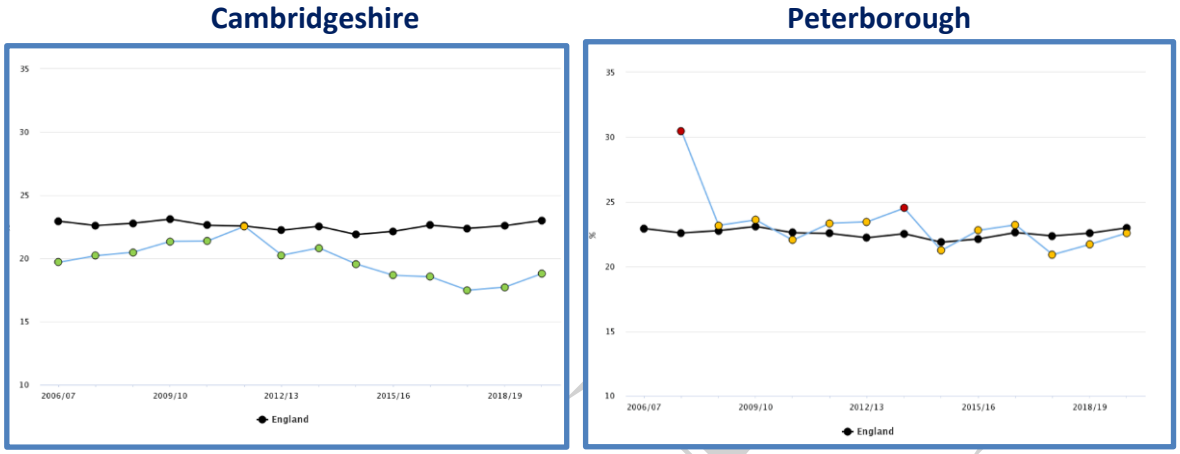


Children - Cambridgeshire and Peterborough

Locally the Cambridgeshire and Peterborough profile is similar, with a big increase associated with COVID-19 in 2020/21. Local results are not yet available for 2021/22 but nationally initial figures

indicate that although there has been an increase on the 2019/20 levels it is below the 2020/21 rates. The increase in rates from Reception to Year 6 is also unchanged. Analysis of the excess weight trends in Reception across Cambridgeshire since 2006 show an increase until 2012 then some small fluctuations until 2018/19. In Peterborough, the fluctuations in rates have been greater and have moved closer to the national figure.

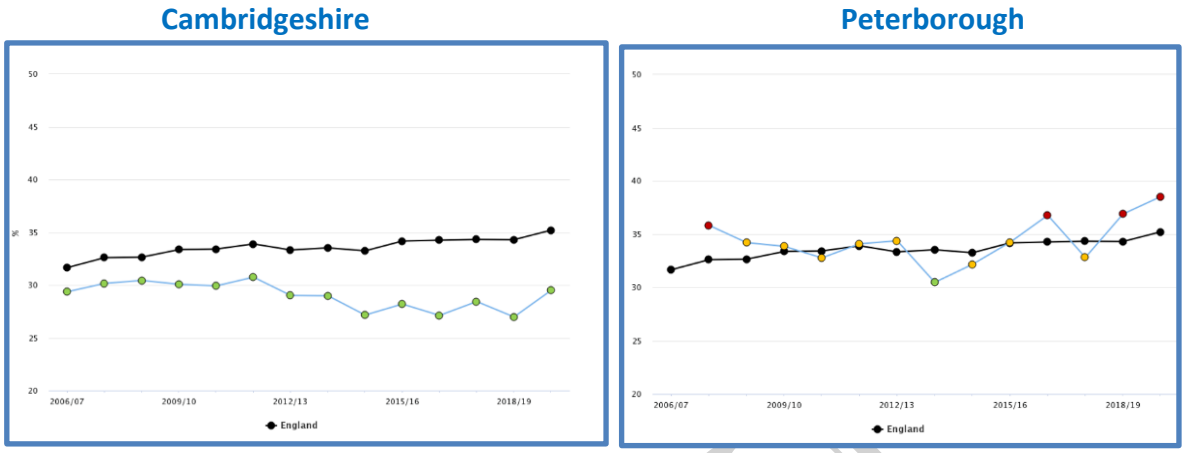
Figure 11: Reception prevalence trend for overweight and obesity 2006/07 to 2018/19



Office for Health Improvement and Disparities 2021

Cambridgeshire Year 6 rates decreased between 2006/7 and 2017/8 but had started to increase in 2018/19, although below the national rate.

Figure 12: Year 6 prevalence trend for overweight and obesity 2006/07 to 2018/19

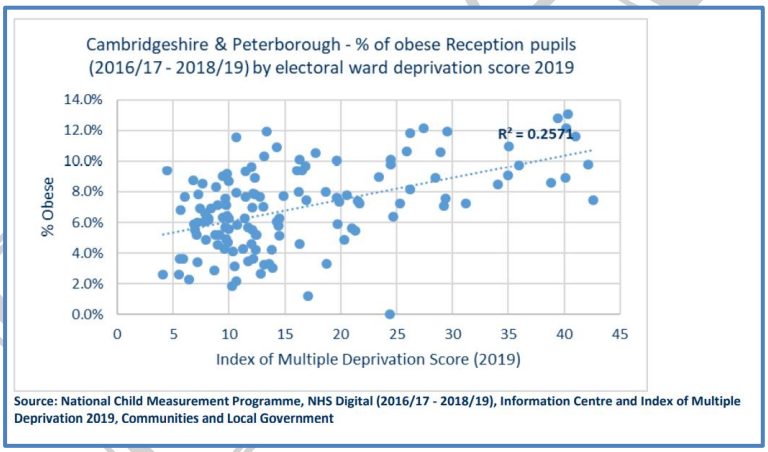


Office for Health Improvement and Disparities 2021 Fingertips

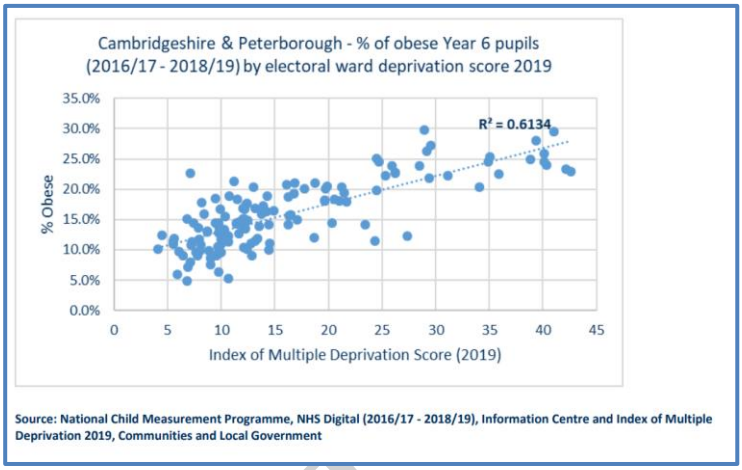
The Peterborough profile differs in that the rate initially fell and remained around or below the national figure. However since 2013/14 there has been a steady increase and for the last two complete years of measuring it was statistically significantly above the national figure.

