OVERVIEW AND SCRUTINY COMMITTEE 2007/08

REVIEW OF OBESITY November 2007

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CHAIRMAN'S INTRODUCTION

I am pleased to introduce the report of the Obesity Review Group, which undertook its enquiries between May and November 2007. Obesity is a growing concern affecting the nation's health and is also an identified local public health area for action. The topic of how the borough can best tackle obesity was brought forward to scrutiny's attention by our colleagues at Harrow Primary Care Trust.

Even at current levels, if action is not forthcoming to tackle these issues, the impact on our communities and services to meet population's needs will be immense. Increases in obesity and diabetes and other health complications associated with these conditions mean a bleak outlook for public health. It is therefore vital that we act now. Every individual has the opportunity to affect the impact of these burdensome prospects. However we recognise that the greatest impact can be made through a strategic drive and willingness across Harrow's public services. This will require a genuine multi-agency approach and a partnership ethic, and our recommendations reflect this.

Our recommendations form a solid base for action in the local drive to tackle obesity. They offer challenges to the Council, our colleagues in health services and other partners to take them forward. The Overview and Scrutiny Committee will be monitoring that these actions are followed through.

The Review Group is indebted to a wide range of witnesses who gave their time and professional expertise to help us in our enquiries. These individuals are listed in the Appendices and I would like to wholeheartedly thank them for their time and willingness to engage with scrutiny. I am particularly grateful to Harrow PCT for raising this issue and supporting the review so fully. I hope we can keep this dialogue going.

Councillor Rekha Shah
Performance Scrutiny Lead for Adult Health and Social Care

EXECUTIVE SUMMARY

The Health Profile of England 2007 shows that England has the highest level of adult obesity in Europe and the level of childhood obesity is also rapidly rising. The cost of treating obesity related conditions significantly impacts on the UK economy.

Tackling obesity is a key local priority in Harrow's Local Area Agreement and Harrow Primary Care Trust suggested the topic to scrutiny for further investigation. The Health Profile 2007 for Harrow estimates that 19.3% of adults in Harrow are 'obese' and while the health and societal ramifications of this may not immediately manifest themselves, it is vitally important to look at prevention strategies especially in a borough like Harrow its with diverse communities and ageing population. The need to look at obesity is further heightened by its links to diabetes and Harrow's position as having the highest rate of diabetes in London.

The Scrutiny Review Group carried out its investigations between May and November 2007 and talked to a range of people. Enquiries were conducted through a number of methodologies – desktop research, meetings, challenge sessions and visits in and out of the borough. Recognising the need to narrow the focus of the review, the Review Group focused on two areas of obesity that are particularly pertinent locally: children's opportunities for physical activity and adulthood obesity links to diabetes.

This review uncovered findings around local strategic drive, the importance of co-ordinating services in encouraging children to access opportunities for physical activities, and enhancing ways to identify and support people with diabetes and those at risk.

The Review Group's findings are reflected in its wide-ranging recommendations. These address the need for an overarching strategy for tackling obesity, the importance of multi-agency working, building up local capacity to deliver services and using best practice as a foundation, targeting provision using the available resources, effective communication to communities and engaging with a spectrum of healthcare professionals, especially local GPs. The recommendations are detailed in full in the next section.

RECOMMENDATIONS

The Review Group makes the following recommendations:

Overarching review recommendations

Recommendation 1: that the borough-wide Obesity Strategy be finalised and presented to the Overview and Scrutiny Committee. The strategy should enable agencies looking to tackle obesity and its links to long term conditions (such as diabetes, and cardio-vascular and circulatory conditions) to work from a single strategic and locally owned policy framework.

Recommendation 2: that the council pilots a walk scheme for staff as part of its staff well-being programme. This should be done in liaison with and seeking the advice of our colleagues at Harrow PCT who have already successfully implemented such a scheme.

Childhood obesity recommendations

Recommendation 3: that the Children and Young People's Partnership considers the local physical activity strategy and discusses with partners how this can be revised and taken forward.

Recommendation 4: that the Council and PCT recognise that much of the work around children's opportunities for physical activity can be built in together with multi-agency working and channelled through schools, children's centres and extended schools.

Recommendation 5: that multi-agency work through schools, children's centres and extended schools links to opportunities to engage and signpost families/parents to healthier lifestyles and encourages family learning.

Recommendation 6: that it is recognised that within Harrow there is a need to take more opportunities to lobby funding bodies regarding the criteria set down for accessing funding streams. The Review Group recommends that the Council and PCT make this representation jointly.

Recommendation 7: that there is a role for scrutiny to play in examining the functions and effectiveness of the Council's funding officer - what the Council's funding officer does and how he can facilitate the local authority to attract more funding and optimise the funding opportunities available to Harrow.

Recommendation 8: that Harrow, through the Harrow Strategic Partnership and its Local Area Agreement, should continue to build the capacity of its voluntary sector so that it can partner the Council and PCT on more joint projects around children's opportunities for physical activity.

Recommendation 9: that local authority provision for children is targeted and addresses areas of deprivation in the borough where there is an identified and relative lack of provision for children.

Adulthood obesity recommendations:

Recommendation 10: that a borough-wide Diabetes Strategy be developed, so that all agencies looking to tackle diabetes and its links to other long-term conditions such as obesity can work from a single strategic and locally owned policy framework.

Recommendation 11: that the Diabetes Partnership Board seeks a representative from the local authority to supplement its multi-agency perspective. The Review Group recommends that this be the Adults Services Portfolio Holder in the first instance.

Recommendation 12: that joint work between the PCT and Council is undertaken on publicising the risks of obesity and also its links to diabetes. Joint articles to the press or in Harrow People updating residents on broader health issues should also be explored.

Recommendation 13: that the PCT makes efforts to do more to advertise its courses on managing type 2 diabetes, including posting them on the PCT website and on the websites of those agencies who also help deliver the multidisciplinary course.

Recommendation 14: that all GPs are encouraged to keep records on referrals to dieticians and the level of uptake of these referrals, and provide this information to the PCT.

Recommendation 15: that information be readily available to diabetics about what they can expect from local healthcare professionals, with a view to supporting self-management of people's diabetes wherever appropriate.

Recommendation 16: that the PCT, in liaison with GPs, devises a template of information on what all diabetics should expect as part of their routine care, and that this be piloted within some local GP surgeries to gauge the success of such an approach.

Recommendation 17: that the Council explores offering people with diabetes concessions at leisure centres to encourage physical activity and form a routine part of their self-management of care. GPs should be asked to promote the availability of such concessions.

Recommendation 18: that using examples of best practice and the successful modelling and delivery of smoking cessation interventions in Harrow as a base, the PCT leads on developing a 'toolbox' of effective interventions available to people with diabetes or at the risk of developing diabetes. This should link to access to schemes around physical activity and healthy eating and lifestyles.

INTRODUCTION

Obesity – basic facts and figures

Definition

The Royal College of Physicians defines **obesity** as:

> *"A disorder in which excess body fat has accumulated to an extent that health may be adversely affected."*

It identifies[1] the cause of obesity as to do with energy balance: people are eating too much for the amount of physical activity they do. A healthy balance would be one where energy intake equals energy expenditure.

Measurement

The common method by which to evaluate an indirect measurement of obesity is based on the relationship between height and weight, through the **Body Mass Index (BMI)**:

> *Divide the weight measurement (in kilograms) by the square of the height measurement (in metres).*

A BMI of 18.5 to 25 is deemed a healthy weight, 25+ overweight and a BMI over 30 is referred to as obese. It is recognised that BMI is not always the best measurement especially in relation to different ethnic groups and in children.

Some facts and figures[2]

- The Health Profile of England 2007[3] shows that England has the highest level of adult obesity in Europe (EU-15 countries) and has the third highest prevalence of obesity amongst the wider cohort of OECD countries, after the USA and Mexico.
- The House of Commons health select committee[4] calculated the cost of overweight and obesity to the nation at up to £7.4billion per year, and this figure is rapidly rising.
- The prevalence of obesity in children aged two to 10 years has increased from 9.6% in 1995 to 13.7% in 2003.
- Rates of obesity have dramatically increased in England over the last decade. It is estimated that if no action is taken, one in five children aged 2-15 years in England will be obese by 2010.
- There is a higher prevalence of obesity and overweight among lower socio-economic groups (especially women) and some black and minority ethnic groups (e.g. women from Pakistani and African-Caribbean communities). The prevalence of obesity and overweight increases with age.
- The health consequences of obesity are wide ranging and there are links to cancers, cardiovascular diseases, type 2 diabetes and osteoarthritis of the knees.
- In 2001 the National Audit Office calculated that obesity shortens life on average by nine years and accounts for 9,000 premature deaths per year.

[1] *Storing up problems: the medical case for a slimmer nation*, Royal College of Physicians and the Royal College of Paediatrics and Child Health, 2004
[2] See Harrow's *Draft Obesity Strategy*, Harrow Primary Care Trust, 2005 unless otherwise stated.
[3] *Health Profile of England*, Department of Health, October 2007
[4] *Third Report*, House of Commons Health Select Committee, 2004

National context

Choosing Health[5]

Many actions to tackle obesity are outlined in the public health white paper 'Choosing Health: Making Healthy Choices Easier'. Cross government actions to tackle the year on year rise in obesity are covered in public service agreement (PSA) targets and Primary Care Trusts (PCTs) are asked to collect the following information as part of their local delivery plans:

- PSA 10a: childhood obesity – measuring heights and weights of all primary school children in the Reception year and Year 6 (baseline in September 2006)
- PSA 10b: obesity status among the GP registered population aged 15 to 75 years (GP screening)

Other cross government actions and PSA targets include those relating to cultural and sporting opportunities, enhancing access to culture and sport for children, offering decent places to live and the provision healthy food.

Tackling Child Obesity[6]

A joint report by the National Audit Office, Healthcare Commission and Audit Commission analyses the effectiveness of the national, regional and local delivery mechanisms to achieve the Government's PSA target:

> *"To halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole."*

The Wanless Report[7] estimated that treating obesity related conditions costs the NHS directly over £1 billion a year and the UK economy a further £2.3 to £2.6billion in indirect costs. It is predicted that if current trends continue, today's children will have a shorter life expectancy than their parents. Obesity is one of the six key national priorities in the Government's public health white paper 'Choosing Health' and the report suggests that there is a need for government departments (Department of Health, Department for Education and Skills, Department of Culture, Media and Sports[8]) to align their work on other PSA targets with work to arrest child obesity.

There is a lack of evidence of what works in addressing child obesity and this makes it difficult to evaluate the effectiveness of obesity prevention strategies. Measuring success in tackling obesity seems to be compounded by a lack of a commonly understood definition of child obesity alongside a lack of baseline data - in the delivery chain (the network of systems, processes and organisations through which strategic objectives are achieved), it is unclear how, when, where, by whom and for what purpose children are to be measured. Ownership of targets and the relationship of other agencies (e.g. schools) in the delivery chain need harnessing. Furthermore, financial complexity presents a major risk to achieving the PSA target in that there are a number of small scale funding streams rather than one ring-fenced budget for the child obesity target.

