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**Evaluation plan and recommendations -  
'Can't Wait to be Healthy'**

A briefing paper on evaluation for Leeds Childhood  
Obesity Prevention and Weight Management  
Strategy

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**November 2008**

## **'Can't wait to be healthy' - Leeds Childhood Obesity Strategy**

### **Summary of evaluation planning workshops**

A series of programme planning and evaluation workshops were facilitated by Leeds Metropolitan University to draw out a 'theory of change' for the overall strategy and the individual objectives. Workshop participants from a range of partner agencies:

- Identified the starting points and long term goals
- Modelled how change would be achieved and what outcomes would be expected across the life of the strategy
- Checked how different strands of work linked together and identified gaps
- Examined how success would be assessed.

There are now simple statements of the programme logic (theories of change) linked to evaluation plans with short term, medium and long term indicators for the overall strategy and the following objectives:

- Objective 1: Frontline staff supporting parents, young people and children
- Objective 3: Prevention and treatment programmes across the lifespan
- Objective 4: Communication
- Objective 5: City-wide strategies
- Objective 6: Urban design

**Leeds Childhood Obesity Theory of Change** is represented in Figure 1. A number of assumptions were identified in the workshops.

### **What does 'Can't wait to be healthy' need to work?**

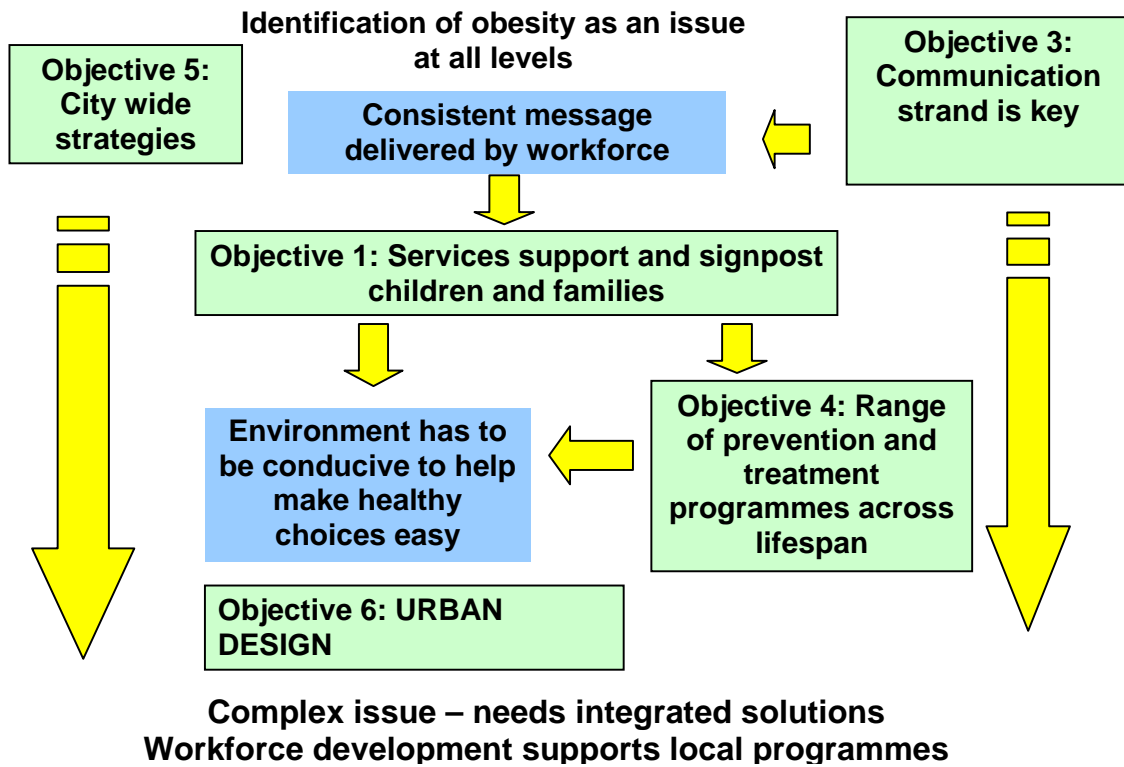
- Everyone needs to recognise childhood obesity as a priority issue. The communication strand is key.
- There are a lot of city wide strategies – these need to work together and there has to be clarity over roles, contribution and capacity.
- Workforce development is an essential component as front line staff will be delivering messages and supporting families, young people and children. Change is challenging, however, as there may be resistance.
- The environment has to be improved to support lifestyle change. There are lots of benefits from improving the built environment, green space, access to food etc. but health is not always prioritised in urban design.
- There needs to be local ownership and also further consultation to ensure messages are tailored to groups and interventions are appropriate.
- Childhood obesity is a complex issue that needs integrated solutions. The value of an integrated approach could be demonstrated through a focus on one/two localities initially.

## Recommendations for evaluation

It is recognised that there is a commitment to integrate evaluation alongside the implementation of the strategy. Some preliminary research will be needed to get a full baseline picture and to consult with staff, families, young people, and children. Based on the workshops, the following recommendations are proposed for the evaluation of 'Can't wait to be healthy':

1. A common reporting framework needs to be agreed with key environmental, social and health indicators (matching any government recommendations). There is potential for everyone to be awash with data but still not know what is going on. Leads from different programmes should take responsibility for feeding in **high level** information about **changes in provision, uptake and impact**.
2. Results from lifestyle and other surveys of children should be accessible for members of the partnership and (where possible) analysed in units that make sense for development and monitoring of interventions.
3. A sub group of the Leeds childhood obesity partnership should take responsibility for negotiating access to existing data sources, collation and interpretation of data, and summarising results for overall strategy evaluation.
4. A toolkit should be developed to help sections of the workforce assess good practice using simple criteria in relation to childhood obesity prevention, support and treatment. The toolkit could be an integral part of the workforce development package.
5. Where an integrated approach is used in specific localities, progress can be monitored through use of routinely collected data and use of mapping techniques for key indicators of behaviour change and supportive environments before and after (e.g. food sales of key items). Not only will this inform programme planning, it will also provide evidence of progress.
6. Some qualitative research should be commissioned to provide a holistic, in-depth picture of what works and whether it makes a difference from the perspective of families, young people and children. It would be sensible to do this where an integrated approach is being trialled in specific localities and/or population groups. This will provide a much needed 'reality check' on the strategy.

**Figure 1: Leeds Childhood Obesity Theory of Change**



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## Section 1 Introduction

The rise in childhood obesity is a major public health challenge and a national priority for health action. Obesity is associated with many illnesses and is directly related to increased mortality and lower life expectancy. The Children's Plan recognises child obesity as one of the most serious challenges for children and links it to a number of poor outcomes, physical, social and psychological (Department for Children, Schools and Families 2007). 'Can't wait to be healthy'- Leeds Childhood Obesity Prevention and Weight Management Strategy 2006-2016 is a comprehensive, city-wide strategy setting out actions to tackle the problem of childhood obesity for all children and young people 0-19 years. The strategy reviews the evidence around prevalence, causal factors and effective interventions. There is recognition of the complexity of the issue and the need for action on multiple levels and in different sectors, including health, education, environment and leisure services. The guiding principles are based on partnership working and local leadership, the active participation of parents, carers, children and young people, and the prioritisation of prevention and early intervention.

'Can't wait to be healthy' was initiated by Leeds Primary Care Trust (PCT) and Children Leeds and its implementation is being overseen by a multi agency partnership. An initial action plan was agreed that gives an outline of proposed actions (2007-2010) grouped around strands of work. There are seven core objectives that are summarised in Box 1. A robust evaluation plan and reporting framework to measure progress and outcomes resulting from the strategy is required. This is supported by recent guidance for local areas indicating the importance of local evaluation and monitoring in tracking progress and informing commissioning (Cross Government Obesity Unit 2008a). The Centre for Health Promotion Research, Leeds Metropolitan University, was commissioned to work in collaboration with the Leeds Childhood Obesity Partnership to develop a strategic approach to evaluation. A series of workshops were held in Spring 2008 to enable stakeholders to engage with the planning process and to consider how evidence would be generated. The workshops used a 'Theory of Change' approach to develop understanding about how and why specific activities or combinations of activities work (Connell and Kubisch 1988). This resulted in a draft evaluation plan and recommendations for ongoing evaluation which are presented here. This briefing paper includes:

- Summary of national guidance on indicators for childhood obesity
- Evaluation planning process and approach
- Theories of change and evaluation plans for each objective and for the overall strategy
- Recommendations for evaluation of 'Can't wait to be healthy' and priorities for data collection.