Analysis of NCMP data in terms of deprivation shows a picture similar to the national with higher rates in the more deprived areas. Figure 13 shows how the most deprived quintiles have higher rates of excess weight in both Reception and Year 6 years.

Figure 13: Cambridgeshire and Peterborough excess weight and deprivation - Reception and Year 6



Source: National Child Measurement Programme, NHS Digital (2016/17 - 2018/19), Information Centre and Index of Multiple Deprivation 2019, Communities and Local Government



Source: National Child Measurement Programme, NHS Digital (2016/17 - 2018/19), Information Centre and Index of Multiple Deprivation 2019, Communities and Local Government

Adult Obesity

The NCMP provides a very robust picture of childhood obesity. For adult rates we rely upon national surveys and GP practice data, Quality Outcome Framework (QOF), neither of which provides a comparable robust profile.

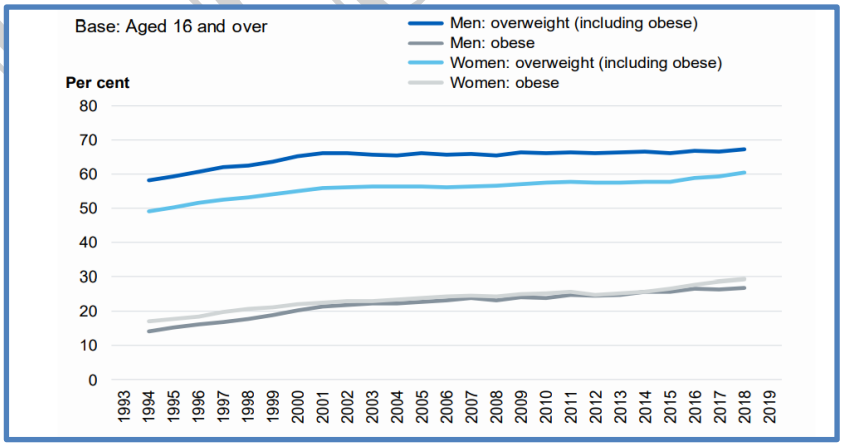
The Health Survey for England (HSE) monitors trends in the nation's health and care. It provides information about adults aged sixteen and over, and children aged 0 to 15, living in private households in England.

The last Health Survey for England was published in 2020 based on data collected in 2019. The 2021 Survey results will not be available until 15th December 2022.

The 2019 Survey headlines were that among adults aged 16 years and over:

Nationally obesity including overweight has increased from 58% of men and 49% of women in 1993 to 68% of men and 60% of women in 2019.

Figure 14: Prevalence of Overweight and obesity in adults, by sex, 1993-2019 (three year rolling averages)



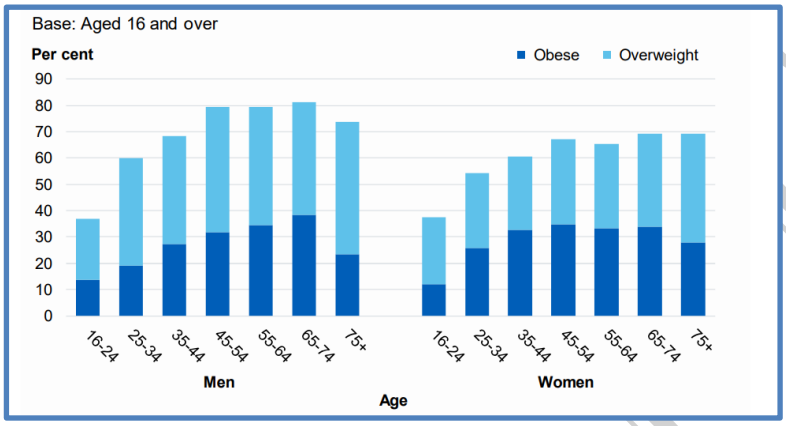
NHS Digital

In 2019, 28% of adults were obese, and a further 36% were overweight but not obese. Obesity levels were not significantly different between men and women: 27% and 29% respectively.

In numbers it was estimated that 12.6 million adults were obese, including 6 million men and 6.6 million women. A further 16.3 adults were overweight but not obese, including 9.2 million men and 7.2 million women.

In all age groups except the youngest (those aged 16 to 24), the majority of adults were overweight or obese.

Figure 15: Prevalence of overweight and obesity, by age and sex (2019)



NHS Digital

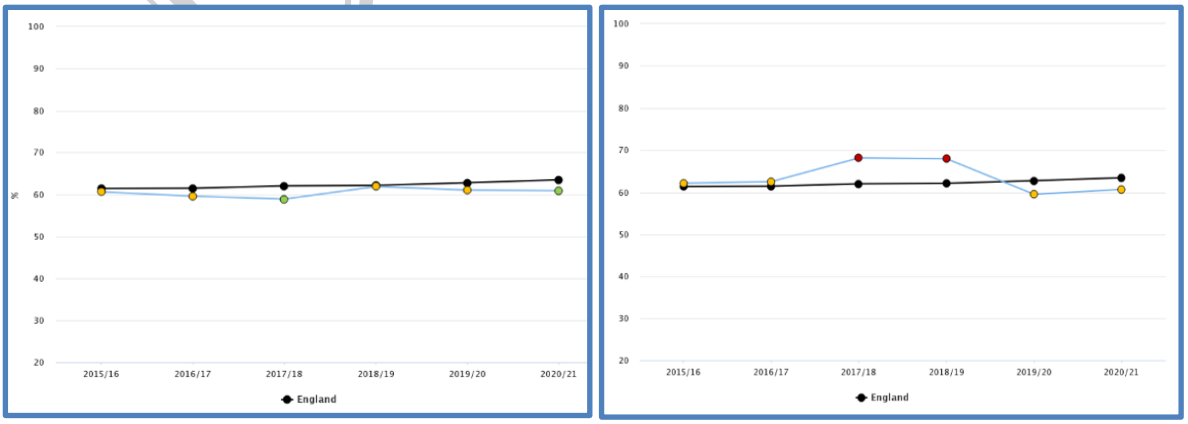
The Survey also found that obesity was higher in areas of deprivation using the Index of Multiple Deprivation. For men obesity was much lower in the least deprived quintile (22%) than the other quintiles; it was highest in the most deprived quintile (30%). Obesity for women was lowest in the least deprived (22%) and highest in the most deprived (39%), a bigger difference for women than men. There was a similar picture when obesity and overweight.