[5] *Choosing Health – Making Healthy Choices Easier*, Department of Health, 2004
[6] *Tackling Child Obesity – First Steps*, Audit Commission, Healthcare Commission & National Audit Office, February 2006
[7] D. Wanless (2002) *Securing Our Future Health: Taking a Long-Term View – Final Report*. London, HM Treasury.
[8] Government departments as they were configured in February 2006.

The joint report highlights four key issues for improving partnership and multi-agency working: co-ordinating the regional roles in the delivery chains, engagement of other departments (e.g. Office of the Deputy Prime Minister, Department for Transport), co-ordinating planning and commissioning arrangements at a local level, support for frontline staff. It also identifies five issues that need to be addressed in order to improve progress towards the PSA target: clarity and direction at a national level, clear regional roles and responsibilities, strong and effective local partnerships, support and capacity building of frontline staff and involving and influencing parents and young people. Relating to the last of these, there is an obesity education campaign due to be implemented in 2007.

The key findings of the report are:

- While the evidence is that a multifaceted approach to child obesity is the most effective, there is little evidence as yet to determine whether the Department's range of programmes and initiatives to improve children's health and nutrition generally is sufficient to achieve the target.
- The three departments are starting to coordinate their action at a national level, but levers to prevent and tackle childhood obesity are not yet sufficiently developed.
- Without reliable baseline data, there is a risk that resources will be wasted in unproductive activity.
- Regional roles are not clear.
- Local structures and mechanisms exist to promote joint working, if used effectively.
- Schools are a key setting for the delivery of effective coordinated interventions and have an important role to play, but need support and clear guidance.
- There is potential to realise efficiencies in the delivery chain associated with the child obesity target.

- It is concluded that good intentions around a cross-departmental target for child obesity need to be backed up by greater leadership and co-ordination at local and national level. The complexity of the number of different agencies, initiatives and strategies contributing to the target presents a challenge for those at the local end of the delivery chain.

Government guidance on tackling obesity

The Department of Health[9] has asked NHS organisations to work towards implementing NICE guidance around tackling obesity with the Healthcare Commission monitoring compliance. The guidance contains recommendations for local authorities, early years settings, schools, commercial and community settings, workplaces and the NHS (as health professionals and as an employer). It also provides information on the assessment, management, behavioural change strategies and costings for tackling obesity.

Using the NICE guidance and other sources of good practice information, the Department of Health suggests[10] that healthy schools coordinators and their partners should concentrate efforts on some key areas and ensure that a school has a 'whole school approach' as a base. The key areas are:

1. Ensure the language and core messages are appropriate

[9] Through the National Institute for Health and Clinical Excellence's (NICE) *Obesity - Implementing NICE Guidance,* December 2006.

[10] In the *Obesity Guidance for Healthy Schools Coordinators and their Partners*, Department of Health, January 2007.

2. Achieving healthy school status - two of the four healthy schools themes – healthy eating and physical activity – are widely recognised as being key to contributing to the obesity PSA. Healthy school status[11] should be the core first step in obesity prevention.
3. Ensuring 'universal' prevention - The healthy schools programme is frequently referred to as the key 'universal' prevention programme in that it provides opportunities for all children to engage in healthy lifestyles. However, this does not mean that all children are actually involved in or adopt a healthy lifestyle. Schools should therefore ensure that their preventative work is in fact 'universal' by e.g. adopting a school food policy, having an engaging PE curriculum, developing opportunities for children to build their physical literacy and personal safety skills, encouraging children to take part in a healthy lifestyle challenge.
4. Engaging parents/carers as the main influence on their children's lives.
5. Exploring additional activities for obese/overweight – school and local programmes are likely to be approached by a range of external providers. Programmes should not provoke bullying or stigmatisation.

Looking to the future

The recent Foresight review of obesity[12] aimed to build on a scientific evidence base to provide challenging visions of the future to help inform government strategies, policies and priorities around obesity. Its key findings and projections/modelling included:

- Most adults in the UK are already overweight. Modern living ensures every generation is heavier than the last – 'passive obesity'.
- By 2050, 60% of men and 50% of women could be clinically obese. Without action, obesity-related diseases will cost an extra £45.5 billion per year, with a seven-fold increase in NHS costs alone.
- The obesity epidemic cannot be prevented by individual action alone and demands a societal approach. Human biology is overwhelmed by the effects of today's 'obesogenic' environment with its abundance of energy dense food, motorised transport and sedentary lifestyles. Evidence is clear that policies aimed solely at individuals will be inadequate and effective action to prevent obesity at population level is required.
- Tackling obesity requires far greater change than anything tried so far, and at multiple levels: personal, family, community and national.
- Preventing obesity is a societal challenge, similar to climate change. It requires partnership between government, science, business and civil society.

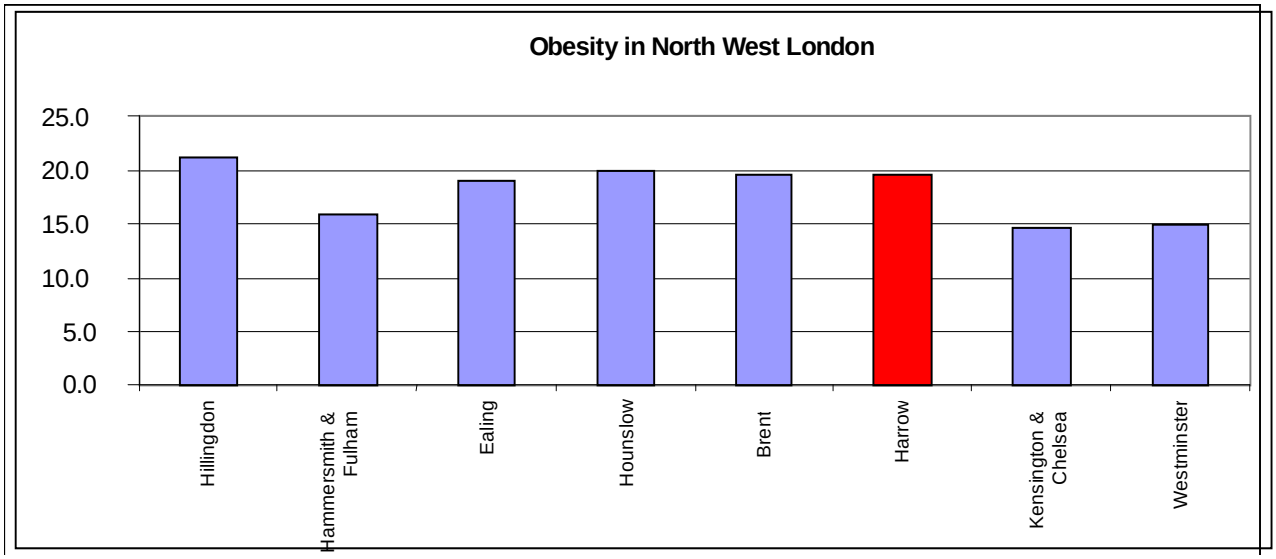
Local context – Obesity in Harrow[13]

Data for January 2006 from General Practices in Harrow shows that Body Mass Index measurements were recorded for 63,561 patients out of a total 177,184 registered population, out of which 13,249 patients (20.8%) showed BMI values over 30Kg/M^2. The synthetic estimated prevalence of obesity in adults in Harrow is 19.6%, ranging from 16.1% in Headstone to 22.7% in Kenton West. This is the third highest obesity percentage in adults in North West London.

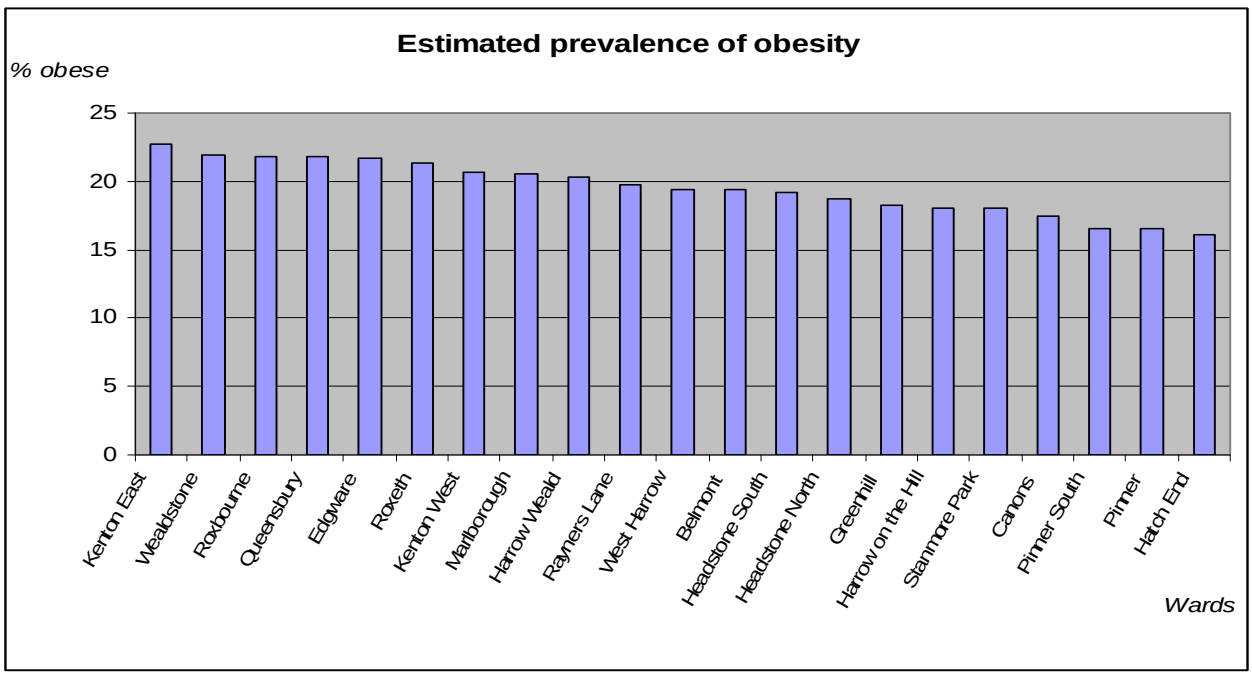
[11] A process whereby schools can structure their work and provide effective prevention and support to young people, staff and parents/carers, to offer benefits for both health and achievement.
[12] *Tackling Obesities: Future Choices*, Foresight Project, October 2007. Copies available at www.foresight.gov.uk
[13] Figures taken from Harrow's *Draft Obesity Strategy*, Harrow Primary Care Trust, June 2006

Tackling obesity is a key local priority in Harrow PCT's Local Delivery Plan and as part of Harrow's approach to tackling health inequalities. It is also identified as a priority in the Local Area Agreement.

The prevalence of obesity has a direct correlation with the prevalence of diagnosed diabetes and Harrow is estimated to have the highest population prevalence rate of diabetes in London. Furthermore information on the activity levels in adults from 1998 Health Survey of England estimated that nearly 115,000 Harrow residents do not reach the current guidelines for physical activity to benefit their health and over a third of these (44,000) are sedentary.