**Box 1: Core objectives - 'Can't wait to be healthy' Action plan**

**Objective 1 – Front line staff supporting parents and children**

- To enable all children's services' staff to deliver appropriate evidence based support to all children, young people and parents and carers wishing to prevent and manage childhood overweight and obesity.

**Objective 2 – Local intelligence**

- To monitor and increase local understanding of childhood overweight and obesity levels in Leeds, including prevalence among specific population groups, to enable a clearer understanding of unmet need and appropriate targeting of local resources.

**Objective 3 - Prevention and treatment programmes across the lifespan**

- To increase the availability and impact of local childhood obesity prevention and treatment programmes in line with the evidence base through sharing best practice, developing local capacity and encouraging robust evaluation of local programmes.

**Objective 4 – Communication**

- To implement a comprehensive communication plan highlighting the problem and potential solutions to childhood obesity in Leeds, creating a local ethos that a healthy active lifestyle is cool and raising awareness of Leeds Childhood Obesity Strategy and associated action locally, regionally and nationally.

**Objective 5 – Contribution of city wide strategies**

- To maximise the contribution that city-wide strategies make to preventing and managing childhood obesity.

**Objective 6 – Urban design**

- To highlight the importance of Urban Design in encouraging regular activity as part of everyday life, access to healthy affordable food, strengthen protection of green space, and lead to the further improvement of parks, play facilities and neighbourhoods.

**Objective 7 – Infrastructure**

- To develop the infrastructure to deliver the childhood obesity strategy.



## Section 2 Childhood obesity indicators

The government is committed to tackling obesity and has pledged to halt the year on year rise in obesity in 11 year olds by the year 2020, enabling all individuals and not just children, to maintain a healthy weight. Obesity is included as a national priority within the NHS Operating Framework and the Child Health Public Service Agreement, requiring all PCTs to develop plans to tackle child obesity and to agree local plans with Strategic Health Authorities (SHAs). In its efforts to address obesity, the government offers guidance for primary care trusts and local authorities on the setting and negotiating of child obesity goals as part of the Local Government National Indicator Set (NIS) (Department for Communities and Local Government 2007). Within the NIS there are two indicators specifically on child obesity:

1. Obesity among primary school age children in reception (NI 55)
2. Obesity among primary school age children in Year 6 (NI 56)

In addition, there are many other indicators within the set that have relevance to tackling child obesity (see Appendix 1). Some are more wide-ranging than others, whilst the link between certain indicators and the development of obesity is rather tenuous. There are, however, key indicators that are clearly relevant for the successful outcome of each particular programme strand and the overall reduction in obesity prevalence. The indicators below have been drawn from Healthy Weight, Healthy Lives guidance (Cross Government Obesity Unit 2008a,b,c) and cross referenced to the National Indicators set.

In relation to the promotion of healthier food choices the important indicators for **healthy growth and healthy weight** are:

- a) The proportion of mothers' breastfeeding at 6 to 8 weeks [NI53] and at 6 months.
- b) The number of portions of fruit and vegetables each child consumes on a daily basis, the aim being for children to be eating at least 5 portions of fruit and vegetables a day.
- c) More families signing up to the Healthy Start scheme, which provides vouchers to exchange for fresh fruit and vegetables and other products.
- d) A reduction in the consumption of high fat, sugar and salt foods, especially amongst children.
- e) Healthier food choices available within local environments including more healthy options in convenience stores, school canteens, vending machines, at supermarkets tills and at non-food retailers.
- f) Increased take up of healthy school meals [NI57]. For example, the School Food Trust 'Million Meals' Campaign ([www.millionmeals.schoolfoodtrust.org.uk](http://www.millionmeals.schoolfoodtrust.org.uk)).
- g) More schools providing access to extended services including breakfast clubs, after school clubs, parenting and cookery classes.
- h) Increased provision for cookery classes within the school curriculum as part of the statutory design and technology National Curriculum for all key stage 3 pupils.
- i) The introduction of the Licence to Cook scheme, a non-statutory entitlement to learn how to cook for 11-16 year olds.

As far as incorporating **physical activity** into children's lives is concerned the important indicators are:

- j) All 5-16 year olds participate in two hours of high quality PE and sport during the school day [NI 57].
- k) All schools have a school travel plan in place that promotes physical activity and active transport. For example, bikeability and walking buses that promote healthy and sustainable transport.
- l) Children traveling to school – normal mode of transport [NI 198].
- m) Increased number of children and families engaged in physical activity on a regular basis, in particular amongst those who are currently the most inactive, resulting in 'more people, more active, more often'.
- n) Less reliance on car use and a reduction in car use especially for trips of less than a mile.
- o) Increased provision for outdoor play by children.
- p) Access to services and facilities by public transport, walking and cycling [NI 175].

In terms of **supportive environments** the key indicators are:

- q) Increased traffic-calming measures and improved street lighting to make outside play, as well as active modes of transport to school (as set out in school travel plans) and other services, realistic and attractive options.
- r) Increased awareness of safety issues in the planning of parks and open spaces and evidence of initiatives to address this. For example, employing dedicated park rangers or youth workers.
- s) Increased evidence of health incorporated into the design of road networks, public buildings and homes. For example, increased provision for cycle lanes, greater capacity for school dining rooms and kitchens, as well as outside areas to play and space to accommodate a table for eating in people's homes.
- t) Increased number of schools achieving National Healthy Schools status. This ensures that schools have policies and procedures in place to support and deliver many of the initiatives targeted at reducing child obesity.
- u) Increased provision for access to advice, support and services regarding healthy lifestyles, especially for parents. For example, weight management services to support overweight and obese children and their families progress towards a healthier weight.
- v) Increased number of practitioners who understand their role and feel empowered to fulfil it.

## Section 3 Evaluation planning process

Evaluation will be integral to the implementation of 'Can't wait to be healthy'. Early discussions with the Leeds Childhood Obesity Strategy partnership highlighted the value of being able to use evaluation findings to aid learning and inform future developments. An evaluation sub group was formed to oversee the process of developing an evaluation plan, to identify priorities for evaluation and to ensure reporting needs were met. The emphasis for evaluation has been on the overarching strategy and gaining an overview of progress. The resulting evaluation plan is therefore complementary to any evaluation studies of specific services and projects, which will be able to provide more robust evidence on the effectiveness of individual interventions.

Theory of Change was adopted as the underpinning approach for the evaluation planning process. Theory of Change was first developed in North America and provides a robust methodology for the evaluation of what are termed complex community initiatives (Connell and Kubisch 1988). In essence, the approach allows stakeholders to make clear how they will achieve change and what steps need to be taken to achieve overall goals. One of the strengths of using a Theory of Change approach is that it promotes insight into the connections between activities undertaken by services and overarching goals (Judge and Bauld 2001). This is very important for 'Can't wait to be healthy' where there are multiple strands of activity, all making a contribution to tackling a complex problem with numerous causal factors. In such a context it will be difficult to attribute population level change in health and health behaviours to the strategy through traditional research designs. The approach adopted for 'Can't wait to be healthy' has therefore placed an emphasis on identification of expected outcomes at different stages of implementation and selection of relevant indicators (Green and South 2006).

A series of **programme planning and evaluation workshops** facilitated by senior researchers were held in Spring 2008. Stakeholders from various partner agencies were invited to participate in the workshops. The first set of one and half day workshops covered Objective 1 and Objective 6 of 'Can't wait to be healthy', while the following set covered Objective 3 and Objective 4. An additional half day workshop was held with strategic leads and commissioners to consider Objective 5 – contribution of city wide strategies. Workshop participants were introduced to the Theory of Change approach and then worked together to:

- Identify the starting points and long term goals;
- Model how change would be achieved and what outcomes would be expected across the life of the strategy;
- Check how different strands of work linked together and identify gaps;
- Examine how success would be assessed.