Adults - Cambridgeshire and Peterborough

Locally Cambridgeshire and Peterborough excess weight rates have remained similar to the national figures. There is also little variation between the district authorities within Cambridgeshire, although rates are lower than the national figures in Cambridge City and South Cambridgeshire.

Figure 16: Percentage of adults (aged 18+) classified as overweight or obese

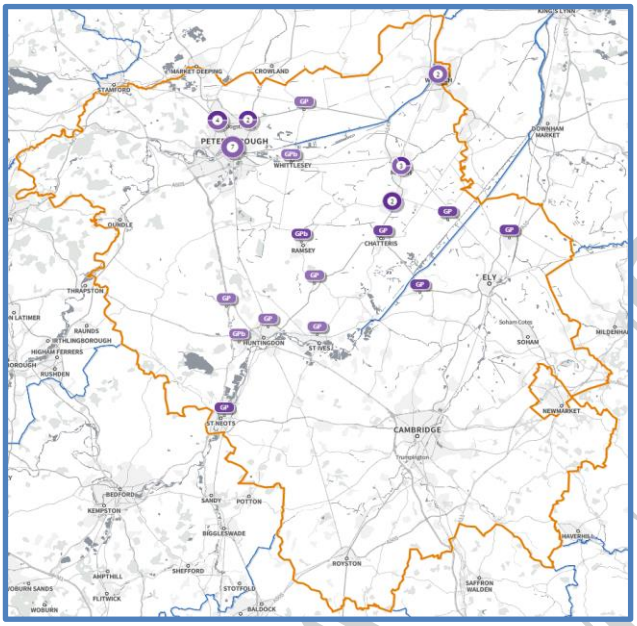
Cambridgeshire **Peterborough**



Office for Health Improvement and Disparities Fingertips

Robust measures of adult excess weight across ethnicity and deprivation in Cambridgeshire and Peterborough are not available. However the data from GP practices that is available shows the highest rates of obesity are found generally in areas of higher deprivation.

Figure 17: Cambridgeshire and Peterborough Adult Obesity and Deprivation



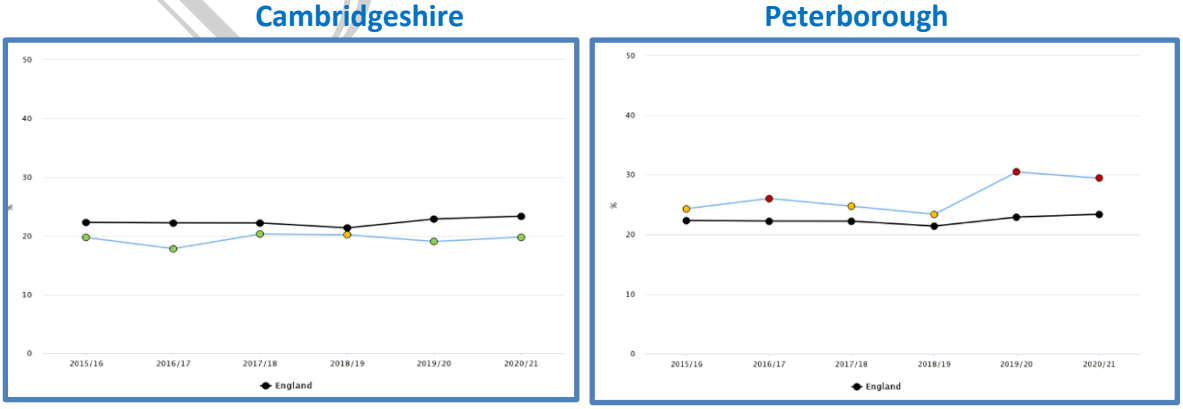
Scope Survey

Physical activity

At its simplest obesity is generally caused by consuming more calories than can be burnt off in physical activity. The national Active Lives survey has found that since 2017 around 33% of children and young people undertook less than 30 minutes of activity every day. There is no local data for this period as the Survey during these years was not undertaken across the whole of Cambridgeshire and Peterborough.

Data for adults is available at upper tier and unitary authority areas. In Cambridgeshire, the percentage of inactive adults has consistently been statistically significantly below the national figure. However Peterborough and Fenland have significantly higher rates of inactivity than the national average.

Figure 18: Percentage of physically inactive adults (2020/21)



Office for Health Improvement and Disparities Fingertips

OBESITY RELATED HEALTH OUTCOMES

Health outcomes - national

Living with excess weight in adulthood is linked to a wide range of diseases most commonly Type 2 diabetes, cardiovascular disease (hypertension and strokes) some cancers, liver disease and mental health issues.

There is evidence that the increases in these outcomes are linked to increases in excess weight. The most marked are found in Diabetes Type 2 and Cardiovascular Disease (CVD). These conditions are preventable and reducing weight is a key factor in stopping the increases in these conditions.

An analysis undertaken by Public Health England in 2014 clearly demonstrated the links between obesity and diabetes.

- 2% of adults were overweight or obese in England in 2012
- 6% of people aged 17 years or older had diagnosed diabetes in England in 2013
- Prevalence of both obesity and diabetes is rising in England
- 90% of adults with type 2 diabetes aged 16-54 years are overweight or obese
- In England, 12.4% of people aged 18 years and over with obesity have diagnosed diabetes, five times that of people with a healthy weight
- Men with a raised waist circumference are five times more likely to have diagnosed diabetes than those without a raised waist circumference; women are over three times more likely