Prevalence of Obesity in North West London based on Synthetic Estimates (ONS)



Estimated Levels by Ward in Harrow (2006)

Harrow PCT's Draft Obesity Strategy[14] identifies a number of local strategic action to tackle obesity and these include links to:

- Promoting breastfeeding.
- Promoting health and nutrition in pre-schools.
- Healthy schools partnership - a programme introducing healthy eating, physical activity, personal, social and health education to children.
- Every child between 4-6years in an LEA school receiving a piece of fruit each day.
- Developing a school meals strategy which aims to improve the availability of healthy school meals.
- The multi-agency obesity strategy group bringing together a number of health professionals.
- A physical activity strategy seeking to remove the barriers to physical activity.
- Improving local leisure and sports services, promoting healthy travel options and the use of parks and green spaces in the borough.
- Enhancing services for those with a BMI of over 30.
- Workplace initiatives.

Choosing obesity as a topic for scrutiny

Originally suggested for scrutiny by Harrow Primary Care Trust, scrutiny members decided to prioritise the topic as an in-depth review, given its importance as a local public health issue. The Health Profile 2007[15] for Harrow estimates that 19.3% of adults in Harrow are 'obese' and while the health and societal ramifications of this may not immediately manifest themselves, it is vitally important to look at prevention strategies especially in a borough like Harrow its with diverse communities and ageing population. The need to look at obesity is further heightened by its links to diabetes and Harrow's position as having the highest rate of diabetes in London[16].

[14] Harrow's *Draft Obesity Strategy*, Harrow Primary Care Trust, June 2006
[15] *Health Profile of England*, Department of Health, October 2007
[16] *Type 2 Diabetes and Obesity*, Harrow Primary Trust report for the Harrow Adult Health and Social Care Scrutiny Sub-Committee, December 2006.

REVIEW METHODOLOGIES

Terms of reference

The Review Group set its scope as the following:

- To examine, analyse and make proposals on the way Harrow Primary Care Trust, Harrow Council and their partners are addressing obesity in the borough.
- In doing so, promote better awareness of the roles and responsibilities in tackling obesity and inform local actions.

The aims/objectives for the review were agreed as:

- To assess the impact of obesity on the people of Harrow and how well local agencies are responding to the growing challenge of obesity.
- To add value to the development of local policy surrounding obesity and the implementation of actions around obesity prevention and treatment.
- To inform multi-agency working in obesity prevention and treatment.
- To promote key messages about measures to tackle obesity and ensure that raising awareness addresses all communities in a diverse borough as Harrow.

Defining focus of review enquiries

A number of scrutiny colleagues across authorities have conducted scrutiny reviews on issues around obesity[17]. The general messages to draw from these reviews on how scrutiny should go about its enquiries include the importance of focusing enquiries perhaps through case studies, targeting recommendations, adding value to local policy development and implementation by identifying areas where scrutiny can make a difference. This review took these messages on board in defining its focus of enquiries. Furthermore, since the original scoping of the review there have been a number of changes locally to scrutiny in terms of resources, priorities and configuration of committees. The Review Group therefore took the decision to drill down on some aspects of the original scope and focus on those specific areas where members can add most value e.g. one area for childhood obesity and one for adulthood obesity, and investigating these primarily through challenge sessions. Scrutiny reviews of obesity by other authorities have recognised that obesity is a vast topic and to add value where it is most needed they needed to prioritise enquiries. The Review Group therefore identified two workstreams to pursue:

Childhood obesity – children's opportunities for physical activity

The latest Wanless report, supported by the Kings Fund, states that if we do not tackle obesity now there will be serious consequences for the NHS and social care as they will not be able to sustain their levels of service needed. After a child turns 7 years, it is often too late as the behaviour patterns for later life have been set[18]. Prevention and intervention programmes pay great dividends. Harrow has also received Lottery funding of £450k for play development and scrutiny can use its review of obesity to inform areas where this Lottery resource can be best channelled.

Adulthood obesity – links to diabetes

[17] A sample of scrutiny reviews on obesity can be surveyed through the Centre for Public Scrutiny's review library www.cfps.gov.uk

[18] Evidence given by witnesses at the Challenge Panel on opportunities for physical activity for children.

Harrow has the highest prevalence of diabetes in London[19]. BME communities are also six times more likely to develop type 2 diabetes and this has a particular relevance to a borough as diverse as Harrow. Whilst it is recognised that diabetes could in its own right have warranted a review, here it was felt important to tie it into work on links to obesity.

Methodologies employed to conduct review

Within this in-depth review of obesity over the last six months, the Review Group has employed a number of methodologies. The Review Group's project plan can be found in the Appendices.

Desktop review of evidence

A literature trawl of research around the national/local policy context and other scrutiny reviews around obesity through the Centre for Public Scrutiny's review library was undertaken. The Review Group used this to inform their decisions around which workstreams to follow.

Meetings

The Review Group met on three occasions[20] to co-ordinate its work and monitor progress.

Challenge sessions

Each workstream was supported by a challenge session[21] which gathered evidence from a range of witnesses through question and answer sessions opening out to broader discussions. A list of witnesses/participants can be found in the Appendices.

The format of each challenge panel contained three components:

1. Preparatory session – to finalise the questioning plan and prepare for the challenge session (Review Group members only)
2. Challenge session – question and answer style session, opening out to broader discussions (Review Group with witnesses and other participants)
3. Evaluation session – to draw conclusions from the challenge session and frame recommendations

On both occasions, all three components were conducted on the same day to maintain continuity of members' availability, with the contingency that the group could meet again should more time be needed.

Visits

- As part of the evidence gathering process for the childhood obesity workstream and to follow up identified good practice, members of the Review Group visited a number of play activity/schemes across Harrow[22] and Ealing[23]. The Review had identified Ealing as having good play services, a vibrant play sector and having received almost £800k in their Big Lottery allocation for play development. In line with the aims/objectives for our review of obesity, the focus of the visits was to investigate the opportunities to physical activity for children.

[19] *Type 2 Diabetes and Obesity*, Harrow Primary Trust report for the Harrow Adult Health and Social Care Scrutiny Sub-Committee, December 2006.
[20] In May, July and November 2007.
[21] Challenge Panel on Children's Opportunities for Physical Activity (12 September 2007) and Challenge Panel on Adulthood Obesity and its Links to Diabetes (2 October 2007).
[22] Harrow visits: Harrow Teachers' Centre Playscheme and Pinner Community Centre Playscheme
[23] Ealing visits: Limetrees Children's Centre, Islip Manor Park Playcentre, Petts Hill Holiday Childcare Scheme, Horsenden Hill Playground

KEY FINDINGS AND CONCLUSIONS OF THE REVIEW

Overarching review findings

Taking a multi-agency approach

In 2005, Harrow PCT established a multi-disciplinary Harrow Obesity Strategy Group to bring together professionals working on different aspects of prevention and treatment of obesity for children and adults. The group has developed a joined up strategy that takes a life-course approach to tackling obesity. This has provided a helpful strategic direction within which to work and has asked for action not just from the NHS but partners as well, reflecting that many of the actions associated with obesity prevention are multi-agency and not just about health needs. Previously there had been very little work in this area and therefore establishing a co-ordinating Obesity Strategy Group to discuss the local issues has been used to tackle the whole spectrum of 'obesity services' (a term used only among policy-makers): prevention, management and treatment. The first strategic priority of the PCT is to adhere to the NICE guidance and develop a cohesive approach to implement this.

Recommendation 1: that the borough-wide Obesity Strategy be finalised and presented to the Overview and Scrutiny Committee. The strategy should enable agencies looking to tackle obesity and its links to long term conditions (such as diabetes, and cardio-vascular and circulatory conditions) to work from a single strategic and locally owned policy framework.

Developing care pathways

Harrow's Obesity Strategy helps develop a care pathway for people at risk of or with obesity and recognises that there is a spectrum of people at different levels needing a care pathway of strategic interventions. Harrow PCT and the Dietetics Department at North West London Hospitals Trust have worked together on developing a locally enhanced service for those with BMIs of 30+ which builds on the skills of local practitioners like GPs, pharmacists, health visitors and practice nurses, who were consulted upon its development of this care pathway for adults.

The care pathway was formally launched in September 2007 and starts in the format of an A5-sized health checks card whereby height/weight can be noted down and provides signposting to further sources of information and support. The details on these cards are raised with health professionals and they can liaise with colleagues to support people for example regarding their BMI and advising about healthy eating.

The Obesity Strategy Group has also established a workstream for adult care pathways in the workplace and in the community. One of the easiest options to develop has proved to be walk schemes for people which also enables them to enjoy and guard their environment. The PCT has trained 12 people to run these walk schemes and wants them to be operated within workplaces also. This intervention is financially viable as it impacts upon other behaviours such as eating and smoking.

The PCT itself has also held its own pedometer challenge for PCT staff and this has proved very successful. It is generally felt that more can be done to support staff to lead

healthier lifestyles and this should positively impact upon staff well-being and absenteeism.

Recommendation 2: that the council pilots a walk scheme for staff as part of its staff well-being programme. This should be done in liaison with and seeking the advice of our colleagues at Harrow PCT who have already successfully implemented such a scheme.

Childhood obesity – Children's access to opportunities for physical activity

Within the prevalence estimates of healthy lifestyle variables generated by Office of National Statistics (ONS), analysis was done in 2004 for Harrow, on physical activity for the Physical Activity Strategy. This estimate used population data of adults in Harrow from 2001 census and information about activity levels in adults from 1998 Health Survey of England and estimated that:

- Nearly 115,000 residents of Harrow do not reach the current guidelines for physical activity to benefit their health
- Over a third of these 44,000 are sedentary.

Although these figures[24] are for the adult population in Harrow, the Review Group feels it vital that the routine of physical activity in daily life is fostered in children as early as possible, and that this will serve long term health benefits.

Strategy/policy development

Harrow Obesity Strategy

Much of the focus of the obesity strategy is on targeting prevention and interventions in childhood. Working with schools is therefore vital and it is clear that preventions must not target children to stigmatise and therefore they should adopt a 'whole school' approach. It is evident that in tackling obesity within children, population-based interventions are more popular.

Children and Young People's Plan

There is a commitment to children's access to physical activity embedded within Harrow's Children's and Young People's Plan. The Joint Area Review of Harrow in 2006[25] was satisfied that children have good access to physical activity therefore there is not a specific action plan for physical activity arising from the JAR.

Physical Activity Strategy

A local review on physical activity in 2003 led to the development of a Physical Activity Strategy produced by Harrow Primary Care Trust[26] in partnership with Harrow Mental Health Service, Harrow Council, and voluntary sector agencies. The strategy focuses on building physical activity into daily life and recommended a number of actions to increase levels of physical activity amongst various age and ethnic groups. The strategy focuses on comprehensive measures towards removing barriers to physical activity including increasing accessibility for vulnerable groups, improving opportunities for walking and cycling, improving environment and transport and removing the fear of crime.