Stakeholders were encouraged to check programme logic to improve planning processes (Nancholas 1998). In addition to the detailed work on individual objectives, stakeholders considered how the overall strategy worked and how different strands linked together. Feedback processes were built into the workshops to allow the emerging evaluation plans to be refined. Workshop participants were also asked to identify relevant indicators and to map sources of existing data. Section 4 presents the emerging theories of change for the separate objectives and also for the overall strategy. The key steps required to reach health goals are summarised.

## **Section 4      Theories of Change and evaluation plans**

Theories of change were developed at the workshops for the following objectives:

- Objective 1 – Front line staff supporting parents and children
- Objective 3 - Prevention and treatment programmes across the lifespan
- Objective 4 – Communication
- Objective 5 – Contribution of city wide strategies
- Objective 6 – Urban design

Each objective has a summary of the theory of change agreed by stakeholders. While the workshops generated much discussion, it was important to simplify the theory of change to a series of key steps that could be easily understood and communicated. The starting point, key steps to achieve change and underpinning assumptions are described. Key indicators of success are listed in tables but the full plans and further details on indicators of success are given in Appendix 2.

Objectives 2 – Local intelligence and Objective 5 – Infrastructure were considered within the workshops but separate theories of change were not developed as these strands of work thread through the whole planning and implementation of 'Can't wait to be healthy' (see page 22). Epidemiological and other health data are being used in to identify priority areas and populations and to monitor progress.

**Objective 1 – Front line staff supporting families, young people and children**

To enable all children's services' staff to deliver appropriate evidence based support to all children, young people and parents and carers wishing to prevent and manage childhood overweight and obesity.

**Starting point**

Workshop participants identified a need for greater awareness and recognition of obesity with children, young people, parents, carers and practitioners. It was felt that some parents' knowledge and recognition of obesity in their children was poor. The scale and scope of the problem is known for school children but there also needs to be recognition of obesity as an issue with pregnant mothers and children under two years.

**Key steps to achieve change and underpinning assumptions**

1. It is important that all stakeholder groups including parents, young people, children, and front line practitioners identify obesity as an issue.
2. There is a need to identify relevant front-line practitioners in different settings by scoping the range of front line staff who have a role to play. Frontline staff are in a good position to raise awareness, educate and provide support to parents and children but will need to be knowledgeable about the range of opportunities and facilities on offer. There also needs to be consultation with families, young people and children to check out the relevance of current services.
3. Multidisciplinary training needs to be developed for front line staff to enable them to support parents, children and young people. Workforce development is an essential component as front line staff will be delivering messages and supporting families. Change is challenging, however, as there may be resistance from parents and from staff.
4. The communication strand is key (Objective 4) as it is important to create messages which are consistent and go across sectors. This will involve raising awareness of other facilities and support services.
5. Children and young people may need mentoring and support to overcome barriers. The development and maintenance of buddy and mentor schemes is vital. Staff should offer essential support at the point of contact and provide connection to activities/services straight away.
6. There is a need to engage with a wide variety of services. More joined up working will allow different opportunities for support to be created. There is often an underlying assumption that support will be delivered through formal services but informal mechanisms can also work.

### Key indicators of success

Given the broad scope of this objective and the differential development of different services, generic indicators are shown to give a sense of the direction and time span of change, followed by a table illustrating indicators for a priority development area.

### Generic Indicators

Short term – 1 year	Evidence of consultations taking place and service changes identified.
Medium term – 3 years	Staff from range of services report change in level of confidence to raise issues. Staff from range of services report good knowledge & awareness of obesity and prevention. (This could be assessed by self evaluation). Increased availability of support services
Long term – 5 years	Families, young people and children report that they receive support. Increased uptake in facilities and services with a role to play in obesity prevention/physical activity. Physical activity indicators: PESSCEL, NI 198 Children travelling to school –normal mode of transport.

### Example of priority development area

Indicators for workforce development for services working with 0-5 years old	
Short term – 2009	Evidence of consultations with parents, carers and staff and service developments identified. Evidence of small number of successful pilots across health, education and social services working with 0-5 age group. Champions identified for rolling out workforce development around HENRY initiative.
Medium term – 2011 years	Numbers of staff involved and trained through in HENRY initiative. Staff from range of services working with 0-5 years report change in level of confidence to raise issues. Staff report good knowledge & awareness of obesity and prevention. Increased availability of support services for 0-5 years through HENRY initiative.
Long term – 2013	Families and children report that they receive support around obesity prevention from educational, health and social services. Increased uptake in facilities and services with a role to play in obesity prevention/physical activity.

**Objective 3: Prevention and treatment programmes across the lifespan**

To increase the availability and impact of local childhood obesity prevention and treatment programmes in line with the evidence base through sharing best practice, developing local capacity and encouraging robust evaluation of local programmes.

**Starting point**

There are a range of prevention and treatment programmes already in place, some delivered through mainstream provision (see Appendix 3). Workshop participants reported that there were gaps in knowledge in relation some areas of work, such as pre-conception and also the contribution of the private and voluntary sector.

**Key steps to achieve change and underpinning assumptions**

1. The first step is to assess what support is available to support healthy lifestyles. Organisations and services will know what works (based on evidence and need) and be able to identify gaps. It will be necessary to identify programmes which model good practice in relation to universal services, prevention plus and specialist prevention and treatment services..
2. Multidisciplinary training will be needed to deliver evidence based support and information (linked to Objective 1). The workforce will need to be skilled to give information, advice and support. It is important that this training is correct, up-to-date and accurate.
3. Weight management and healthy lifestyle advice should be made accessible and available. It is vital that there is a clear message about the risks of childhood obesity and the benefits for a healthy lifestyle (Objective 4).
4. There needs to be greater integration of programmes across the lifespan, working with whole family. There needs to be support to help people access programmes and services. People in priority groups (bottom 10% - IMD indicators) should receive effective information and support from treatment and prevention programmes. There is also an identified need to ensure that all provision meets the needs of obese children.
5. In the long term, children, young people and families will make and maintain positive changes in behaviour. A set of health related goals across the lifespan were articulated in the workshops including children, young people and families with knowledge, skills and motivation around healthy lifestyles. Healthy choices should start at the beginning of lifespan with women conceiving at a healthy weight.
6. While commissioning, planning and delivery of programmes will take place across the city, there is a strong rationale for initially focusing efforts on developing fully integrated programmes in specified priority localities. A series of steps was mapped out for the locality work (see Box 2). In effect these areas would act as demonstration projects and will be accompanied by in depth evaluation.

**Box 2: Steps in building integrated approach in a locality**

**Step 1:** Identify one or two areas using agreed criteria on need, current provision and local leadership.

**Step 2:** Get childhood obesity on local agenda.

**Step 3:** Draw on local data and evidence to inform and enthuse key stakeholders.

**Step 4:** Understanding people and place. This would involve engaging local parents and consultation. There is value in using a social marketing approach to tailor action plan and programmes.

**Step 5:** Revisit stakeholders with new/detailed evidence and identify new partners.

**Step 6:** Begin activity plan. Identify mechanisms for strategic change, considering a range of alternatives.

**Key indicators of success**

Individual programmes and projects will be based on available evidence and monitoring and evaluation will be needed. Some pilot programmes will require more intensive research studies to provide the necessary evidence base. The indicators below are for the overall childhood obesity strategy. A more detailed plan is given in Appendix 2.

**Generic indicators**

Short term – 1 year	Completed mapping of provision and gaps in relation to need across the lifespan: <ul style="list-style-type: none"><li>• Universal services</li><li>• Prevention plus</li><li>• Specialist prevention and treatment</li></ul> Criteria for services relate to NICE and key policy guidance.
Medium term – 3 years	Increase in uptake of relevant services & specialist prevention and treatment programmes. Provision in schools in line with national initiatives e.g. licence to cook. People asking for help; self referrals; agency referrals. Evidence that services and frontline staff responsive to needs of priority groups.
Long term – 5 years	Numbers reporting that they eat 5-a-day. Supermarket data on consumption. Parental involvement in adopting and maintaining healthy lifestyles. Breastfeeding rates – NI 53. Uptake of healthy school meals – NI 57. Behaviour change in obese and overweight children and young people.