Public Health England Adult Obesity and Type 2 diabetes 2014

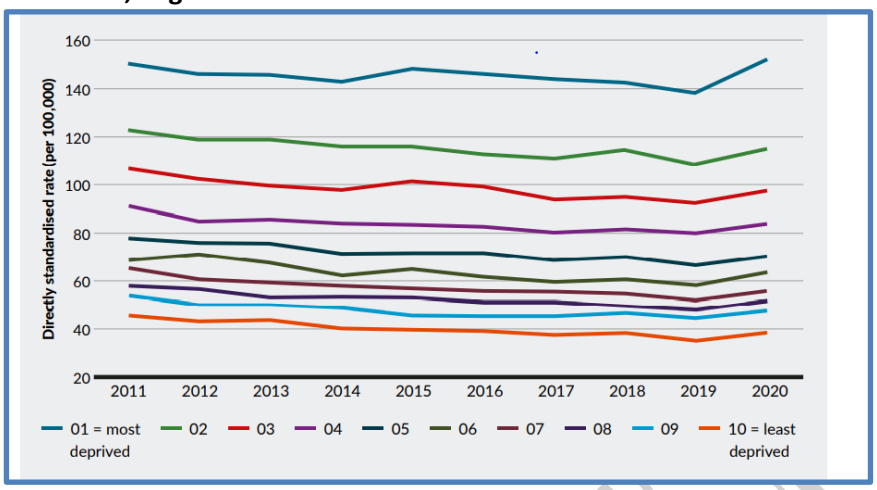
There is also an association with inequalities with higher rates of diabetes found in areas of deprivation and people with learning disabilities.

Around 25% of deaths can be atributed to CVD it is a leading cause morbidity, diability and mortality in England and locally. It includes many of the most common conditions including stroke and heart disease.

It is largely preventable through the reduction of risk factors which includes hypertension, high chlesterol levels, high blood sugar/diabetes and atrial fibrillation, which have also seen increases in recent years. Obesity, unhealthy diet and low levels of physical activity are strongly associated with CVD as modifiable risk factors.

People in the most deprived areas of England and locally are four times more likely to die prematurely from CVD than those in the least deprived areas. High rates are also found amongst people of Black or South Asian ethnicity, those with mental/physical disabilities and mental health conditions. CVD is the largest contributor (one-fifth) to the life expectancy gap between the most deprived and least deprived communities (Figure 17), equivalent to a reduced life expectancy for the most deprived groups of 2 years for males and 1.4 years for females.

Figure 19: CVD age -standardised mortality rates per 100,000 population at ages under 75 by deprivation decile, England 2011-20



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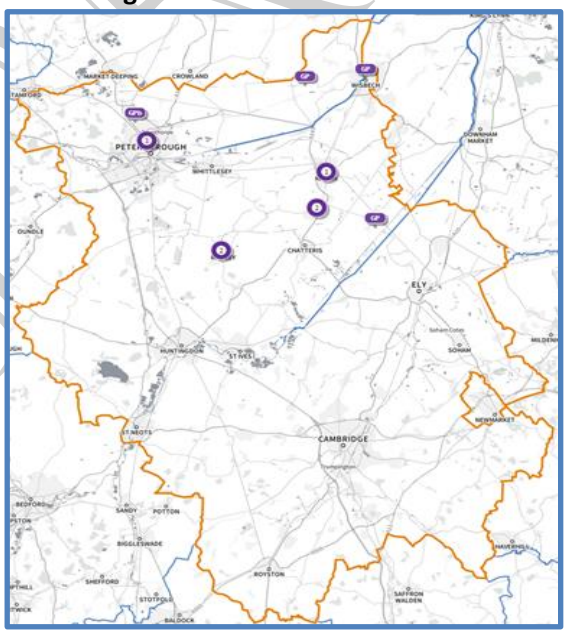
A recent review of CVD by the Kings Fund concluded that the upward trend in risk factors has been exacerbated by the increase in obesity.

Health outcomes - Cambridgeshire and Peterborough

Analysis of data for Cambridgeshire and Peterborough shows similar trends to the national figures. There is an increasing trend in the prevalence of diabetes across the area, although Cambridgeshire has the lowest recorded prevalence of diabetes in the East of England, Peterborough has the third highest.

Looking at GP practice data demonstrates the link between diabetes and deprivation with practices in more deprived areas experiencing higher rates of diabetes.

Figure 20. GP Practices with high rates of diabetes

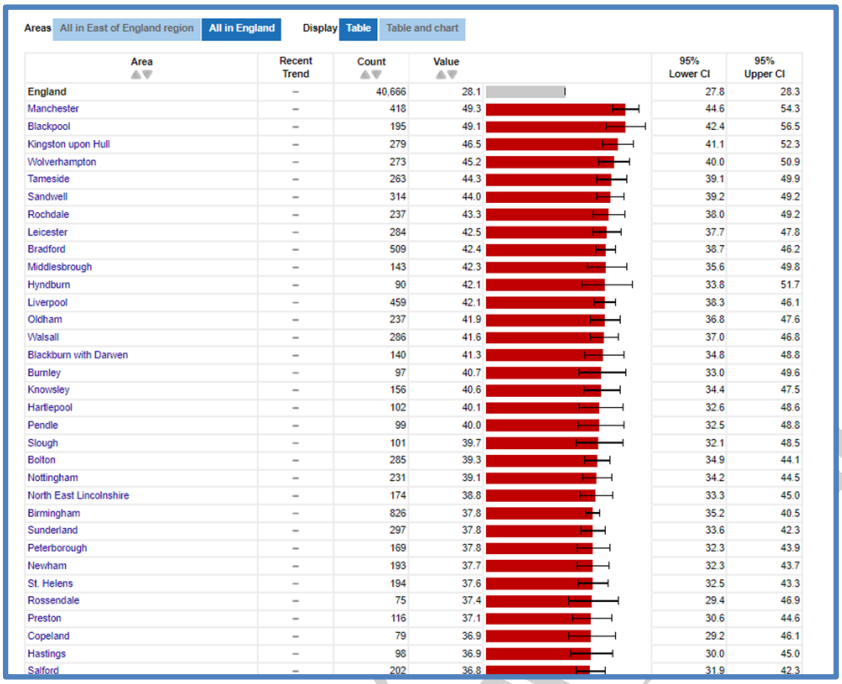


Quality Outcomes Framework (QOF) 2020/21

In Cambridgeshire and Peterborough CVD accounted for 24.9% of all deaths.

Preventable under 75 mortality in Peterborough is significantly worse than England and regional averages, ranked the 26th highest district/unitary authority in the country. This means that 37.6 people per 100,000 die prematurely from CVD conditions in Peterborough, 22.1 per 100,000 die in Cambridgeshire.