[24] Harrow's *Draft Obesity Strategy*, Harrow Primary Care Trust, June 2006.
[25] Report available on Harrow Council's website www.harrow.gov.uk
[26] *Harrow Physical Activity Strategy*, Harrow Primary Care Trust, 2004.

The strategy and action plan belong to a number of different agencies however it is seriously out of date. Although currently the local authority and PCT are working on its revision, there is a need to address who within these organisations should lead on updating the document. In terms of timescales, these are not yet ascertained as the relevant partners have not sat around the table to discuss the future of the physical activity strategy for a while. One avenue through which this could be progressed and pay especial note to the needs of children and young people is through the Children and Young People's Partnership, partnership on all the relevant partners are represented, for example the PCT, local authority, police and voluntary sector.

Recommendation 3: that the Children and Young People's Partnership considers the local physical activity strategy and discusses with partners how this can be revised and taken forward.

Play Strategy

The impetus for the development of local play strategies arose from a review by the Department of Media, Culture and Sports in 2004 that led to £155mill of Lottery funding being set aside for play development. Play, defined as a free choice of activity for children that is not structured as sports activity, also features in each of the outcomes in the Every Child Matters framework. Local strategies have taken a cross-departmental approach with partners.

25% of the Harrow population are 0-19 years old and therefore addressing opportunities for this section of the population is important. It is the play and early years services that that cover service provision for the bulk of play opportunities and Harrow is fortunate that it has a relatively high number of parks and open spaces at its disposal within which play opportunities can be explored. Often older children do not refer to many of the activities as 'play' but rather as 'hanging out' and consultation has shown that they do not feel that they have enough opportunities for this.

Encouraging physical activity in children

MEND programme

The MEND (mind, exercise, nutrition and do it!) programme is an evidence-based and outcome-driven programme[27] which targets children aged 7-13 years and offers them and their families access to exercise and healthy lifestyles advice, encouraging them to become fitter and healthier and to stay that way. It is not billed as an 'obesity programme' as children should be comfortable among peers of a similar physical build.

The programme has been funded by the Lottery and is free to the children accessing it. The funding operates for seven programmes over two years. Its first programmes have run 2-hour sessions twice weekly for 10 weeks at Whitmore High School. Children's excitement and building of confidence to participate made this a very successful programme and in future this will be part and parcel of the children's care pathways.

Although referrals were taken from health professionals, self-referrals from families were not the preferred form of recruitment as it showed that the family wanted to take part and

[27] www.mendprogramme.org

had taken the initiative to approach those running the programme. Eligibility was based on a range of factors including age and commitment to regularly attend. For those who had not been eligible, the PCT looks to engage the families in future programmes or similar initiatives.

Exercise is part of the care pathway in the MEND programme and the PCT liaises with the local leisure centre to ensure that there is an exit strategy for those on the MEND programme (for example discounted access to the leisure centre) to maintain their healthier lifestyles behaviours. The Review Group notes that at present the MEND programme cannot accommodate many children especially given the child population of Harrow and there was a need to build on this if it is to have an impact.

There is no official follow up in place at the moment but Harrow PCT will follow up families after three months and six months with telephone conversations. The qualitative and quantitative data gathered will be used to evaluate the success of the programme and there will be a comprehensive report after the two-year programme has completed.

It is important that the learning from the first programmes is carried forward and used to inform initiatives once funding has ceased. There are materials for the MEND programme (e.g. handbooks and lessons plan resources) and the PCT is looking at how these can be used to cascade learning in future. After Lottery funding has ceased, the PCT will need to look for additional support whether this be in the form of funding, venues, staffing etc and partnership initiatives like at the Children's Centres or cluster schools may be an appropriate avenue to approach.

Encouraging physical activity in holiday playschemes

As some members of the Review Group visited a couple of the local authority run summer playschemes in the borough, it became very clear that there are wonderful opportunities for children to regularly undertake physical activity through these schemes. The schemes themselves particularly promote physical activity within their daily timetables - the playscheme at Harrow Teachers Centre for example is a particularly active playscheme and parents/children are aware of this. At that scheme, in the afternoons there is often only physical activity (e.g. football) offered and this gently encourages children to participate as the only other option is to sit and watch - often not a preferred option for children.

The playscheme run at Pinner Community Centre has found that children's choice of snacks greatly impacts upon their behaviour and willingness to participate in activities. Playworkers have stopped using the fizzy drinks machine in the community centre foyer and the children have tended to follow this lead and also not use the machine. Tuck is provided as snacks to sustain children between meals and includes fruit, fruit squash, raisins and rich tea biscuits. Playworkers have noticed a marked improvement in children's behaviour as a consequence.

Review Group members with staff at Pinner Community Centre Holiday Playscheme

Recognising barriers to physical activity
Harrow's Play Strategy[28] identifies a number of barriers to accessing opportunities for physical activity and these barriers were identified through consultation with and perceptions from children and young people themselves. These include safety (e.g. children never go the park on their own), physical access (e.g. transport links and distance to places) and the demands of schoolwork.

A further barrier to physical activity can be seen as the culture within society and the disadvantages of playing outside. Children and young people recognise a changing societal attitude towards them and note that often the perception of them say kicking a ball around outdoors is now a threatening one. The PCT would like more people to be out and about and this in turn should help reduce the fear of crime, as well as increasing physical activity and fostering civic pride e.g. through walk schemes.

Co-ordinating services for children and promoting multi-agency working

The Play Partnership
There has been great enthusiasm about the development of a Play Partnership in Harrow which involves the PCT, Police and voluntary sector and serves to pulls together people from many diverse areas. The initial impetus for the Play Partnership was developing a bid for the Big Lottery funding but the Partnership continues to meet. The Partnership represents a good networking group for the underdeveloped play sector in Harrow and therefore one of its aims is to develop a more active play sector.

It is acknowledged that Harrow is at the beginning of its work in developing a cohesive framework of play opportunities and that it is quite a way behind other London boroughs in this respect. The Council's Play Service currently sits within the Youth Service and has only 1.5FTE who focus on developing after-school clubs and holiday playschemes. However many services are contributing to play without knowing it! The most feasible way to develop a more vibrant play service in a broader sense is through multi-agency working and the Play Partnership provides a good foundation for this.

Furthermore the voluntary sector leads on two of the schemes under the Big Lottery funding bid (Mencap and Kids Can Achieve) and the faith sector is equally active in running a lot of physical activity too. There is a lot of existing activity and the Play Strategy offers the opportunity to bring this into a coordinated framework.

Schools and extended schools
Schools are recognising that the extended schools programme can help them deliver the Every Child Matters[29] agenda and also other benefits. The ambition is for all schools to make the extended schools offer and Harrow is exceeding current targets.

Formal organised physical activity is offered with greater variety through extended schools. Not all children like to take part in competitive sports and therefore it is ensured that there

[28] *Harrow Play Strategy 2007-2012*, Harrow Council, May 2007.
[29] *Every Child Matters: Change for Children*, Department for Education & Skills, 2004. The Every Child Matters agenda concerns the well-being of children and young people from birth to 19 years. It aims for every child, whatever their background or their circumstances, to have the support they need to: be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic well-being.

is a range of different opportunities offered across the school clusters. Extended schools funding opens out school buildings to the community and the perception of schools as safe educational settings helps reinforce their image as community resources. Extending schools out into the wider community makes it even more important that schools co-ordinate their efforts with that of partner organisations. To this end it must be ensured that the programmes run by the local authority and the PCT link up and that each organisation keeps the other informed of development and progress of their programmes.

Recommendation 4: that the Council and PCT recognise that much of the work around children's opportunities for physical activity can be built in together with multi-agency working and channelled through schools, children's centres and extended schools.

Guidance for schools

Harrow PCT and the local authority have been working together on the local implementation of the National Healthy Schools Standard since the introduction of the programme in 1999. This partnership programme takes a whole school approach to introducing healthy eating, physical activity, personal, social and health education to children. Furthermore the recent Department of Health obesity guidance for schools[30] includes that physical activity is not just about sport and that healthy lifestyles are not just about eating healthily but rather schools facilitating increased physical activity. Because of a technicality Harrow is not hitting all of the targets contained within the Healthy Schools Standard, however it does have the buy-in of all schools. The anomaly lies in high schools - with each lesson at 50 minutes and therefore two lessons (a double period) constituting 1hour 40minutes of activity, this falls under the two-hour threshold. To raise the quality of provision in high schools, primary school coordinators have been based in high schools.

The Department of Health obesity guidance for schools also highlights the need to avoid stigmatisation with regard to obesity prevention and promotes a whole school approach, ('population-based' intervention) encouraging universal prevention. The culture within Harrow schools embraces an inclusivity agenda whereby stigmatisation will not be tolerated. Staff are aware that obese children are subject to bullying but schools have strong anti-bullying policies and there is support available for those children who are picked on. The appropriateness of actions must also be taken into consideration and therefore children are only encouraged to take part in physical activities that schools know they can do and alternatives to sports are considered e.g. aerobics and pilates.

The Student Advisory Group (made up of secondary school students) every year holds a PHSE conference for Year 9 students. Workshops, which the students run themselves, identify physical activity and healthy eating as key topics. This year's conference centred on how children and young people can make a difference to others and this included thinking about their own diets and well-being, therefore children on the whole are well-informed.

Healthy eating

There are new national healthy foods standards in place and as of September 2007 there are no fizzy drinks and sweets offered in schools. This will make an impact as most

[30] *Obesity Guidance for Healthy Schools Coordinators and their Partners*, Department of Health, January 2007.

children are also not allowed out of school and therefore rely on food within school boundaries or packed lunches brought in from home - there are requirements on schools on what they should provide for school lunches however schools cannot legislate for the contents of packed lunches. As noted above by the Review Group on their visits to playschemes, there was a marked difference in children's demeanour when they were not using vending machines but offered healthy snacks as an alternative.

Children and young people will make positive choices if they are well-informed. In 2002, the National School Fruit Scheme was implemented in Harrow and within one year, the uptake reached 100% by all eligible schools. As a result of this scheme, every child aged between 4-6 years in an LEA primary school receives a piece of fruit each day and there is evidence that this scheme increases the intake of fruit and vegetables.

For many children fruit has become part of a normal routine and this is also reflected in their increased consumption of fruit in their own homes. There has been a marked improvement in children's behaviour since the healthy eating scheme was put in place in Harrow schools.

Whilst fruit consumption has been a success in Harrow schools, the Review Group heard that the general agreement that the general quality of school meals will not improve until there is more education around healthy meals. To help tackle this, Standards funding has funded a free dietician service whereby dieticians will advise about healthy eating to help schools meet the new schools standards. Although free school meals do not include breakfast, the Review Group monitor with interest the success of breakfast clubs and whether breakfast choices inform those at lunchtimes and also children's learning capacity throughout the day. Breakfast clubs have been shown to demonstrate a positive impact on children's diet, attention and attendance.