### Indicators for integrated approach for designated area or target group

Short term – 2009	Evidence of change in awareness and willingness to act on childhood obesity with key stakeholders. Local champions identified. Completed mapping of provision in target area and gaps identified in relation to need across the lifespan.
Medium term – 2011	Changes in patterns of services and facilities in target area. Evidence of involvement of parents, children and young people in design of services. Increased number of self referrals and agency referrals to local services. Evidence of local services and frontline staff responsive to needs of priority groups around obesity (signed up).
Long term – 2013	Selection of relevant indicators around health behaviours (related to local strategic plans) Parental involvement in adopting and maintaining healthy lifestyles Behaviour change in obese and overweight children and young people.

**Objective 4 – Communication**

To implement a comprehensive communication plan highlighting the problem and potential solutions to childhood obesity in Leeds, creating a local ethos that a healthy active lifestyle is cool and raising awareness of Leeds Childhood Obesity Strategy and associated action locally, regionally and nationally.

**Starting point**

Workshop participants noted the extent of media coverage of childhood obesity but the quality and effectiveness was felt to be varied. Messages about childhood obesity can be negative, contradictory or confusing. There was some evidence of successful campaigns, such as Be Healthy and 5-a day, but in contrast the physical activity message was much less effective. Workshop participants commented that there was some lack of awareness in families about issues such as sedentary behaviour and the recognition of obesity. Families face societal pressures, such as the drive to have computer games, or fear of letting children out to play.

**Key steps to achieve change and underpinning assumptions**

1. Stakeholder analysis is the first stage in order to gather local evidence on children, young people and families and better understand the target audience(s). This would be consistent with a social marketing approach and would also involve gathering evidence of what works.
2. There is a need to scope the potential partners and achieve understanding from partners of the importance of the issue. In addition the communication plan will be shared with the children and young people network.
3. Partners should then agree the communication strategy and message. Getting ownership in the partnership will ensure resources are allocated and the message is effectively disseminated.
4. Campaign materials will then be developed. A consistent, simple, unambiguous message will work best. Emphasis on fun not health may work better. Campaign materials will need to be targeted at different market segments in line with a social marketing approach.
5. The message on childhood obesity is communicated through local agencies and the workforce. The workforce will need to be skilled to give information, advice and support (Objective 1). Local champions, role models and opportunities for action will be highlighted and the local media involved. It needs to link to national and regional communication strategies.
6. Families receive the messages and are able to make healthy choices. The assumption is that it is necessary to communicate to whole family. Communication of a message alone will not be enough to lead to behaviour change as families, young people and children will need supportive environments.
7. The ultimate goal is that parents and children will know how to make healthy choices (skills) and message will inspire action (focusing on fun as much as

health). It will be important to not only raise the overall bar but also to narrow the gap in understanding, narrowing health inequalities.

### Key indicators of success

Each target group relating to the main market segments will have a distinct programme and evaluation plan relating to communication. By 2009, priority groups will have been selected, health and information needs mapped and key evidence gathered (Stage 1 of the theory of change). Communication plans will set out the timescale for implementation for each group.

### Generic indicators

Short term – 1 year	Report outlining local evidence and priorities.
Medium term – 3 years	Children, young people and families involved in pilots report increased awareness, understanding and motivation in relation childhood obesity. Numbers of staff trained. Staff know message and understand its importance.
Long term – 5 years	Children, young people and families demonstrate increased knowledge and understanding. Parents and children involved in meal times together. Increased use of open/leisure spaces. Physical activity indicators.

### Example of indicators for priority development group

Short term – 2009	Report outlining local evidence and priorities. Priority groups selected to fit with market segments.
Medium term – 2011	Children, young people and families involved in pilots report increased awareness, understanding and motivation in relation childhood obesity. Numbers of staff trained to deliver targeted message for specific group. Staff know message, understand its importance and are able to relate it to the target group.
Long term – 2013	Children, young people and families in the target group demonstrate increased knowledge and understanding. Selection of relevant behaviour change indicators (healthy lifestyle).

### **Objective 5 – Contribution of city wide strategies**

To maximise the contribution that city-wide strategies make to preventing and managing childhood obesity

#### **Starting point**

Programme leads and commissioners mapped existing strategies and identified where there were gaps and weak links (Appendix 4). The overall picture is one where there are a large number of distinct strategies and plans, both at city level and within specific sectors and localities. While there are some existing links, there are also some weak links.

#### **Defining the vision**

The workshop participants identified what the vision was in 5 years time. A number of themes emerged:

- Access to food and physical activity. This includes fruit and vegetable shops in all communities and provision of cycle ways, play areas and easy access to outdoor activities in all communities.
- Standardised training for all front line staff and staff feeling comfortable talking to families regarding weight issues.
- Communication with consistent healthy eating messages and raised parental awareness of services.
- More of the population adopting healthy lifestyle around physical activity. Parents actively enjoying happier children through healthier lifestyles.
- All children enjoying school meals.
- No families making poor food choices for their children.

#### **Key actions and underpinning assumptions**

Questions of how work at a strategic level would make a difference on the ground and how integrated planning and practice would be achieved were considered in the workshop. These are summarised below but are not placed in order.

1. **Strategic links.** Leadership was required with strategic links to decision making clear and well publicised through the LSP, Children Leeds and adult plans. Having the right infrastructures and the capacity to meet targets was important. There was a perceived danger of having too many strategies rather than one all encompassing strategy. There was a need to strengthen links between the childhood obesity strategy and adult obesity plans.
2. **Information flows.** There need to be improved information flows. Data and solutions (evidence base) need to be presented to new local Health and Wellbeing Partnerships, Joint Strategic Needs Assessment and health needs aspect of CYPP. Mechanisms for data sharing should be explored. Suggestions included using Leeds Initiative interactive website and creating a potential space for messages, sharing data, virtual meetings etc.
3. **Links to local level.** Local level planning was seen as important. Various suggestions were made about using local structures and linking in to Local Area Children's Delivery Partnerships and local area committees.
4. **Settings.** There was potential to look at a workforce approach on the basis that many parents and carers can be reached through their work. However

this would require raising awareness amongst higher level decision makers. Schools are also an important setting for promoting healthier lifestyles.

5. **Communication.** Positive food messages and activity messages needed to be promoted. The style of communication should be positive. There needs to be greater awareness of the evidence base around healthy lifestyles and obesity.

**Key indicators of success**

Short term – 1 year	Strategic links made at a high level in the city.
Medium term – 3 years	Key partnerships show strengthened and simpler links Information flows on evidence improved. Local planners have access to information/ evidence Evidence of access to food and physical activity taken into account in other strategies. Evidence that other strategies take into account emotional health.
Long term – 5 years	Evidence of integrated planning that takes into account health needs. Seamless delivery on ground in different priority settings reported by front line staff and families, young people and children. Access to services and facilities by public transport, cycling and walking - NI 175

## **Objective 6 – Urban design**

To highlight the importance of Urban Design in encouraging regular activity as part of everyday life, access to healthy affordable food, strengthen protection of green space, and lead to the further improvement of parks, play facilities and neighbourhoods.

### **Starting point**

Workshop participants identified that currently there was a disparate approach to urban design, planning, and green space work in relation to health. The issues of access to food, location of food retailers, the existence of food deserts and transport choices are significant factors in relation to creating supportive environments. Health and well-being was perceived as being given a low priority overall compared to economic development. There was, however, reported to be a willingness to engage in more joined up work between the urban design and planning sectors and health.

### **Key steps and underpinning assumptions**

1. The importance of health issues in urban design and improving the quality of living environments needs to be raised at a political level. This is seen as a crucial first stage.
2. Improved joint working both on new developments and existing urban areas needs to take place. This will lead to the outcome of joint funding and plans that address health as part of design. The importance of aligning strategies and communications within the council, PCT and other agencies was stressed.
3. Priorities for investment should be clarified, for example, in improving green spaces in areas of need. This will include action to improve the quality and accessibility of attractive, usable green spaces and to promote walking and cycling, e.g. cycle routes. Access to food and transport choices are parallel priorities for investment.
4. Improved input by all stakeholders into new area plans at an early stage will be sought. Better joint working will enable the creation of healthier local environments which will in turn lead to increase in physical activity levels. This may involve protecting town centres where accessible facilities are offered.
5. It will be essential to provide facilities which are affordable. Prioritising improvements in green space/ local facilities will lead to increased usage and therefore an increase in physical activity levels. Lifestyle change will only happen if there are convenient, attractive and affordable facilities including green spaces, walking and cycling routes. It is not possible to separate the prevention of childhood obesity from obesity in adult population.