Figure 21: Preventable CVD mortality – Peterborough ranked 26th highest in the country



Areas: All in East of England region | All in England — Display: Table | Table and chart

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	40,666	28.1	27.8	28.3
Manchester	–	418	49.3	44.6	54.3
Blackpool	–	195	49.1	42.4	56.5
Kingston upon Hull	–	279	46.5	41.1	52.3
Wolverhampton	–	273	45.2	40.0	50.9
Tameside	–	263	44.3	39.1	49.9
Sandwell	–	314	44.0	39.2	49.2
Rochdale	–	237	43.3	38.0	49.2
Leicester	–	284	42.5	37.7	47.8
Bradford	–	509	42.4	38.7	46.2
Middlesbrough	–	143	42.3	35.6	49.8
Hyndburn	–	90	42.1	33.8	51.7
Liverpool	–	459	42.1	38.3	46.1
Oldham	–	237	41.9	36.8	47.6
Walsall	–	286	41.6	37.0	46.8
Blackburn with Darwen	–	140	41.3	34.8	48.8
Burnley	–	97	40.7	33.0	49.6
Knowsley	–	156	40.6	34.4	47.5
Hartlepool	–	102	40.1	32.6	48.6
Pendle	–	99	40.0	32.5	48.8
Slough	–	101	39.7	32.1	48.5
Bolton	–	285	39.3	34.9	44.1
Nottingham	–	231	39.1	34.2	44.5
North East Lincolnshire	–	174	38.8	33.3	45.0
Birmingham	–	826	37.8	35.2	40.5
Sunderland	–	297	37.8	33.6	42.3
Peterborough	–	169	37.8	32.3	43.9
Newham	–	193	37.7	32.3	43.7
St. Helens	–	194	37.6	32.5	43.3
Rossendale	–	75	37.4	29.4	46.9
Preston	–	116	37.1	30.6	44.6
Copeland	–	79	36.9	29.2	46.1
Hastings	–	98	36.9	30.0	45.0
Salford	–	202	36.8	31.9	42.3

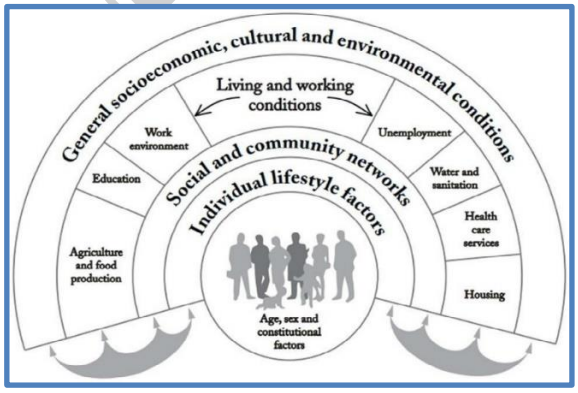
Quality Outcome Framework

What we should be doing - the evidence

In simple terms preventing obesity is about reducing food intake and increasing activity levels. The evidence for influencing behaviours focusing upon lifestyle factors alone is less likely to be effective. Efforts should be more balanced and should move beyond the individual level to include interventions and policies that address the wide range of often complex environmental factors which requires efforts from different parts of the system.

The Dahlgren and Whitehead model of social determinants of health perfectly reflects the obesity challenge, a small proportion of people have a genetic predisposition to obesity, but the lifestyle factors of diet and physical activity are very much governed by the environment in which they live.

Figure 22: Dahlgren & Whitehead model of the main determinants of health (1979)



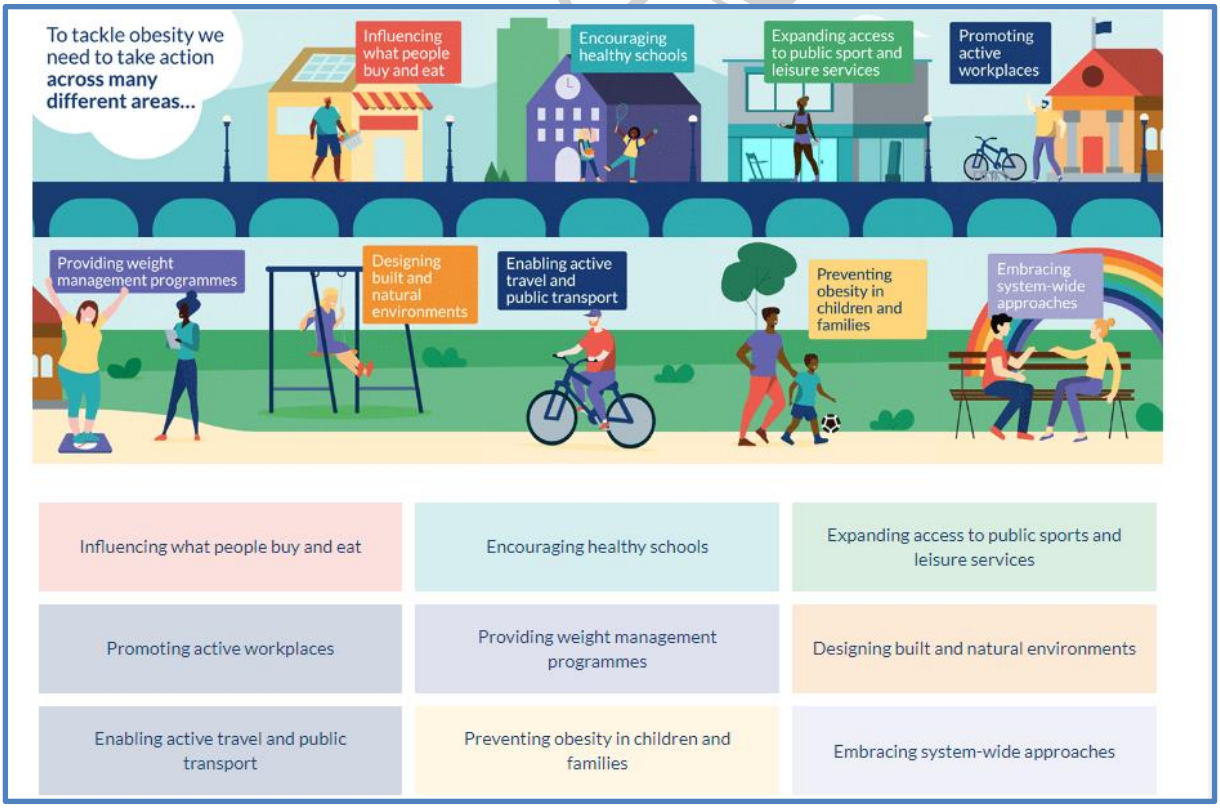
The system wide approach (see Fig 2) to addressing obesity reflects the importance of environmental and behavioural factors for addressing obesity and its consequences. Policies that change and shape the environment and impact on the whole population are necessary, if we are to have any impact on the high rates of obesity found in all population groups. These policies need to be wide ranging and implemented in different settings. For example, local authority planning authorities can influence access to unhealthy food e.g. fast-food outlets, schools also have this ability through the food made available for children. Local health services can support people who have obesity related conditions have rapid access to services to address their obesity and related health issues.