Walk to school schemes

There are some initiatives around walk to school schemes and some examples of broadening this out, for example to dedicated 'walk to school weeks' - Harrow is looking to extend these and offer certificates as incentives/enhancements. Walking buses have not proved that successful mainly due to their reliance on parents' participation – parents are often reluctant to get involved. A number of schools have been offered extra funding to operate their walking buses however Harrow is a densely populated area and therefore there are many routes to schools. With so many routes for walking buses to take, they can become logistically complicated with a hub and spoke set up. All schools are required to have a travel plan and in Harrow about 30 of the 84 schools (including private schools) have a travel plan.

Measuring obesity

The programme in measuring children in schools (height and weight) continues with national funding for all children in Reception and Year 6 to be measured. School nurses work in partnership with schools and schools train their own staff. The programme is running smoothly locally with no objections from parents. Year on year data will form a database through which monitoring can take place. There are no plans to roll this out to other years as the age cohorts represent target age groups – as children start school and as they reach puberty. The data will help identify trends (e.g. by geographical areas and demographic groups) and this can help focus resources and educational programmes.

Through gleaning this population-level data, the aim will be not to target individual children but inform school policies and educate parents

Involving parents/carers
Often schools work well with health professionals however it can be parents/carers who difficult to engage with. With regard to children's lifestyle choices they understandably are highly influential agents. The biggest challenge is that parents are not a homogeneous group. Many schools have schemes as part of the Healthy Schools Scheme and there is a need to target the generation who do the household shopping and make food choices not only for themselves but also for the rest of the family.

On a more Harrow-wide basis, children's centres (encompassing health and education) are there to support families and signpost them to advice and support. This is a key function of children's centres and this may be the way forward to engaging whole families - there is a lot of focus and activity on early years work through children's centres and catching them children's habits young may be the key. The parenting groups at local children's centres provide a good network for parenting advice and this recognises the crucial role children's centres play as key settings in children's development.

The Children's Centre[31] in Ealing visited by the Review Group highlighted in particular how children's centres can be the hub for partnership working between the local authority and the local PCT. Ealing Council often approaches the PCT for funding for joint projects and it also offers up Council facilities as community access e.g. baby weighing sessions in children's centres. Commonalities across services are identified and complementary approaches to projects progressed, a further example being between Ealing Play Service and their colleagues in the Parks Service.

Within Harrow's own playschemes, there is evidence of parental involvement through the parent consultation panel which is drawn upon to advise on the running of the schemes. The staff also offer advice to families e.g. advice about physical activity and diet, including lunchtime workshops on healthy eating (balanced diets and 'what is a good plate'). This encourages parents to think about healthy meals and allows playschemes to keep an eye on what the children are eating. Children are required to bring in their own lunches and the booking form for the schemes includes suggestions on what makes a good balanced packed lunch to guide parents/carers.

Recommendation 5: that multi-agency work through schools, children's centres and extended schools links to opportunities to engage and signpost families/parents to healthier lifestyles and encourages family learning.

Funding

Indices of deprivation
Harrow is not seen as a borough of great deprivation and thus often misses out on some streams of funding. For example, in the Big Lottery Well-Being Grant, the London sector prioritised programmes only in those boroughs which held the 10% most deprived super-output areas and as such Harrow did not receive any of the funding. Funding criterion

[31] Limetrees Children's Centre, Northolt.

often does not help Harrow attract external monies and in effect Harrow is often 'penalised' for its image of a green and leafy borough hosting a number of successful schools.

Harrow does not have below average levels of child poverty but it does have pockets. Neighbouring boroughs such as Ealing attract more funding for children (e.g. through the Play fund and Children's fund) and the quality of their children's facilities highlights this. It is to Ealing's benefit that it has a very high child/adult ratio and in turn this high ration helps funding, as DfES and Children Centres funding depends upon children numbers. However the Review Group is clear that whilst Harrow may not have the facilities, it still maximises the opportunity for physical activity within its playschemes.

New layout and play equipment at Horsenden Hill, funded by Ealing's Big Lottery Fund for Play Development

Recommendation 6: that it is recognised that within Harrow there is a need to take more opportunities to lobby funding bodies regarding the criteria set down for accessing funding streams. The Review Group recommends that the Council and PCT make this representation jointly.

Innovative approaches to maximising funding opportunities

The visit to Ealing schemes demonstrated the real dividends of a corporate team supporting bids for funding through thorough feasibility scoping and pre-assessment of applications. Ealing Council has a small team of officers who help put together bids for funding e.g. assess feasibility and content. Ealing has therefore been successful in attracting various pots of money and there are officers who keep track of new sources of funding. The Review Group agree that the schemes visited in Ealing demonstrated real innovation and were based in solid funding applications and Harrow would do well to follow up developments at Ealing with regard to provision for children and seek advice on how to make successful bids to funding bodies.

In terms of the play areas visited in Ealing, these tended to move away from formal concrete areas with swings, slides and a roundabout and move towards integrating play into the environment, with different levels of play opportunities. The officer landscaping the play areas for Ealing had included mounds. These contained clean waste with companies paying for the dumping of their waste and also the landscaping costs. A large-scale example of this approach is Northala Fields in Ealing (on the A40) which brings in an income of £6-8mill per annum to the Council.

Review Group members with Ealing's Head of Play Service at the Pirate Ship in Horsenden Hill

Furthermore Ealing has sought very competitive prices for their play equipment.
The opportunities for physical activity at Horsenden Hill for example hosts play in a natural setting including a willow maze and wooden play equipment (a pirate ship and look-out tower on soft child-friendly ground amid natural boulders) costing only about £45k. Just opened nearby is a new playground on the north side of Horsenden Hill which mixes natural boulders with standard play equipment.

Previous experience has shown that there is a need to be careful how Harrow's case is presented in funding applications and therefore the preliminary work around feasibility of submitting bids is vital. Ealing has demonstrated that their feasibility work was done well and therefore when Ealing Council applied for funding it was confident of success. It can be demoralising if bids are unsuccessful and they do not represent best use of officers' time. Funding opportunities need to be optimised. The Review Group learnt that Harrow does have a funding officer who proactively seeks out streams of funding that the council could tap in to, however his job is not to submit the applications themselves but rather support the process. This is a function within the authority which requires development, publicity and more transparency.

Recommendation 7: that there is a role for scrutiny to play in examining the functions and effectiveness of the Council's funding officer - what the Council's funding officer does and how he can facilitate the local authority to attract more funding and optimise the funding opportunities available to Harrow.

Building capacity
There is a need to build the capacity of Harrow's voluntary sector in putting forward bids (either individually or jointly with partners) and Ealing's situation further highlights the benefits of having a well resourced voluntary sector. Future bids around those to Sport England and linking into work around the Olympics 2012 should be promoted and local leisure budgets re-examined to ascertain whether they meet the needs of local people especially in light of the growing debate about obesity and people's access to opportunities for physical activity.

Recommendation 8: that Harrow, through the Harrow Strategic Partnership and its Local Area Agreement, should continue to build the capacity of its voluntary sector so that it can partner the Council and PCT on more joint projects around children's opportunities for physical activity.

Targeting provision and using existing local resources

Targeting provision
Harrow's Play Strategy recognises that there is a relative lack of play provision in the east of the borough, and there are also more private/expensive playschemes operating on that side of Harrow. Children and young people consultation reinforced in the Play Strategy what was already recognised in the borough's Open Spaces Strategy. Children and young people have the perception that there is a lack of provision for young people in the east of the borough and therefore they 'hang around' more. Money from the Prosperity Action Teams (PATs) provides an opportunity for capital expenditure to address this gap and this

has already begun for example in purchasing goalposts at Canons Park and playground shelters at Stag Lane School.

Open spaces and other local resources
Harrow has a wealth of open spaces open to it for developing outdoor play opportunities. To their increase usage and to encourage children to use outdoor facilities, all play areas should be lit and positioned so that responsible adults can keep an eye on children playing there. This would serve to address parents' fears with regard to play areas and safety.

The Play Strategy has highlighted that there is a lot of deprivation in the east of the borough, yet a relative lack of provision for children in that part. Related to this, there are plans to roll out the Canons Safer Neighbourhoods schemes as and when across the borough with a view is to take children away from anti-social behaviour through offering them more organised activities. Community Safety Officers (CSOs) have a role in dispersing groups of children and young people but often it is hard to identify where they can go. Even the Police recognise that they can no longer play or just hang out without being dispersed and therefore there needs to be some reconsideration of the approaches being employed locally. Sometimes children and young people are not seen very positively, for example when children hang out, the police tend to get many calls from residents who are nevertheless reassured by the presence of CSOs.

Recommendation 9: that local authority provision for children is targeted and addresses areas of deprivation in the borough where there is an identified and relative lack of provision for children.

Developing the play workforce

Harrow Council has a very small play service (1.5FTE) coupled with a small play workforce and therefore there is much scope to develop the local workforce for example through more people on the NVQ in Play. Nationally however the play workforce is not well recognised and people tend to opt for youth qualifications.

The local authority run playschemes in the borough usually staff themselves through university students and 'playscheme assistants' who previously attended the schemes and are now being trained up to become playleaders themselves. This encourages the young people to keep out of trouble (to maintain a clean CRB) and the supporting training scheme helps workforce development. A bootcamp for playscheme assistants has been set up, for children who previously attended the schemes and want to work at the schemes when old enough and these train up assistants to NVQ2/3 level.

There is a buddy system in place in some schools whereby during term-time, playleaders can spend an hour a day supporting children in playgrounds and this can help in tackling possible bullying. However although schools appreciate the support, this cannot be a job in its own right. Likewise a staffing problem faced by local playschemes is when offering staff only after-school or holiday scheme hours, this does not represent a full time salary. Therefore this type of work better suits students who however will eventually graduate and go into full-time employment elsewhere.

Adulthood obesity – Links to diabetes

Diabetes

Diabetes UK[32] describes **diabetes** as:

> *"A condition in which the body cannot make proper use of carbohydrate in food because the pancreas does not make enough insulin, or the insulin produced is ineffective, or a combination of both."*

Insulin is the hormone that helps glucose (sugar) from the digestion of carbohydrate in food, move into the body's cells where it is used for energy. When insulin is not present or is ineffective, glucose builds up in the blood. Using the analogy of insulin as the key which unlocks the door to the body's cells, once the door is unlocked glucose can enter where it is used as fuel for energy. Diabetes develops when glucose cannot enter the body's cells to be used as fuel.

Type 1 diabetes: The insulin-producing cells in the pancreas have been destroyed therefore there is no key (insulin) present to unlock the door to the body's cells, and thus the glucose stays in the blood.

Type 2 diabetes: When there is not enough insulin and so the cell doors are only partially unlocked (the key is unable to unlock the door properly) and/or when there is insulin (the key) but the lock does not work properly (insulin resistance).

Over two million people are diagnosed with diabetes in the UK and an estimated three quarters of a million people have it without knowing it. Over three quarters of people with diabetes have Type 2 diabetes and one of the risk factors to developing this type of diabetes is being overweight.