### Key indicators of success

The theory of change and indicators will be initially applied to priority areas and issues. The evaluation would focus on change in relation to the indicators in designated localities and developments and the process would be expected to demonstrate gradual improvements:

Short term – 1 year	Evidence of more collaborative working. Evidence of high level support in sectors relating to urban design
Medium term – 3 years	Increased evidence of health incorporated into the design of road works, public buildings and homes. Increased evidence of health incorporated into the plans of new developments (transport, retail and residential). Number and quality of green spaces improved.
Long term – 5 years	Increased % people using improved spaces. Mix of activities reported/observed (walking, cycling etc.). Increase in % of young people and children walking and cycling. Increase in % of young people and children reporting they play outside. Normal mode of travel to school – NI 198.

### Example of indicators for priority developments

Short term – 2009	Evidence of more collaborative working in relation to identified priority areas/developments. Evidence of high level support in sectors relating to urban design for one of the key issues e.g. green space or cycle lanes.
Medium term – 2011	Evidence of health needs having been taken into account in a small number of new developments or existing facilities. E.g. improvements in quantity or quality of play spaces or public transport to leisure facilities.
Long term – 2013	Increased % people using improved spaces in priority areas/developments. Mix of activities reported/observed (walking, cycling etc.). Increase in % of young people and children walking and cycling. Increase in % of young people and children reporting they play outside.

## **Overall Theory of Change 'Can't wait to be healthy'**

Leeds Childhood Obesity Prevention and Weight Management Strategy

### **Starting point**

The strategic approach espoused in 'Can't wait to be healthy' was predicated on an understanding of the complexity of causal factors for childhood obesity (Box 3) that operate at individual and community levels. It is important that the strategy is viewed as a whole as well as its constituent strands of work. Change, whether at community, organisational and individual level, is more likely to result from an integrated approach with synergy occurring as different strands of work reinforce and support other activities.

### **Box 3: Key contributing casual factors for childhood obesity**

*Source: 'Can't wait to be healthy' (Children Leeds 2006: 11)*

Individual health behaviour around nutrition and physical activity

Family customs and choices

School practices and peer influences

Community (including access to facilities in neighbourhoods)

Local planning controls and strategies

Organisational and commercial practices

Social policies and national legislation.



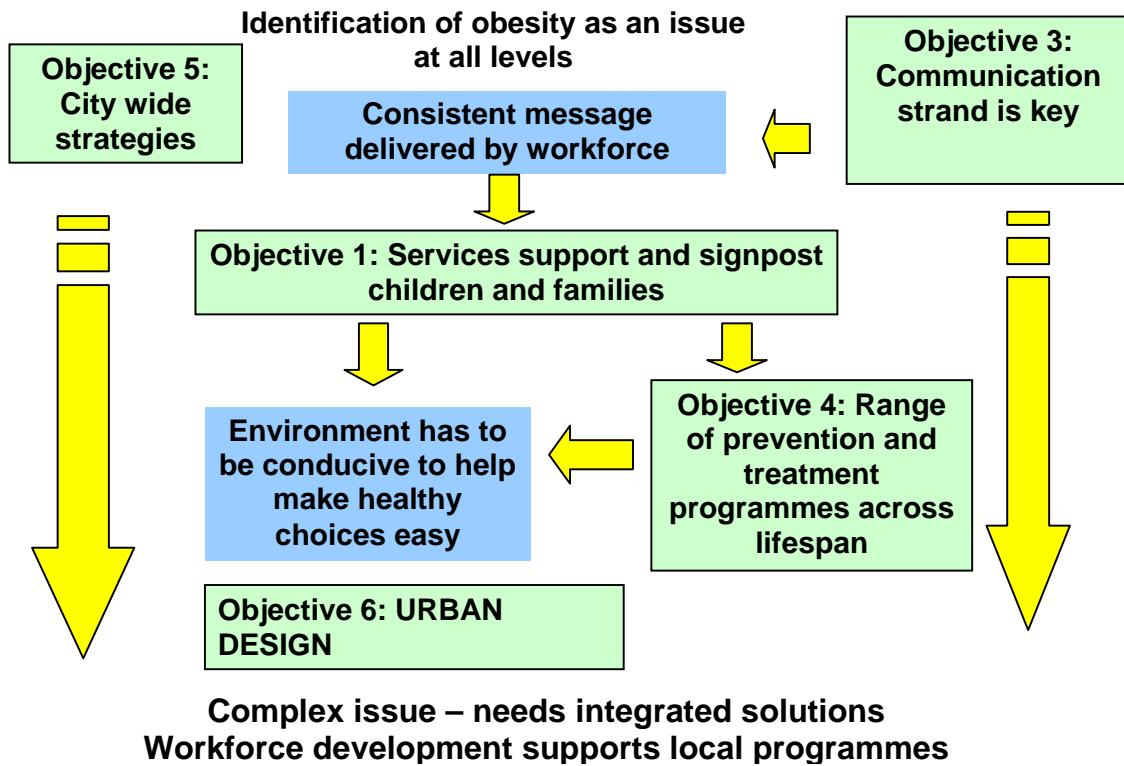
### **Key steps and underpinning assumptions**

In each of the workshops, stakeholders looked at the theory of change for the overall strategy. Figure 1 illustrates how the various objectives fit together.

1. The starting point is the need for evidence to inform and provide a basis for action. Childhood obesity needs to be recognised as an issue at all levels, from individual families, young people and children, through to local agencies and organisations. **Objective 2** increasing understanding of obesity and its prevalence is significant here in terms of providing local intelligence and identifying 'hotspots' and priority groups.
2. The communication strand is key (**Objective 4**). This will enable a consistent, positive message to be delivered to families, young people and children. Communication will thread throughout the life of the strategy. An initial stage involves recognition of the importance of the workforce, particularly front line staff from a range of services who will have a major role in delivering the message on childhood obesity. The communication work will also raise the profile of 'Can't wait to be healthy' and build the partnership.
3. Workforce development is an essential component as front line staff will be delivering messages and supporting families and children (**Objective 1**). Change will be challenging, however, as there may be resistance. In the long term, investment in workforce development will mean that programmes can be scaled up. Frontline staff will have a key role in signposting families, young people and children to local facilities/services and also where appropriate to specialist prevention and treatment services (**Objective 3**).
4. There needs to be local ownership and also further consultation with communities, families, young people and children to ensure messages are tailored to groups and interventions and mainstream services are appropriate and meet need. Services may need to be reshaped to meet the needs of all groups (**Objectives 1 and 3**).
5. The environment has to be improved to support lifestyle change (**Objective 6**). There are lots of benefits from improving the built environment, green space, access to food, pedestrian and cycle routes, but health is not always prioritised in urban design. Increasing access to healthy food and opportunities for physical activity requires a shift in priorities in planning and highways, yet is considered vital to the success of the overall strategy. There are links to ecological sustainability and increased local food production and having common objectives is essential.
6. Underpinning the whole strategy is the importance of partnership working, with collaboration across key agencies and partnerships. All stakeholders have a potential role to play. Given the plethora of parallel strategies in the city, workshop participants highlighted need for clarity over roles, contribution and capacity (**Objectives 5 & 7**).
7. Childhood obesity is a complex issue that needs integrated solutions. A strong theme to emerge from the work shops was the value of testing out a truly integrated approach in one or more localities. This would involve stakeholder and wider community engagement, changes to local environments (**Objective 6**), and commissioning of a complete range of programmes across the lifespan

**(Objective 3).** An in depth evaluation would run alongside this to provide evidence and the results would influence later commissioning practice.

**Figure 1: Leeds Childhood Obesity Theory of Change**



## Section 5 Recommendations for evaluation

The process of evaluation planning has enabled stakeholders from different agencies to come together and undertake further programme planning in relation to the individual objectives. It has also promoted shared understanding of the overall strategy and how strands of work link together. A theory of change will always be a dynamic framework which can be adapted in response to new developments. The initial theory of change for Leeds Childhood Obesity Strategy reflects the perspectives of those stakeholders who were involved in the workshops. Inevitably there will be aspects that need further development or other perspectives that need to be incorporated.