However, we also know from evidence that changing the environment does not always lead to the health-related behaviours that the change demands. For example, establishing Active Travel opportunities does not lead always to these opportunities being adopted by local communities. There is a need to understand the motivators for people's behaviours, how messages will best resonate and provoke change. What are the emotional and psychological barriers to change or is poor mental health an issue.

Environmental factors

The National Institute for Health and Care Research colourfully captures some of the key environmental changes associated with influencing obesity related behaviour. The evidence for these is presented below along with factors that need to be considered when implementing any changes. The role of behavioural change insights could help us understand the ambivalent evidence relating to some of these interventions.

Figure 23: Environments that influence health behaviours



National Institute for Health and Care Research 2021

Built Environment

Environments that encourage walking and are close to natural spaces can increase physical activity and have been associated with a lower BMI in children. In addition, investing in environmental design that supports active lifestyles is in line with environmental imperatives. Multiple factors underpin how people use these spaces. A key factor is the proximity to green spaces as some people rarely leave their locality. Small changes can encourage use of parks, such as removing bushes that obscure the line of sight and can make park users feel unsafe.

Active travel, infrastructure, community sport and physical activity

Investing in active travel and increasing access to public transport should be key elements of a systems-wide strategy that aligns with local sustainability and carbon reduction plans. Active travel can encourage people to become more physically active. It has been shown to lower BMI in children, to reduce health inequalities and to provide value for money. Research points to good practice. For example, where walking and cycling paths connect with transport hubs, they are more likely to be used. Encouraging use of public transport can have health benefits for certain groups of the population and goes hand in hand with active travel. Further research is needed to clarify which groups engage with active travel and how it addresses health inequalities.

Free access to public sport and leisure services

There is a mixed picture of effectiveness for free access to physical activities and whether it reaches those most in need. Programmes to encourage walking can be cost-effective, but findings on community exercise programmes are mixed – studies have not demonstrated sustained physical activity beyond 12 months. The effectiveness of programmes depends on the local area served, the level of deprivation, and the extent of inactivity. The evidence is mixed on whether extending access to public gym and swim facilities reaches those living in disadvantaged neighbourhoods. This will be more relevant for some places than others. Travel to public facilities can also be a key consideration.

Obesity in children and young people

Programmes aimed at preventing obesity in children and young people in the community can be effective, but the impact varies across age groups.
Few interventions over the last 25 years have targeted the wider determinants of childhood obesity (such as infrastructure, environmental and policy factors). Instead, they have encouraged children to change their individual food and activity behaviours.

There is evidence that interventions that include diet or physical activity components, or both, can reduce the risk of obesity in children aged 0 to 12 years and do not worsen health inequalities. However, most studies have reported outcomes at 12 months or earlier, so the long-term effectiveness of these interventions is not known. Young teenagers in particular need approaches that chime with their interests and the importance of friendship groups.

School Interventions

Interventions in schools to increase physical fitness or alter dietary habits have achieved limited results. Many interventions in UK schools have not been effective. Research tells us that leadership and parental and community involvement along with whole school approaches that have a wide focus beyond just maintaining a healthy weight are effective.

Evidence suggest that Strategies should be redirected away from interventions focused on changing the behaviours of school children (particularly of primary school age). Instead, they could concentrate on the wider environmental factors that influence behaviour through the life course.

Workplaces

Workplaces have been targeted with various interventions for preventing and managing obesity. However there is limited research that shows that actions to encourage office workers to sit less and move more is limited. This has become challenging with the introduction of hybrid working by many employers.

The food environment

Schools are an important environment for young people they can influence behaviours through the provision of healthy school meals, banning school-based sales of unhealthy snacks etc. Restricting new fast-food outlets close to schools has been introduced in some areas but there is mixed evidence as yet and a longer time period is required to fully evaluate their impact.

Working with food outlets to reformulate recipes and portion sizes, reflecting a 'health by stealth' approach, has been well-received by outlets and customers. However further research is needed into how these interventions impact consumption, overall diet, and body weight.

There is currently no robust research that planning guidance to restrict new fast-food outlets near secondary schools has been effective in decreasing the number of outlets. However, this is seen as being due to low numbers of new outlets opening during the studies; long term monitoring of exclusion zones around schools are needed. The rise of home food delivery services poses challenges to influencing the food environment, at the same time as allowing new business models to flourish.

Moreover the current cost of living crisis can people's ability to make choices (for example, to eat healthily versus heat their homes), or their dependence on food banks or food pantries, dictate the success of strategies to alter the food environment, local council staff said.

Advertising environment

Evidence has shown that advertising can affect when children eat, what they eat and over time can lead to them having excess weight. It has also been shown that restricting junk food advertising can impact household food purchasing decisions.

CHANGING BEHAVIOURS

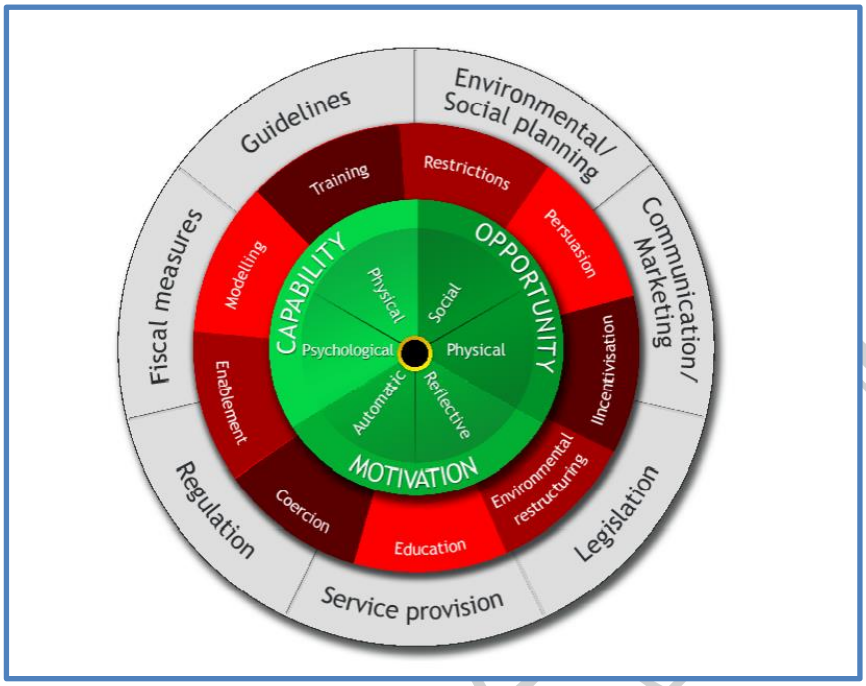
Behaviours are deeply rooted in people's social and material circumstances along with their cultural context which means that change can be challenging. The science underpinning behavioural change is concerned with understanding behaviour and developing effective interventions to influence it. The models of health-related behaviour change can be aimed at the individual, organisational, community and population levels. Behaviour change interventions are designed to influence the way people respond and act to activities, policies, products, and services in their environments that aim to reduce the risks of obesity.