Although there is no 'cure' for diabetes, it can be managed successfully. The aim of diabetes management is to keep blood glucose levels as near to normal as possible (4-6mmol/l before meals and up to 10mmol/l two hours after a meal). Treatment for diabetes includes insulin injections (for Type 1 diabetes and some Type 2 diabetes), taking tablets (for Type 2 diabetes), eating healthily, balancing meals and taking regular physical activity.

Obesity triggers a state of insulin resistance. The more overweight you are, the higher the risk of developing Type 2 diabetes. Some sources suggest that up to 80% of people with Type 2 diabetes are obese. The exact causes of Type 2 diabetes are unknown however it does develop because of a mixture of genetic and environmental factors and in Type 2 diabetes a poor diet and sedentary lifestyle are among the most important environmental factors.

In 2005, Harrow PCT undertook a Diabetes Equity Audit[33] and findings from this showed that diabetes is a major cause of morbidity and early mortality in Harrow. Harrow has the highest prevalence rate of diabetes in London – 2005 figures showed that the diagnosed prevalence is 4.8% and the estimated prevalence is 5.7% of the local population. Those of an African-Caribbean or Asian background are up to six times more likely to develop diabetes. This is a particularly pertinent issue to note given Harrow's diverse community.

[32] Diabetes UK is the largest organisation in the UK working with people with diabetes. It is a registered charity which funds research, campaigns and helps people live with the condition. www.diabetes.org.uk
[33] *Diabetes Equity Audit*, Harrow Primary Care Trust, 2005.

Strategy/policy development

National Service Framework for Diabetes – Standards

The diabetes national service framework (NSF) [34] established 12 national standards aimed at raising quality and reducing variation across diabetes services. The delivery strategy[35] set out a 10-year programme of change and improvement to drive up service quality and tackle variations in care. The 12 National Service Framework standards are as follows:

Standard 1:	Prevention of Type 2 diabetes – key interventions stated include reducing the prevalence of overweight and obesity in the general population. Individuals at increased risk of developing Type 2 diabetes can reduce their risk if they are supported to change their lifestyle by eating a balanced diet, losing weight and increasing their physical activity.
Standard 2:	Identification of people with diabetes
Standard 3:	Empowering people with diabetes – key interventions include that personal care plans can help empower people with diabetes.
Standard 4:	Clinical care of adults with diabetes
Standard 5 & 6:	Clinical care of children and young people with diabetes
Standard 7:	Management of diabetic emergencies
Standard 8:	Care of people with diabetes during admission to hospital
Standard 9:	Diabetes and pregnancy
Standard 10,11 &12:	Detection and management of long-term complications

Healthcare Commission review of diabetes services

The recent national service review of diabetes[36] states that diabetes shortens people's lives and in addition to the human cost to the person with diabetes, the financial cost to the NHS of caring for people with diabetes is estimated to be around £9 billion every year, representing around 10% of total NHS expenditure. With the number of people with diabetes predicted to rise as the population becomes more obese and lives longer, NHS costs will also rise. Caring for people with diabetes also has an impact on social services expenditure, as it is four times more expensive to care for people suffering from long-term complications than without.

NICE issued guidelines for the NHS on the management, care and education of people with diabetes[37]. The new General Medical Services (GMS) contract with GPs, which was introduced in 2004, contains the Quality and Outcomes Framework (QOF)[38] including 18 indicators for financially rewarding primary care practitioners for identifying people with diabetes and reaching thresholds for diabetes-related quality targets.

[34] *National Service Framework for Diabetes: Standards*, Department of Health, 2001.
[35] *National Service Framework for Diabetes: Delivery Strategy,* Department of Health, 2003.
[36] *Managing Diabetes: Improving Services for People with Diabetes*, Healthcare Commission, July 2007.
[37] *Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults*, National Institute of Clinical Excellence, 2004.
[38] Health and Social Care Information Centre (2005-06) *Quality and Outcome Framework data (QMAS database)*

The total number of people with diabetes (those diagnosed and undiagnosed) is forecast to rise by 15% between 2001 and 2010; 9% of the rise is due to increasing numbers of obese people and 6% to an ageing population.

The review by the Healthcare Commission looked at services commissioned by PCTs focusing on how well healthcare systems support adults with diabetes to care for themselves. Data was collected about all of the 152 PCTs in England and was taken from three sources: Healthcare Commission's national patient survey of people with diabetes, the Health and Social Care Information Centres' Quality and Outcomes Framework and Hospital Episode Statistics. Each PCT then received in July 2007 a score based on its performance – 'weak', 'fair', 'good' or 'excellent'.

The majority (73%) of PCTs scored 'fair' in their work supporting adults with diabetes to care for themselves. The review showed that the level of deprivation of a PCT area is not a factor in how well it supports people with diabetes to look after themselves. The national review identified five areas for improvement:

1. Better partnership between people with diabetes and their healthcare professionals when planning and agreeing their care.
2. Increasing the number of people with diabetes attending education courses and improving their knowledge of diabetes.
3. Working more closely with all organisations providing and commissioning diabetes services.
4. Increasing the number of people with diabetes having long-term blood glucose levels of 7.4 or a lower safe level.
5. Reducing variation in general practices' achievements.

Harrow PCT scored a rating of 'fair' – performance that meets minimum requirements and the reasonable expectations of patients and the public. It highlighted as an exemplar of good practice (one of eight PCTs) with regard to having emergency admission rates for diabetes ketoacidosis (DKA) and hypoglycaemic coma that were lower than expected. PCTs in London did not fare particularly well with 26% scoring 'weak' and none scoring 'excellent'. 'Fair' was the best achieved by any London borough and according to the Healthcare Commission, Harrow's weaknesses centre around a lack of structured patient education, however this is also a national issue. Harrow PCT recognises that when looking at the distribution of care in Harrow, there are good pockets but there are also areas where care is not so good and one of the PCT's priorities is to address this need to level up the distribution across the borough.

Lack of local strategy

Although Harrow has the highest incidence of diabetes in London, it has no diabetes strategy. There is however a Diabetes Partnership Board which aims to deliver the National Service Framework for Diabetes and also local written guidelines, targeting an audience of GPs, practice nurses and other practitioners. Therefore in the absence of the written strategy, there is nevertheless strategic direction and papers from the health sector. The local authority has no specific strategy for diabetes care.

Recommendation 10: that a borough-wide Diabetes Strategy be developed, so that all agencies looking to tackle diabetes and its links to other long-term conditions such as obesity can work from a single strategic and locally owned

policy framework.

The Diabetes Partnership Board supports multi-agency working through its involvement with local GPs, nurses, consultants, Diabetes UK and patient representatives. However as yet it does not involve the local authority and the Review Group feels that this is gap in representation that needed addressing as a matter of urgency.

Recommendation 11: that the Diabetes Partnership Board seeks a representative from the local authority to supplement its multi-agency perspective. The Review Group recommends that this be the Adults Services Portfolio Holder in the first instance.

Joining up messages

Currently Harrow PCT's website provides links between diabetes and heart disease but not to obesity and therefore there is a need to raise community awareness of this association. The PCT and Council should work together to publicise the dangers of obesity and provide the link to diabetes. The PCT is looking into the possibility of setting up a website on 'Well Harrow' providing local information on health and well-being issues such as diabetes care encourage people to actively undertake exercise. This provides an opportunity to link up with some of the work that the Harrow Council is doing and publicising on its own website. Developing joint articles to the press to update residents on health issues should also be explored.

Recommendation 12: that joint work between the PCT and Council is undertaken on publicising the risks of obesity and also its links to diabetes. Joint articles to the press or in Harrow People updating residents on broader health issues should also be explored.

Information and education

The Healthcare Commission has identified one of Harrow's weaknesses in diabetes services as a lack of structured patient education. The PCT is trying to work on the areas of weakness, focusing now on the information/education aspects of care and not just urgent care situations[39].

There are two particular courses in structured patient education – DAFNE (Dose Adjustment for Normal Eating) and DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed), which is a 4-day intensive course for diabetics. However often people who have been dealing with diabetes all their life, do not necessarily want to go on a 4-day course. DAFNE is run at Central Middlesex Hospital however the last patient from Harrow who was referred to this waited 18 months to receive the course which is very labour intensive and expensive in terms of resources. It is recognised that the PCT should do more to advertise its courses for type 2 diabetes, especially to those

[39] For 2008, Harrow PCT (Diabetes Specialist Nurse Team) plans the following diabetes education sessions:

- 24 individual one-off sessions, throughout the year.
- 3 Diabetes X-PERT Structured Patient Education programmes, each consisting of six afternoon sessions over a six-week period: 1) 10 April to 15 May every Thursday; 2) 24 July to 28 August every Thursday; 3) 16 October to 20 November every Thursday. Each programme is quality assured using an auditing tool and then evaluated.

newly diagnosed with diabetes. These are at various community locations around the borough and are delivered on a multidisciplinary basis. This has proved very successful for some groups but is currently underused.

Recommendation 13: that the PCT makes efforts to do more to advertise its courses on managing type 2 diabetes, including posting them on the PCT website and on the websites of those agencies who also help deliver the multidisciplinary course.

The distinction should be made between professional education and education for patients in community settings. If courses are run by the PCT, the uptake is not usually very good however if GPs promote group education classes, this is much better. Pharmacists have reported good feedback from people about the diabetic advice and support they receive from their GPs. As a minimum standard, GPs should offer an annual review and 6-monthly checks for long term blood glucose levels (HbA1c tests) and it is suggested that more pharmacists could be used, if suitably trained up, to support this provision.

The PCT budget is very stretched and this has seen a drop in the number of specialist diabetic nurses from 6 to 5 in the last year. The Review Group feel that this is unfortunate as good dietary advice is often available from practice nurses. A local target is for every practice to have a GP and practice nurse trained in diabetes. At present, Harrow is close to achieving this target for practice nurses. The diabetes service model for Harrow includes diabetic clinics at Northwick Park Hospital for type 1 diabetics, antenatal care and children and young people, with most type 2 diabetes being addressed in the community.

A particular challenge is in addressing diabetes in the South East Asian population and locally, specific work has been done around diabetes education with specific communities, especially BME groups which are up to six times more likely to develop Type 2 diabetes.

Healthcare professionals work well with Diabetes UK, the recognised diabetes charity in the country. Diabetes UK is holding a 'Living with Diabetes Day' at Harrow Civic Centre on 30 November with the support of Harrow PCT. Diabetes UK asserts that any campaign on obesity needs to address the risk factors of diabetes, avoid blame-making, encourage those at risk to come forward and therefore start to manage complications as soon as possible. There is also evidence that cognitive behavioural therapy can help diabetics control their blood-sugar levels more effectively. Diabetes UK acknowledges that the realms of mental health and well-being (in the general populus) in relation to diabetes are under explored and following up on this could put Harrow at the forefront of addressing the needs of diabetics locally.

Identifying and supporting people with diabetes and those at risk

Identification

Harrow's locality profile by Diabetes UK[40] shows that between 2004 and 2005, the undiagnosed diabetes rate declined from 41% to 11% for Harrow PCT and the PCT is to be commended on its work in identifying people with diabetes and lowering its undiagnosed rate by such a margin. It is part of the GP contract to monitor diabetes prevalence and that the annual data gleaned is reliable. The Brent York model identifies

[40] Available through the Diabetes UK website: www.diabetes.org.uk

the expected prevalence level of diabetes for each area and Harrow's observed prevalence is getting closer to the expected level.