It is very positive that the partnership has shown a commitment to integrate evaluation alongside the implementation of the strategy. The broad aim of the evaluation of 'Can't wait to be healthy' should be to provide an overview of progress and to capture significant changes resulting from implementation. The focus will be on how the strategy works as a whole not on the detail of specific services, which will have their own reporting requirements. As discussed earlier, the strategy evaluation cannot provide all the answers about all aspects of work. There will still be a need for some in depth intervention studies where the evidence base is lacking or innovative work is being piloted. In addition, some preliminary research will be needed to get a full baseline picture and to consult with staff, families, young people, and children.

Some initial mapping work around existing data sources took place in the workshops (see Box 4). Participants noted a number of challenges including:

- Timescale and resources
- Commitment at higher levels
- Data are 'all over the place' and therefore there is a need to develop a system where data are held in one place.
- Complexity of the situation means that even within a culture of sharing information it remains difficult in practice to collect data.
- Ethics, freedom of information and reporting. There may be conflicts between the role of agencies in data protection and the value of increasing access to data.
- Reliability of self-reporting of health behaviours.
- There is a need to be transparent however there is the risk of stigmatisation when data are mapped at local level.

### Recommendations

Based on the workshops, the following recommendations are proposed for the evaluation of 'Can't wait to be healthy'. The first three recommendations relate to providing an overview of progress while recommendations 5 and 6 reflect the importance of undertaking in depth qualitative research to provide a 'reality check' from the viewpoint of front line staff and families, young people and children. The ultimate measure will be changes in prevalence of overweight and obese children (Cross Government Obesity Unit 2008a).

1. A common reporting framework needs to be agreed with key environmental, social and health indicators, matching any government recommendations. There is potential for everyone to be awash with data but still not know what is going on. Programme leads should take responsibility for feeding in high level information about **changes in provision, uptake and impact**.

2. Results from lifestyle and other surveys of children should be accessible for members of the partnership and (where possible) analysed in units that make sense for development and monitoring of interventions e.g. at cluster level.
3. A sub group of the Leeds childhood obesity partnership should take responsibility for negotiating access to existing data sources, collation and interpretation of data and summarising results for overall strategy evaluation.
4. Given the significance of workforce development to the success of the strategy, a toolkit using simple criteria should be developed to help staff and managers assess good practice in relation to childhood obesity prevention, support and treatment. The toolkit could be developed as an integral part of the workforce development package and involve self assessment and benchmarking of services.
5. Where an integrated approach is used in specific localities, progress can be monitored through use of routinely collected data (see above) and use of mapping techniques for key indicators of behaviour change before and after (e.g. food sales of key items or use of parks). Not only will this inform programme planning, it will also provide evidence of progress.
6. Some qualitative research should be commissioned to provide a holistic, in-depth picture of what works and whether it makes a difference from the perspective of families, young people and children. It would make sense for this to be linked to where an integrated approach is being trialled in specific localities and/or population groups. This will provide a much needed 'reality check' on Leeds Childhood Obesity Strategy.

**Box 4: Mapping data sources -What exists at the moment?**

- National child measurement programme
- Growth measurements for under 5's (although data are not collated)
- 5-A-Day data (regional and possibly local)
- Yr 6 and Yr 9 survey based on sample schools
- School travel survey
- RAD scheme
- Every Child Matters survey. This will include Yrs 5/6,7 and 9 in the future.
- Schools and sports partnership maps hours of physical activity
- Children's District Partnerships
- Information on 'food deserts' and opportunities to access affordable fruit and vegetables
- Grab 5
- Information on where green spaces are and location of play areas (but no knowledge of all green spaces)
- 3 years worth of data relating to the use of parks
- Data from various local research projects linked to obesity that could be used alongside wider population based data
- WATCH IT
- Carnegie Weight Management programme
- Area committees

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## **Appendix 1: NIS indicators linked to tackling obesity** (Department for Communities and Local Government 2007)

1. Prevalence of breastfeeding at 6-8 weeks from birth (NI 53)
  - Evidence suggests that there is a reduced incidence in obesity at 5 years old in breast-fed compared to bottle-fed-babies (Horta et al 2007).
2. Take up of school lunches (NI 52)
  - An increase in total uptake of school lunches can promote nutritional intake and may reduce obesity (School Meal Review Panel 2005).
3. Emotional health of children (NI 50) and children who have experienced bullying (NI 69)
  - Overweight children are more likely to be bullied and suffer from low self-esteem (Wardle 2005).
4. Children and young people's participation in high quality PE and sport (NI 57)
5. Adult participation in sport (NI 8)
  - To promote a healthy weight, adults should be doing 30 minutes of planned and incidental physical activity every day and children 60 minutes (Chief Medical Officer 2004).
6. Self-reported measure of people's overall health and wellbeing (NI 119)
7. All age all cause mortality rate (NI 120)
8. Mortality rate from all circulatory diseases at ages under 75 (NI 121)
9. Mortality from all cancers at ages under 75 (NI 122)
10. Healthy life expectancy at age 65 (NI 137)
11. Working age people claiming out of work benefits (NI 152) and (NI 153)
12. People falling out of work and on to incapacity benefits (NI 173)
  - Obesity increases the risk of a number of diseases including cardiovascular disease and cancer (Kopelman 2007). Obesity also has a significant impact on morbidity which impacts on healthy life expectancy. For example, obesity greatly increases the risk of developing Type 2 diabetes (Field et al 2001).
13. Children travelling to school – mode of travel usually used (NI 198)
14. Perceptions of anti-social behaviour (NI 17)

15. Reduction in road traffic accidents (NI 47) and (NI 48)

16. Access to services and facilities by public transport, walking and cycling (NI 175)

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## Appendix 2: Evaluation frameworks

Evaluation frameworks have been cross referenced to indicators on pages 7-8

### Objective 1: Frontline staff supporting parents and children

*Long term goal: Develop understanding amongst front line staff so that they can support children, young people and parents to prevent and treat obesity*

Activities	Expected outcomes	Indicators	Data collection methods
<b>Short term – 1 year</b>			
Key agencies signed up to obesity strategy and identifying practitioners and services for children and families (mapping across different settings)	Frontline services practitioners working with children and families identified.  Awareness of range of staff and settings able to contribute	List of all frontline practitioners working and services with children and young people.	Documentary evidence
Involvement of commissioners	Commitment from commissioners and managers with workforce development remit.	Champions identified for rolling out workforce development.	Reports to partnership group
Consultation with parents, children and young people regarding their awareness of healthy weight management <sup>1</sup> & development of services	Redesign of services as a result of consultation	Short term: Evidence of consultation taking place and service changes identified. Medium term: Changes in services in line with consultation	Reports to partnership group  Key services identified – feed in service use data

<sup>1</sup> Link to Objective 4 – communication

Medium term – 3 years	Expected outcomes	Indicators	Data collection methods
<p>Multidisciplinary team training developed and delivered. Initially training with individuals able to act as champions.</p> <p>?Toolkit developed for workforce development</p>	<p>Knowledgeable frontline staff confident to raise obesity issues with families</p> <p>Staff able to deliver simple, consistent messages</p>	<p>A range of staff from different agencies undertake training.</p> <p>Staff report increased confidence to raise issues.</p> <p>Staff report good knowledge &amp; awareness of obesity and prevention (v)</p>	<p>Monitoring data from training</p> <p>Workforce development toolkit could include self evaluation element.</p>
<p>Development of communication strategy in relation to signposting to services/facilities<sup>2</sup></p> <p>Families given information by frontline staff</p>	<p>Staff aware of support available and able to signpost</p> <p>Activity centres linked to learning centres</p> <p>Parents and children more aware of physical activity facilities and opportunities</p>	<p>Increased awareness of physical activity facilities and opportunities in key stakeholder groups</p> <p>Increased uptake of relevant services</p>	<p>Workforce development toolkit could include self evaluation element.</p> <p>Monitoring data on service use. Key services identified – feed in service use data</p> <p>Qualitative research with families, young people and children.</p>

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<sup>2</sup> Link to Objective 4 - communication