It is recognised that some behaviour change interventions have had limited impact which is associated with a lack of a strategic approach to behaviour change across all sectors. This has seen the use of many different models, methods and theories being used in an uncoordinated way. The most effective ones are those that target several levels simultaneously.

There are number of models of behaviour change; the Behaviour Change Wheel is recognised as providing an integrative framework for pulling together all the factors that can influence behaviours. The Behaviour Change Wheel has at its centre a 'behaviour system' at the hub, encircled by intervention functions and then by policy categories. The green inner hub which represents the factors that influence any behaviour (Capability, Opportunity and Motivation); the red circle shows

the range of types of intervention (Restrictions, Persuasion, Incentivisation, Environmental restructuring, Education, Coercion, Enablement, Modelling and Training); and the grey outer circle shows policy options that can be used to deliver interventions (Environmental/Social planning, Communication/marketing, Legislation, Service provision, Regulation, Fiscal measures and Guidelines).

Figure 24: The Behaviour Change Wheel



Michie,S. Stralen M.M. & West R. 2011

The approach has been used to address a wide range of issues including increasing physical activity in schools, reducing sitting time in desk-based office workers, and supporting parents to reduce provision of unhealthy foods to children.

Behaviour change techniques are important in that they support behaviour change and include for example motivational interviewing, brief interventions, extended brief interventions. These have been adopted by a wide range of organisations and professionals to support behaviour change to prevent poor health or to support improvement.

Managing Obesity

There is a range of interventions that focus upon the treatment and management of obesity. Structured weight management programmes along with bariatric surgery are effective to varying degrees in supporting people to lose weight. With bariatric surgery having the best long-term outcomes. Early identification and management of obesity will contribute to decreasing the risk of comorbidities of obesity most notably cardiovascular disease and certain cancers. Integral to the management of obesity is decreasing the behavioural risk factors which includes addressing the multiple influences upon behaviour and understanding the motivators for change.

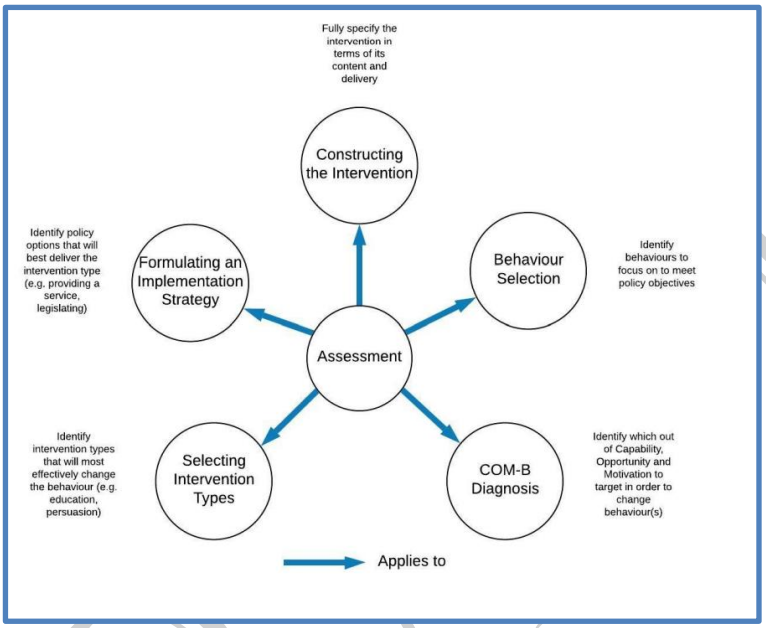
Behavioural insights

Fundamental to models of behaviour change is identifying what are the drivers of behaviours. Behavioural insights combine insights from psychology, cognitive science, and social science with empirically tested results to discover how humans make choices to inform policy. It can be used for

example to complement behaviour change wheel and the development of effective behaviour change interventions.

Developing a behavioural change strategy that takes an integrated approach is recommended by researchers as the most effective approach for addressing health behaviours. This starts with understanding motivation to determine the interventions that will involve individuals, communities, organisations, and all parts of the system that have been identified as impacting upon certain behaviours.

Figure 25: Processes involved in developing effective behaviour change interventions



Public Health England 2020

DEVELOPING THE STRATEGY

What are we doing now?

There are many interventions currently existing in the Cambridgeshire and Peterborough system that include strategies, prevention and management activities that tackle diet and physical activity along with those that address the emotional and mental health factors that influence people's obesity related behaviours.

There are some common themes in the strategies and interventions. For example, improving access to prevention services, opportunities for being more physically active or providing information and skills for improving diet. There have been workforce development programmes where professionals in different occupations have been trained to use behavioural change methods such as motivational interviewing. There are "behavioural change" services that include health trainers and health coaches who provide bespoke support to individuals to support them adopt healthier behaviours.

There are some limited interventions where local planning and organisational policies have been used to tackle environmental factors such as active travel planning. However, there are gaps; efforts to address access to healthier food options through for example limiting fast food outlets have not had any widespread traction with policy makers. For example, the siting of fast-food outlets close to schools or in hospitals.

The impact of the wider socio-economic determinants of health upon obesity is especially relevant currently due to the cost-of-living crisis which has closely followed COVID-19 pandemic which affected people's health behaviours and is manifesting through ongoing increased obesity rates. Although there are examples of interventions that reflect the impact for example on income, they have not had any long-standing influence upon people's ability to be able to afford a healthier lifestyle.

Current contextual challenges

However, we are mindful of the current contextual challenges found in the image below, that addressing obesity related behaviours presents. Any interventions will need to be responsive to the pressures that these exert upon behaviours.