Support
This would suggest that Harrow PCT's programme for early identification for diabetes is working although there are no strict national guidelines to follow and therefore often it is more a case relying on opportunistic screening linked to other risk factors such as blood pressure and obesity. In the main, this is left for individual practices to determine and follow the Diabetes UK recommendations. Upon first diagnosis of diabetes, a GP should arrange consultation with a registered dietician. Dieticians are available to all GPs but the level of uptake is not known. There is a data collection issue here as GPs are not required to record this information, and therefore any conclusions drawn on data from only some GPs will not be representative of the borough as a whole.

Recommendation 14: that all GPs are encouraged to keep records on referrals to dieticians and the level of uptake of these referrals, and provide this information to the PCT.

Retinal screening
The National Service Framework makes specific reference to screening for diabetic retinopathy, as diabetes is the leading cause of blindness for people of working age in the UK. The PCT holds no data on annual eye checks. Retinal screening is commissioned by the PCT and the contractor is obliged to contact all diabetics to offer this service. At the last count, 99% of people were offered the screening (demonstrating that the contractor is fulfilling their contractual duties) and 68% of people had received the screening. Patient education could improve this level of uptake and practice nurses are seen as the drivers for this. Screening is offered at the Wealdstone Centre and Alexandra Avenue Centre with no waiting lists, offering high quality and meeting the national service framework.

Empowering/enabling self-care management of condition
The NSF for diabetes recognises that it is important to support people to look after themselves ('self-care'). A growing body of evidence demonstrates that this is fundamental to daily life and that supporting people with long-term conditions to care for themselves means that they do better in clinical terms and in their quality of life. It also contains increases in healthcare costs. The importance of making support available for people with long term conditions to care for themselves is further reinforced in the recent White Papers *Choosing Health*[41] and *Our Health, Our Care, Our Say*[42].

Taking this on board, there is local consensus Harrow could improve in its support and interventions in this area and inform people what to expect from local healthcare professionals. With regard to self-care, there are significant gaps in the ability of the NHS to empower people with diabetes to manage their condition effectively. Local development (e.g. by the PCT and local authority) to support diabetes self-help groups where people can learn together and have a support network to manage their condition seem to lean upon Harrow's Diabetes UK - a voluntary group which does not offer diabetes services but rather offers peer support and gets involved in consultations and planning issues, giving people with diabetes a local voice.

[41] *Choosing Health – Making Healthy Choices Easier*, Department of Health, 2004
[42] *Our Health, Our Care, Our Say: A New Direction for Community Services*, Department of Health, 2006.

Recommendation 15: that information be readily available to diabetics about what they can expect from local healthcare professionals, with a view to supporting self-management of people's diabetes wherever appropriate.

Standard 3 of the NSF highlights that personal care plans for those with diabetes can help empower people. Following also the NSF Standard 12 which highlights the need for multi-agency support in delivering integrated health and social care, the Review Group would recommend that these be ensure a multi-agency focus and that these include signposting to further sources of information and support. Indeed Diabetes UK would encourage written plans, perhaps in the form of checklists of what diabetics should do/expect every year for example annual eye checks and blood tests. This would foster empowerment of self-care and generally encourage uptake of services.

In Harrow, healthcare services are perhaps not the best at giving patients written information on what diabetics should expect every year as part of their care. Diabetes is specialised and each person has different needs and therefore it is difficult to have generic information for all. However if such information could be available at a singe point of contact/information, it would serve as a good aide-memoire for diabetics and foster a sense of empowerment in their self-care regime. The Review Group feels that it is possible to devise such a template to put on practice computers, after which the GP can tailor the information for the individual patient.

Recommendation 16: that the PCT, in liaison with GPs, devises a template of information on what all diabetics should expect as part of their routine care, and that this be piloted within some local GP surgeries to gauge the success of such an approach.

Concessions for diabetics

The local authority's could look to offer concessions for diabetics, for example to local leisure centres to encourage physical activity among diabetics as part of their self-management care regime. Such an approach of offering appropriate concessions has been implemented for other vulnerable or at-risk groups such as looked after children and so it is feasible that it can be rolled out for other population cohorts such as diabetics.

Recommendation 17: that the Council explores offering people with diabetes concessions at leisure centres to encourage physical activity and form a routine part of their self-management of care. GPs should be asked to promote the availability of such concessions.

Partnership working between organisations providing, commissioning and supporting diabetes services

Investing budgets

In a time when the budgets of most local health and social care providers is stretched, there is a particular need to look at chronic diseases as a whole and target prevention accordingly for example through diet, lifestyle and exercise. Within the PCT, aspects of diabetics care fall within different budgets. Likewise there is no specific budget within the

Council for obesity or diabetes but work in these areas is channelled through preventative budgets. From a local authority perspective, spend on diabetes is coincidental rather than specific, for example through Healthy Living initiatives and work within schools.

There appears to be a general need to shift more investment to prevention and primary health prevention strategies however equally it is recognised that it is always more difficult to get investment for preventative work as most funding allocations are rather more short term.

Joint work

Within the National Service Framework, Standard 12 highlights the need for multi-agency support in delivering integrated health and social care. In offering packages of care, there is the need to look beyond a package of care involving just the PCT and local authority. Although in general there is a lack of proved interventions, the PCT is carrying out an appraisal of other local schemes to draw upon successes in interventions.

In tackling diabetes, Harrow should build upon the successful model of its smoking cessation project which proved an effective service for healthcare professionals to channel in to. GPs were not successful with one-to-one advice but an accessible and effective group scheme meant that this option was available to GPs tap in to. Pharmacists provided full support for this scheme and this pharmacy model worked in Harrow whereas in London it often did not. The scheme tackled education plus behavioural and motivational change, offering a 'toolbox' of options. Applying this model of a 'toolbox' of effective interventions in diabetes would include local interventions and tailor it to at-risk groups such those who are obese. Proving its effectiveness will be a tall order but it can help make local headway, for example the walk schemes have proved a combination of social activity and exercise. This should engage healthcare professionals as appropriate.

Diabetes tends to get medicalised but an outlook towards prevention will be more beneficial in the long term. The best place to start in terms of working up local preventative models would be to look at best practice in order to achieve a solid evidence base on which to build interventions and preventative work. There are evaluations in neighbourhood renewal areas of what is effective and those that are appropriate could be employed in Harrow. Health and social care partners know the population that they provide services for and also have a successful smoking cessation model upon which to build.

Recommendation 18: that using examples of best practice and the successful modelling and delivery of smoking cessation interventions in Harrow as a base, the PCT leads on developing a 'toolbox' of effective interventions available to people with diabetes or at the risk of developing diabetes. This should link to access to schemes around physical activity and healthy eating and lifestyles.

APPENDICES

APPENDIX A: RECOMMENDATIONS MATRIX

KEY:

Prioritisation – (Timescale)	Requiring action immediately:	S
	Requiring action in medium term:	M
	Requiring action in long term:	L
Incorporated information - (Info)	Evidence received from officers (Council/PCT)	O
	Evidence received from “best practice”	BP
	Evidence received from local people	LP
	Evidence received from voluntary groups	VG
	Evidence received from relevant portfolio holder(s)	PH

Recommendation	Time scale	Identified officer/ member/ group to action	Info	Partnership (Yes/No)	Action taken (6 months or 1 year)	Measure of success
Overarching review: **Recommendation 1:** that the borough-wide Obesity Strategy be finalised and presented to the Overview and Scrutiny Committee. The strategy should enable agencies looking to tackle obesity and its links to long term conditions (such as diabetes, and cardio-vascular and circulatory conditions) to work from a single strategic and locally owned policy framework.	M/L	Harrow PCT Board Obesity Strategy Group	O	Yes		6 months: progress update on development/ revision of borough-wide Obesity Strategy to Overview and Scrutiny Committee. 1 year: an Obesity Strategy for Harrow published and adopted by all relevant partner agencies.
Recommendation 2: that the council pilots a walk scheme for staff as part of its staff well-being programme. This should be done in liaison with and seeking the advice of our colleagues at Harrow PCT who have already successfully implemented such a scheme.	M	Corporate Director of Strategy and Business Support, Harrow Council	O / BP	Yes		3 months: the staff well-being programme includes a (pilot) walk scheme for staff. A scheme has been, or is about to be, piloted.
Childhood obesity: **Recommendation 3:** that the Children and Young People's Partnership considers the local physical activity strategy and discusses with partners how this can be revised and taken forward.	S	Corporate Director Children's Services, Harrow Council Children and Young People's Partnership	O	Yes		3 months: the agenda for the next meeting of the Children and Young People's Partnership includes the local physical activity strategy.
Recommendation 4: that the Council	L	Corporate Director	O /	Yes		1-2 years: the revised local

Recommendation	Time scale	Identified officer/ member/ group to action	Info	Partnership (Yes/No)	Action taken (6 months or 1 year)	Measure of success
and PCT recognise that much of the work around children's opportunities for physical activity can be built in together with multi-agency working and channelled through schools, children's centres and extended schools.		Children's Services, Harrow Council Harrow PCT Board	BP / LP / VG / PH			physical activity strategy highlights partnership work through schools, children's centres and extended schools.
Recommendation 5: that multi-agency work through schools, children's centres and extended schools links to opportunities to engage and signpost families/parents to healthier lifestyles and encourages family learning.	L	Corporate Director Children's Services, Harrow Council Harrow PCT Board	O / BP / LP / PH	Yes		1-2 years: local Council and PCT strategies refer to partnership work through schools, children's centres and extended schools, as conduits for family learning.
Recommendation 6: that it is recognised that within Harrow there is a need to take more opportunities to lobby funding bodies regarding the criteria set down for accessing funding streams. The Review Group recommends that the Council and PCT make this representation jointly.	M/L	Chief Executive, Harrow Council Leader of Harrow Council Chief Executive, Harrow PCT	O / BP	Yes		As and when the opportunities arise: joint representations to central government funding bodies by the Council and PCT.
Recommendation 7: that there is a role for scrutiny to play in examining the functions and effectiveness of the Council's funding officer - what the Council's funding officer does and how he can facilitate the local authority to attract more funding and optimise the funding opportunities available to Harrow.	S	Overview and Scrutiny Committee	O / BP	No		3 months: the scrutiny work programme includes examination of external funding opportunities and the role of the Council's funding officer.