Long term – 5 years	Outcomes	Indicators	Data collection methods
<p>Expansion of workforce development programme.</p> <p>Frontline staff support individual families and children in different settings</p> <p>Development of mentor and buddy schemes.</p>	<p>Staff comfortable with tackling issue at individual level. Part of routine practice.</p>	<p>Increased coverage of staff attending workforce development training.</p> <p>Families in contact with services report that they receive support from staff.</p>	<p>Toolkit could be used as benchmark services.</p> <p>Qualitative research with parents, young people and children.</p> <p>Information gathered from Children and young people network.</p>
<p>Check communication at point of contact that key messages being delivered well.</p> <p>Care pathways being used.</p>	<p>Evidence of participation and behaviour change by young people and children</p> <p>Increase in accessing support.</p>	<p>PESSCEL measurement<sup>3</sup></p> <p>More 'active living' in the community (structured and unstructured). <a href="#">NI 198 Normal mode of travel to school</a></p> <p>Increase in referrals from key schemes</p>	<p>Resident based survey</p> <p>Monitoring data on referrals and service use.</p>

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<sup>3</sup> Link to physical activity targets and indicators

### Objective 3: Prevention and treatment programmes across the lifespan

*Long term goal: Children, young people and families with knowledge, skills and motivation around healthy lifestyles. Healthy choices should start at beginning of lifespan with women conceiving at a healthy weight.*

Activities	Expected outcomes	Indicators	Data collection methods
<b>Short term – 1 year</b>			
Assess what support is available to support healthy lifestyles.	Organisations and services will know what works (based on evidence and need). Gaps will be identified.	Completed mapping of provision and gaps in relation to need across the lifespan: <ul style="list-style-type: none"> <li>• Universal</li> <li>• Prevention plus</li> <li>• Specialist prevention and treatment</li> </ul> Mapped to inequalities indicators	Documentary evidence.  Current provision will be mapped with prevalence data (Objective 2).  This will be made available to commissioning group and for those involved in locality work.
Guidelines for good practice agreed. Social marketing approach used.	Services model good practice.	Criteria for services relate to NICE and key policy guidance.	Internal audit - reporting to partnership
<b>LOCALITY FOCUS</b> Consultation with parents, children and young people regarding their awareness of healthy weight management <sup>4</sup> & development of services in a locality	Plan for integrated programme ion one locality with menu of services.	Evidence of new and existing services shaped as a result of consultation.  (u) (t)	Reports to partnership group

<sup>4</sup> Link to Objective 1 4 – communication

Medium term – 3 years	Expected outcomes	Indicators	Data collection methods
<p>MDT training (as required) to deliver evidence based support and information (see Objective 1)</p> <p>SE 6</p>	<p>Workforce are skilled to provide information and support on childhood obesity.</p> <p>Needs of obese children are taken into account.</p> <p>Workforce signpost and refer to specialist prevention and treatment programmes.</p>	<p>Increase in uptake of relevant services &amp; specialist prevention and treatment programmes.</p>	<p>Monitoring data on referrals and service use.</p> <p><b>LOCALITY FOCUS</b> Qualitative research with parents, young people and children to check out experience.</p> <p>Qualitative research with frontline staff and key partners in priority localities.</p>
<p>Weight management, and healthy lifestyle advice, is made accessible and available through range of programmes.</p>	<p>Weight management and healthy lifestyle advice is accessible and available through universal services and targeted programmes.</p> <p>People make use of programmes</p> <p>People in priority groups receive effective information and support from treatment and treatment programmes.</p>	<p>Number of programmes and partner agencies. Variety of programmes. (g) (h) (i)</p> <p>Numbers accessing. Programmes known of locally<sup>5</sup>.</p> <p>People asking for help; self referrals; agency referrals.</p> <p>Services and frontline staff responsive to needs of priority groups.</p> <p>Families in contact with services report that they receive support from staff.</p>	<p>Equality and diversity impact assessment.</p> <p>Monitoring data on referrals and service use. Monitoring systems would need to be more sensitive for locality work.</p> <p><b>LOCALITY FOCUS</b> Qualitative research with parents, young people and children to check out experience.</p>

<sup>5</sup> Needs to link to p) Access to services by public transport NI 175

Long term – 5 years	Expected outcomes	Indicators	Data collection methods
<p>A range of programmes are commissioned and delivered across the lifespan. Breadth programmes across city with greater integration and depth in locality work.</p> <p>Infrastructure to support greater integration of programmes across the lifespan.</p> <p><b>LOCALITY FOCUS</b> Local partnership supporting delivery of childhood obesity programmes to ensure all access</p>	<p>Children, young people and families are aware of importance of PA and recognise obesity as an issue (link to Objective 3)</p> <p>Children, young people and families make and maintain positive changes in behaviour.</p> <p>Overweight and obese children, young people and families access appropriate support and are able to make changes.</p>	<p>Numbers reporting that they eat 5-a-day. (b)</p> <p><b>LOCALITY FOCUS</b> Supermarket data on consumption. No. of fruit and vegetable outlets increased (link to Objective 6 on urban design and accessibility of supermarkets). (e)</p> <p><b>Breastfeeding rates – NI 53</b></p> <p>Behaviour changes in obesity/overweight children and young people (may be small observable changes) (b) (c) (d) (l) (m) (o)</p> <p>Reduction long term, short term increase in referrals. Physiological measures.</p> <ul style="list-style-type: none"> <li>• BMI in pregnancy</li> <li>• Child BMI.</li> </ul> <p>Changes in prevalence halting rise and reversal of trends.</p>	<p>Mapping techniques and consumer (lifestyle) surveys. [ it is suggested that more intensive research is undertaken only in priority localities]</p> <p>Need good evaluation of targeted programmes with common data set to look at changes in priority groups (may be case of 'small change, big difference' that would be lost in aggregated data).</p>

## Objective 4: Communication

### Long term Goals

- *Parents and children will know how to make healthy choices (skills) and message will inspire action (focusing on fun as much as health)*
- *There will be strategic buy-in in LCOS across the City. Wider media will be on board with message*
- *It is important to not only raise the overall bar but also to narrow the gap in understanding, narrowing health inequalities.*

Activities	Expected outcomes	Indicators	Data collection methods
<b>Short term – 1 year</b>			
Stake holder analysis Local evidence gathered on children, young people and families.  Scope evidence of what works. Decide on priorities	Have data on where children, young people and family are in terms of knowledge, behaviour, geography etc.  Knowledge would be shared amongst partners. Understanding of what works with audience.	Report outlining local evidence and priorities.	Documentary evidence
Scope who are partners  Achieve buy-in and commitment of resources	LCOS know who the partners are. Partners are engaged	Report maps partners Agreement on communication priorities Resources committed	Documentary evidence

Medium term – 3 years	Expected outcomes	Indicators	Data collection methods
Partners agree communication strategy and message  Communication plan developed and resourced	Clear consistent message in place  Plan works in conjunction with community plans steered by Children and YP community network.	Communication plan in place.  Evidence of a number of key partners and stakeholders involved in development of message/strategy	Documentary evidence
Develop campaign materials using a social marketing approach.  Materials piloted and evaluated.	Set of materials/resources that are effective and flexible to work across population AND with priority groups	Evaluation of pilot provides evidence of effective communication.  Children, YP and families involved in pilots report increased awareness, understanding and motivation in relation childhood obesity.	Pilot study with target groups.  Evaluation of materials
Workforce receive training/support to deliver message. <sup>6</sup>	Staff gain understanding and skills around communicating childhood obesity message.  All staff understand the importance of message being delivered to all population and priority groups	Numbers of staff trained. Staff know message and understand its importance  Staff report that they confident to deliver message in work setting. (e) (g) (h)	Monitoring of dissemination of materials in services.  Potential to link to workforce development evaluation. See Objective 1.

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<sup>6</sup> Links to Objective 1



Long term – 5 years	Expected outcomes	Indicators	Data collection methods
<p>Message is disseminated by relevant stakeholders to target groups and wider population.</p> <p>Local and regional media communicate message</p>	<p>Parents and families get the same message from all professionals.</p> <p>Correct message being communicated through various media in consistent fashion.</p>	<p>Reduction long term, short term increase in referrals.</p> <p>Column inches- publicity and promotion. Saturation of information.</p>	<p>Monitoring data on service use. Key services identified – feed in service use data.</p> <p>Content analysis of local media</p>
<p>Communication strategy maintenance</p>	<p>Children, YP and families are aware of importance of PA and recognise obesity as an issue</p> <p>Children, YP and families know how to make healthy choices</p> <p>Children, YP and families feel inspired to make healthy choices</p>	<p>Children, YP and families demonstrate increased knowledge and understanding. Message is relevant (makes sense to them). (f) NI 57 uptake of school meals</p> <p>Parents and children involved in meal times together.</p> <p>Behaviour change (b) (c) (d) (l) (m) (o)</p> <p>Increased use of open/leisure spaces<sup>7</sup></p>	<p>Qualitative research with parents, young people and children to assess impact of message.</p> <p>5-a-day data</p> <p>Monitoring data on school meals and extended school services e.g. cookery classes.</p>

<sup>7</sup> Links to Objective 6 with changes in uptake of physical activity.