- Mental Health is a major factor in the prevention and treatment of obesity, the COVID-19 pandemic has increased levels of poor mental health
- Cost of living crisis affects people's behaviours and their ability to have healthy lifestyle
- Long waiting lists for services
- Ongoing impact of the COVID-19 pandemic on behaviours and services

The "Let's Talk" Health and Care community engagement report clearly highlights the impact of the current cost of living crisis upon people's ability to eat healthily with over 50% of people responding that the cost-of-living pressures has affected their ability to have healthy behaviours. People are unable to buy healthy food such as fresh fruit and vegetables and that consumption of cheaper foods, which are often high in calories and less nutritious, had increased. Also some reported that they could no longer afford exercise classes or visits to the gym.

Around 50% of respondents were unsure or did not think that they have enough support to help them make changes to their lifestyle such as eating well and being more physically active.

What would good look like

Despite considerable efforts and a diverse range of interventions we have not seen any significant improvement in our childhood or adult obesity. The vision for the obesity priority is to build on the work already underway, to embed an evidence-based and transformational approach into current work and new interventions.

Embedded into our approach is the adoption of environmental policies and changes that evidence says can impact on obesity related behaviours across the population. However we know that within our local population there are various needs and different behavioural responses to policies and services. We want to avoid the risk of increasing inequalities that population wide changes can precipitate. Consequently, understanding these differences in behaviour motivation will be key to designing and nuancing our interventions, whether environmental policies or services.

Our transformational approach acknowledges the relative importance of factors that we need to address. Figure 3 in the introduction draws attention to these and their relative impacts from the wider determinants of health, mental health and wellbeing, behaviours and then illness. It also highlights how the biggest and most long lasting and cost-effective impacts arise from having a focus on childhood and younger people.

Our work will require organisations in different parts of the system to work together to synchronise interventions that will change the obesogenic environment and reflect the behavioural insights into how people will change their behaviour in response to changes in their environments and services.

To start this process we have identified three key priority areas to address in the first year of taking forward strategy (Figure 25). These reflect a need to make improvements in the environments that contribute to increases in obesity and to have local behavioural insights into people's obesity related behaviour. Secondly the sharp increase in childhood obesity and evidence that the internal and external school environment can be powerful behavioural influencers. The increase in comorbidities associated with obesity such as CVD presents an urgent need to prevent and identify adult obesity with a focus upon primary care. Primary care is well placed to identify those at risk behaviourally or clinically and instigate action.

The Strategy will be iterative and develop over time as we acquire more insight into the key environmental factors and what is driving behaviours. Figure 26: is an outline strategic framework that we need to build on and develop to ensure that the Strategy is driven forward.

Figure 26: Our approach and priority Interventions

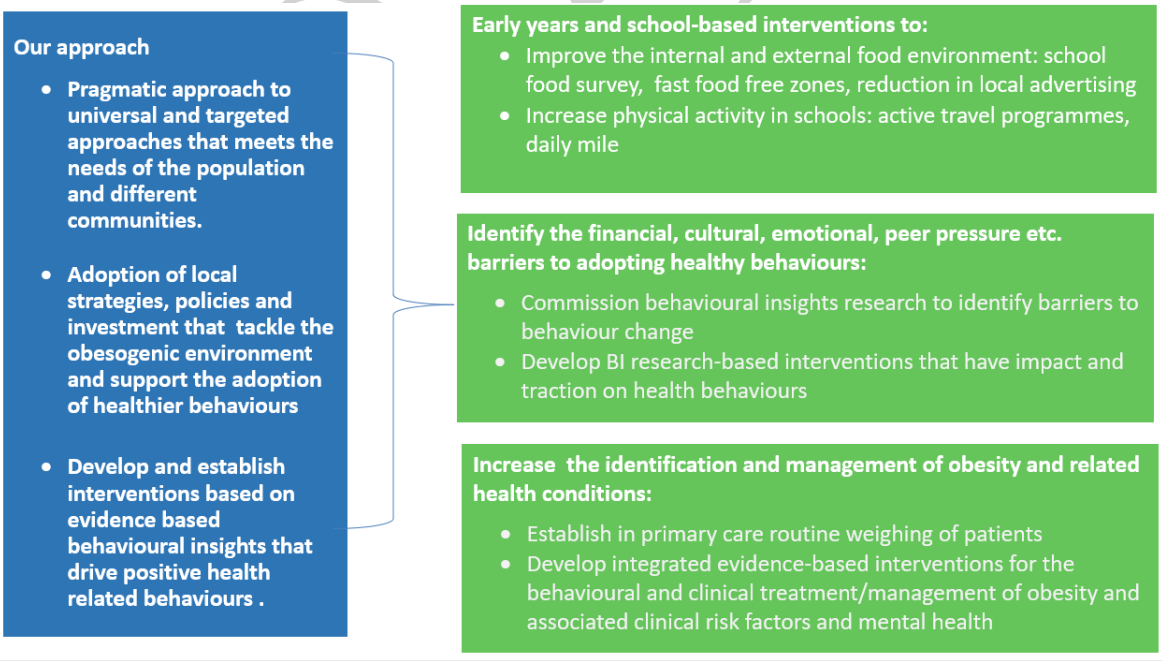


Figure 27: Framework for the Cambridgeshire and Peterborough Changing Behaviours for Healthy Weight Strategy

INTERDEPENDENCIES WITH OTHER HWICS PRIORITIES

Reducing obesity features across the priority chapters, its impacts and determinant factors span several ICS priorities. Most notably there is a direct cross over in relation to the support and interventions required for children and young people in early years and education settings, to the development of accessible open spaces to support physical and mental health. It will be a priority for the system leaders to engage, prioritise and work together to ensure ownership and that duplication of effort is removed from delivery of interventions.

Further work is scheduled to focus on overlapping activities within the priorities. Where uniting, identifying, and working as one to focus on specific activities and tasks to tackle defined goals. These activities will form through projects coupled with measures, timelines, and the appropriate governance applied.

This is where the system golden thread pulls together and collectively identifies added value and efficiency, whilst the service user experience is more personable, tailored, and effective.

SYSTEM PARTNERS' COMMITMENT TO ALL PRIORITIES

Further discussion on topics we all attribute focus:

- System leader support for policies that have impact and require collaboration across boundaries.
- Share data from our collective and varied analytical groups to present the case of need.
- Our organisations to offer apprenticeships and work experience placements to our local schools.
- Work with system partners to reduce inequalities and combat the known wider determinates of health that have a negative impact on our residents.
- Ensure our organisations have robust work policies which focus on well-being and support employees on Mental Health issues

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