Recommendation	Time scale	Identified officer/ member/ group to action	Info	Partnership (Yes/No)	Action taken (6 months or 1 year)	Measure of success
Recommendation 8: that Harrow, through the Harrow Strategic Partnership and its Local Area Agreement, should continue to build the capacity of its voluntary sector so that it can partner the Council and PCT on more joint projects around children's opportunities for physical activity.	L	Harrow Strategic Partnership	O / BP	Yes		1 – 2 years: an increased number of projects offering physical activity opportunities for children led by voluntary sector groups.
Recommendation 9: that local authority provision for children is targeted and addresses areas of deprivation in the borough where there is an identified and relative lack of provision for children.	L	Corporate Director Children's Services, Harrow Council	O / LP / PH	No		1- 2 years: more provision for children in areas, as identified in the Play Strategy, as relatively lacking provision currently.
Adulthood obesity: **Recommendation 10:** that a borough-wide Diabetes Strategy be developed, so that all agencies looking to tackle diabetes and its links to other long-term conditions such as obesity can work from a single strategic and locally owned policy framework.	L	Harrow PCT Board Diabetes Partnership Board	O / VG	Yes		1 -2 years: a Diabetes Strategy for Harrow published and adopted by all relevant partner agencies.

Recommendation	Time scale	Identified officer/ member/ group to action	Info	Partnership (Yes/No)	Action taken (6 months or 1 year)	Measure of success
Recommendation 11: that the Diabetes Partnership Board seeks a representative from the local authority to supplement its multi-agency perspective. The Review Group recommends that this be the Adults Services Portfolio Holder in the first instance.	S	Diabetes Partnership Board	O / PH	Yes		As soon as possible (3 months): the local authority is represented on the Diabetes Partnership Board.
Recommendation 12: that joint work between the PCT and Council is undertaken on publicising the risks of obesity and also its links to diabetes. Joint articles to the press or in Harrow People updating residents on broader health issues should also be explored.	S/M	Chief Executive, Harrow PCT Adults Services Portfolio Holder	O / VG / PH	Yes		3 months: the next edition of Harrow People includes an article on health issues, jointly written by PCT and Council representatives.
Recommendation 13: that the PCT makes efforts to do more to advertise its courses on managing type 2 diabetes, including posting them on the PCT website and on the websites of those agencies who also help deliver the multidisciplinary course.	S/M	Harrow PCT Board	O / VG	Yes		3 months: the PCT website includes signposting to diabetes courses. 6 months: PCT-run diabetes courses are featured on partner websites.
Recommendation 14: that all GPs are encouraged to keep records on referrals to dieticians and the level of uptake of these referrals, and provide this information to the PCT.	L	Harrow PCT Board	O / BP	No		1-2 years: the PCT holds systematic records of GP referrals to dieticians and levels of uptake.
Recommendation 15: that information be readily available to diabetics about	L	Harrow PCT Board	O / BP /	No		1 year: information leaflet on local diabetes care available to

Recommendation	Time scale	Identified officer/ member/ group to action	Info	Partnership (Yes/No)	Action taken (6 months or 1 year)	Measure of success
what they can expect from local healthcare professionals, with a view to supporting self-management of people's diabetes wherever appropriate.			VG / PH			all residents through GP surgeries and other sources.
Recommendation 16: that the PCT, in liaison with GPs, devises a template of information on what all diabetics should expect as part of their routine care, and that this be piloted within some local GP surgeries to gauge the success of such an approach.	L	Harrow PCT Board	O / VG / PH	No		1-2 years: Implementation of (pilot) diabetes information/referral template on local GP's computers.
Recommendation 17: that the Council explores offering people with diabetes concessions at leisure centres to encourage physical activity and form a routine part of their self-management of care. GPs should be asked to promote the availability of such concessions.	M/L	Corporate Director Community and Environment, Harrow Council	O	No		6 months: completed assessment of financial implications and feasibility of extending leisure centre concessions to people with diabetes. 18 months: implementation of concessionary scheme for people with diabetes (if assessed as financially/ operationally feasible).
Recommendation 18: that using examples of best practice and the successful modelling and delivery of smoking cessation interventions in Harrow as a base, the PCT leads on developing a 'toolbox' of effective interventions available to people with diabetes or at the risk of developing	L	Harrow PCT Board	O / BP / VG / PH	Yes		1-2 years: a 'toolbox' of effective interventions for people with (or at risk of) diabetes has been piloted across the borough.

Recommendation	Time scale	Identified officer/ member/ group to action	Info	Partnership (Yes/No)	Action taken (6 months or 1 year)	Measure of success
diabetes. This should link to access to schemes around physical activity and healthy eating and lifestyles.						

APPENDIX B: AGREED PROJECT PLAN FOR REVIEW GROUP

ADULT HEALTH & SOCIAL CARE AND CHILDREN & YOUNG PEOPLE SCRUTINY SUB-COMMITTEES 2007

REVIEW OF OBESITY

Aims/objectives of Obesity Review:

- **To assess the impact of obesity on the people of Harrow and how well local agencies are responding to the growing challenge of obesity.**
- **To add value to the development of local policy surrounding obesity and the implementation of actions around obesity prevention and treatment.**
- **To inform multi-agency working in obesity prevention and treatment.**
- **To promote key messages about measures to tackle obesity and ensure that raising awareness addresses all communities in a diverse borough as Harrow.**

AGREED PROJECT PLAN:

DATE	ACTIVITY	MEMBER INPUT	OFFICER RESOURCE	OTHER NOTES
9 May 2007	**Meeting 1** of Review Group: • Procedural arrangements • Policy briefing on obesity (national and local contexts) • Scoping review and activities	Review Group (9 councillors plus AHSC co-optee Mr Owen Cock)	Nahreen Matlib – Scrutiny Team Shikha Sharma – Harrow PCT	
June	**Project planning** for review activities within agreed workstreams: • Adult obesity – links to diabetes • Childhood obesity – physical activity and play for children		NM	Workstreams to be conducted as two challenge panels – "Diabetes Challenge Panel" and "Play Challenge Panel"
18 July	**Meeting 2** of Review Group: • Agreement of project plan • Update on local work on obesity	Review Group	NM SS	

DATE	ACTIVITY	MEMBER INPUT	OFFICER RESOURCE	OTHER NOTES
	(PCT pathways) • Briefing on local play and physical activity strategies • Determining details for challenge panels e.g. membership and external witnesses		Kashmir Takhar – Community Development Team	
August	**Visits** to playschemes – to inform Play Challenge Panel of opportunities for physical activity for children	Members from Review Group	NM Council officers from Childcare and/or Youth teams	
12 September	**Play Challenge Panel**: • School activities including PE, physical activity and play, extracurricular activities, school walking buses • Out of school activities in school/community settings e.g. playschemes, neighbourhood walks • Safety awareness - links to the work of police e.g. Safer Neighbourhood Teams • Development of borough's play strategy and Lottery funding application Anticipated outputs: see aims/objectives of Review. In addition, inform the plans for Lottery bid expenditure, link to the development of play strategy and sports service review	Members from Review Group Children's Services Portfolio Holder Schools and Children's Development Portfolio Holder	NM SS Invite as witnesses: • Childcare officers • Youth workers • Corporate Director of Children's Services • Community Development Team	To invite as external participants/witnesses: • Borough Commander • Member of Youth Parliament • Association of Harrow Governing Bodies • Academic researcher – measuring childhood obesity • Headteacher

DATE	ACTIVITY	MEMBER INPUT	OFFICER RESOURCE	OTHER NOTES
2 October	**Diabetes Challenge Panel**: • Facts and figures for Harrow, including prevalence rates and demographic profiles • Links to older people • Strategic framework – National Service Framework and local actions • Role and responsibilities of clinicians - presentation from clinician at Northwick Park Hospital Anticipated outputs: see aims/objectives of Review	Members from Review Group Adult Services Portfolio Holder	NM SS Invite as witnesses: Corporate Director for Adult Services	To invite as external participants/witnesses: • Respondent to Harrow People scrutiny advert – dietician at Northwick Park Hospital • British Heart Foundation • Diabetes UK • Dr Keith Steer – Endocrinologist at Northwick Park Hospital
1 November	**Meeting 3** of Review Group: • Receive report backs from the two challenge panels • Frame overall Review Group report and recommendations *Possible: Meeting 4 of Review Group:* • *Sign off final report, taking account comments in drafting stage*	Review Group	NM SS	Ensure that all people involved in Review Group's work have the opportunity to comment on draft report Sign off of final report to be conducted online or another Review Group meeting to be held
20 November	Presentation of Review Group report to **Overview and Scrutiny Committee**	For presentation by Chairman of Review Group (Councillor Rekha Shah)	NM	Agenda dispatch 12 November
December	*Possible: In case of project slippage, there is likely to be an additional O&S meeting in December*	For presentation by Chairman of Review Group (Councillor Rekha Shah)	NM	Agenda dispatch tba

APPENDIX C: LIST OF REVIEW MEMBERS, PARTICIPANTS AND WITNESSES

Name	Title / Organisation	Review Group meetings	Visits to play schemes and other activities	Challenge panel on children's opportunities for physical activity	Challenge panel on adulthood obesity and its links to diabetes
Councillor Rekha Shah	Review Group Chairman	✓	✓	✓	
Councillor Margaret Davine	Review Group member	✓	✓	✓	✓
Councillor Julia Merison	Review Group member	✓		✓	✓
Councillor Myra Michael	Review Group member		✓	✓	✓
Councillor Vina Mithani	Review Group member	✓			
Councillor Joyce Nickolay	Review Group member (until July 2007)	✓			
Councillor Dinesh Solanki	Review Group member	✓			
Councillor Jeremy Zeid	Review Group member	✓			
Owen Cock	Local resident and member of Review Group	✓			
Shikha Sharma	Head of Health Improvement, Harrow Primary Care Trust	✓		✓	✓
Louise Taylor	Harrow Primary Care Trust Lead for Obesity	✓			
Kashmir Takhar	Service Manager Community Resources and Projects, Harrow Council	✓		✓	
Councillor Christine Bednell	Schools and Children's Development Portfolio Holder			✓	
Sergeant Sam Carson	Metropolitan Police			✓	

Name	Title / Organisation	Review Group meetings	Visits to play schemes and other activities	Challenge panel on children's opportunities for physical activity	Challenge panel on adulthood obesity and its links to diabetes
Heather Clements	Director Schools and Children's Development, Harrow Council			✓	
Councillor Eric Silver	Adults Services Portfolio Holder and local pharmacist				✓
Dr Ken Walton	Local GP and Chair of Harrow Primary Care Trust Professional Executive Committee				✓
Philip Watson	London Region Manager, Diabetes UK				✓
Jasvinder Perihar	Strategy Manager Adults and Housing, Harrow Council				✓
Yvonne Dempster	Play Development Officer, Harrow Council		✓		
Staff and children at Harrow playschemes	Harrow Teachers Centre Playscheme, Pinner Community Centre Playscheme		✓		
Jeff Parkinson	Head of Play Service, Ealing Council		✓		
Staff and children at Ealing playschemes and activities	Limetrees Children's Centre, Islip Manor Park Playcentre, Petts Hill Holiday Childcare Scheme, Horsenden Hill Playground		✓		

APPENDIX D: REPORTING HISTORY AND FURTHER INFORMATION

REPORT DRAFTING HISTORY
Version 1 completed 26 October 2007
Version 2 completed 23 November 2007
Version 3 completed 20 December 2007
Version 4 completed 9 January 2008

FURTHER INFORMATION
For more information on the work of Obesity Review Group, please contact:

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