## Objective 6 Urban design

*Goal: more people more active more often – both informal action and formal activities*

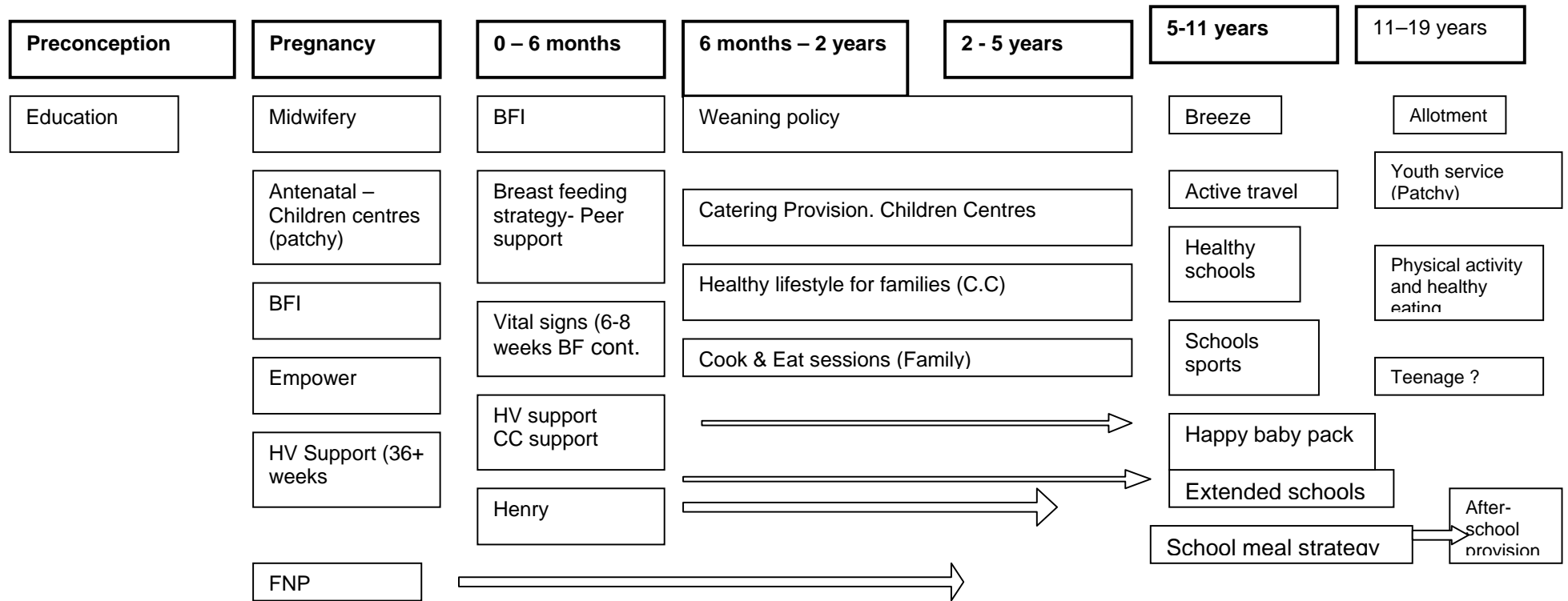
Activities	Expected outcomes	Indicators	Data collection methods
<b>Short term – 1 year</b>			
<p>Raise importance health issues in urban design &amp; improving the quality of living environments at political level.</p> <p>Make link between childhood obesity and urban design.</p>	<p>Increased awareness of health issues in urban design agenda</p> <p>Better joint corporate working on design which addresses health</p>	<p>Evidence of more collaborative working.</p> <p>Evidence of commitment at a high level in sectors relating to urban design.</p>	<p>Documentary evidence (reports to partnership)</p>
<p>Clarify priorities for investment in green space</p>	<p>Actions to improve/increase green space in Leeds.</p>	<p>Priority areas identified.</p>	<p>Audit quality and quantity</p>
<p>Create high level partnership between highways and health</p>	<p>Priorities agreed and health issues integrated into highways planning.</p>	<p>High profile event on cycling held bringing different sectors together.</p>	<p>Documentary evidence (reports to partnership)</p>

Medium term – 3 years			
<p>Improved joint working both on new developments and existing urban areas.</p> <p>Improved input by all stakeholders, e.g. PCT, into new plans for an ARSA at an early stage.</p>	<p>Health issues incorporated in preparing area plans e.g. West Leeds Gateway</p>	<p>Joint commissioning and joint funding obtained.</p> <p>Numbers of planning briefs/frameworks/plans that address health issues as a key component.</p> <p>Increased evidence of health incorporated into the design of road works, public buildings and homes (q) (r) (s) (o)</p>	<p>Documentary evidence (reports to partnership)</p> <p>Evidence from priority localities.</p>
<p>Continue to improve the quality and accessibility of attractive, usable green spaces.</p> <p>Promote and protect allotments</p>	<p>Increased use of green spaces</p>	<p>Number and quality of green spaces improved. Number improved to green flag standard</p> <p>Increased % people using improved spaces</p> <p>High levels of utilisation of new spaces</p> <p>Mix of activities reported/observed (walking, cycling etc.)</p>	<p>Monitor quality</p> <p>Mapping techniques and consumer surveys [it is suggested that more intensive research is undertaken only in priority localities]</p>
<p>Improve highways for pedestrians and cyclists</p> <p>Develop more cycle lanes</p> <p>Child/ family friendly cycle routes</p>	<p>Increased provision for cyclists</p>	<p>Increase in quality and quantity of cycle provision</p> <p>Parents, young people and children can identify safe routes for cycling and walking (k)</p>	<p>Audit quality and quantity</p>
<p>Provide local amenities and environments that are affordable, convenient,</p>	<p>Improvements in local environments</p>	<p>Parents, young people and children can identify safe, attractive leisure spaces (o)</p>	<p>Monitor service changes</p> <p>Mapping techniques and</p>

attractive and safe		Increase use in improved spaces.	consumer surveys [see above]
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Long term – 5 years	Outcomes	Indicators	Data collection methods
Promote and facilitate walking and cycling  Maintenance of improved environments.	Behaviour change - more people, more active, more often  Increase in walking Increase in cycling More young people and children playing outside	Increase in % of young people and children walking  Increase in % of young people and children cycling  Increase in % of young people and children reporting they play outside. <a href="#">NI 198 – normal mode of travel to school</a>	Mapping techniques and consumer surveys [see above].  Physical activity census?

### Appendix 3 – Diagram of current provision for obesity prevention and management across the lifespan



## Appendix 4 Leeds Childhood Obesity Strategy - Identifying common goals and linked strategies

Existing links/strong connections	Missing or weak links	Gaps in a strategic approach to childhood obesity
Physical activity strategy PESSCL links to physical activity side		
Food strategy links	More information needed on nature of strategy and links	
Strong links to Early Years and Children's Centres	Weakness is the link between childhood obesity and other outcomes	
Healthy Schools - clear criteria re, meals and physical activity		School Improvement plans are lever for influencing schools but lack of ownership of association between school improvement and childhood obesity
Play strategy and Extended schools		
School meals strategy	Weak link is ownership	
Family support strategy in place		?more strategic approach for family work on obesity
Emotional health linked to obesity Youth Offer	Adult obesity strategy being developed. There are gaps in the transition to adulthood.	
Leeds Strategic Plan – includes indicators on CO.  Locality plans – e.g. East Leeds plan	Planning and highways; Urban development agenda. There is a missing link to childhood obesity. Tension between economic and health drivers  Local Development Plan is an opportunity to influence but need to promote an understanding of links.	Need to ensure good communication and infrastructure. Should LCOS sit within Children Leeds?  IT people not involved – could support communications and systems