Fieldwork Validation Report:

Prevention of pre-diabetes among adults in high-risk groups

Report for The Centre for Public Health Excellence,
at The National Institute for Health and Clinical Excellence

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Executive summary

This section first examines a number of overarching themes, and then summarises key findings on individual recommendations

Overarching themes

Views on the draft NICE guidance: participants welcomed the guidance as an important contribution to improving the work of public health prevention in general, and of pre-diabetes in particular. NICE guidance was regarded as an important 'stamp of approval' and an opportunity to give a topic renewed impetus. However, some thought the guidance lacked innovation and that most of the recommended actions were already in place: this, together with the following concern, led many participants to conclude that the potential impact of the guidance overall would be limited.

Public expenditure and NHS reorganisation: there was an overwhelming response that the political and economic context was unfortunate and unfavourable to the aims of the guidance. Key concerns related to the reductions in resources for prevention activities in the face of more urgent demands, cuts to the supporting social infrastructure that enable public health prevention to take place, and a view that the proposed changes in primary care and public health will lead to prevention work slipping down the priority list.

The balance between local and national responsibilities: many participants perceived too great a responsibility in the guidance on the local level, and not enough at national level, particularly in terms of mass media campaigns, working with the commercial sector, the absence of recommendations on legislation, and the absence of a national strategy.

The age focus of the guidance: participants queried the focus on the age range 18-74, making three different points.

- It seemed to preclude a family centred approach
- There should be more reference to differing risk levels within the 18-74 age range, with varied approaches according to age segments
- It was argued that prevention work aimed at young adults should begin with under 18s

Equality issues: a number of equality concerns were raised by participants.

- There was no mention of disabled people in any of the recommendations, and yet there were clear needs assessment issues for this group
- Mobile populations required an iterative approach to needs assessment and strategy development, and regional or national strategies were needed for such groups
- Religious organisations could play a very important role, but it should not be assumed that "all BME people are automatically religious."
- The community infrastructure in low-income white working class neighbourhoods was often underdeveloped; reliance on delivery through such infrastructure could inadvertently marginalise these communities

Making the case for investment: the guidance should include advice on constructing a business case for pre-diabetes prevention.

Commissioning models and the risk of short-termism: "stop/start" commissioning was a major problem - the community rooted would require a well thought through commissioning model, with long-term commitment to partners.

Action and leadership: the "who should take action" section should specify the body responsible for leadership, and this should often be the local Health and Well-Being Board.

Unclear incentives and accountability: one suggestion was for a role for local authority Review and Scrutiny committees in monitoring implementation.

Research and evaluation: a number of participants suggested that a discrete recommendation should pull together all references to research, evaluation and monitoring.

The role of the private sector: participants were not confident in terms of their ability to engage private sector food companies - large companies were seen as out of reach for local organisations, and there was little experience of successful engagement with local businesses.

A preference for integrated strategies: most participants would prefer to have an integrated strategy covering the prevention of the main long-term conditions (CVD, Obesity, Diabetes, Hypertension etc), and the related lifestyle and public health measures, as the key actions and the main at risk groups were considered to be common.

Style and presentation: some suggestions were made -

- It would be useful to identify the links by cross referencing within each recommendation.
- More references should be provided to related NICE public health guidance.

Summary of findings for individual recommendations

Recommendation 1 Local joint strategic needs assessments

- NICE guidance was welcomed, because it focused attention on the subject of pre-diabetes prevention.
- Many participants would prefer to see pre-diabetes drawn together with certain other long-term conditions, in a common needs assessment and strategy.
- Some questioned whether the JSNA was the right place to assess the effectiveness of interventions - and if it were to be a requirement, the guidance should set out the appropriate assessment criteria.
- Needs assessments were impaired by a lack of good quality data - they tended to be over reliant on poor quality quantitative data (because they are more available), and there were concerns that the ability to obtain more relevant, "softer" data through community engagement would be limited by lack of resources for engagement activities.
- High-quality needs assessment and strategy development required a high level of stakeholder commitment, and there were doubts over whether stakeholders would have the resources to make this commitment in the foreseeable future.
- Overall, participants were cautious in assessing the potential impact of this recommendation, due to the reservations explained above.

Recommendation 2 Developing a local strategy to prevent diabetes

- There was a welcome for the recommendation on developing a strategy on long-term prevention of pre-diabetes, because it focused attention on a subject that had suffered in the past from being a lower priority, with short-term funding and poor cooperation among relevant parties.
- Nevertheless, participants were concerned that this situation would not improve, given the financial constraints and issues around NHS reorganisation to be faced in the next few years.
- As with recommendation one, there was a view that prevention of pre-diabetes should be drawn together in an integrated strategy with other related long-term conditions, given the overlaps in terms of relevant messages, delivery channels and high-risk groups.
- The recommendations seemed to assume that it would be possible to develop new services to meet the identified needs, but the focus over the next few years, was likely to be on mitigating the impact of service reductions.
- The guidance should be more specific about the content and structure of a strategy (e.g. providing a template), particularly since there was no recommendation for a national strategy, which could have served as a template for local strategies.
- The strategy should contain actions on improving data quality available for future needs assessment and evaluation.
- This recommendation was seen as helpful, despite some opinions that it was not new or innovative. However, participants were reluctant to claim it would have a major impact, not least because of uncertainties around measuring impact.
- Participants were keen to see local authorities specified under "who should take action", particularly the Health and Well-Being Boards, though there was some scepticism about this work being seen as a priority for action by GP consortia.
- Participants suggested that without incentives to conduct both needs assessments and strategies, it was difficult to see what would encourage local health planners to act on these recommendations. They also recommended that monitoring and accountability procedures would be required to assess the impact of these recommendations.

Recommendation 3 Conveying messages about lifestyle and the risk of diabetes

- This recommendation was broadly welcomed, although some participants expressed disappointment that it did not contain more innovation.
- The focus on community involvement was welcomed by the great majority of participants - community engagement was seen as essential in understanding important cultural nuances, and delivery through community settings was seen as adding credibility to the messages conveyed.
- The recommendation that local areas should consider mass media campaigns was met with widespread scepticism - this was generally seen as a national responsibility, with local areas lacking the resources, specialist skills and appropriate media channels were not always on a local footprint.
- It was believed that this recommendation needed to make a clear link between the conveying of messages and the application of behaviour change theory, with many participants saying that past efforts had failed to help people with the practical steps towards behaviour change.
- The third action point specifies, "when the opportunity arises, disseminate these messages" - many thought that this wording was too passive, and that a firmer line should be taken. However, other participants, outside mainstream NHS roles, were more comfortable with the recognition that an opportunistic approach was appropriate.
- In order to maximise the contribution of non-health professionals in sectors such as education and catering, the strategy should consider offering training and support materials, in order to boost confidence and capability among this related workforce.
- In terms of impact on prevention of pre-diabetes, most participants thought that this recommendation had great potential, but they also had concerns that resources would not be made available, and implementation would therefore not be fully effective.
- Participants were pleased to see a broad range of agencies mentioned in the "who should take action" section.

Recommendation 4 Targeting interventions at communities at risk of diabetes

- This recommendation was welcomed, and was seen as consistent with current best practice, although some did comment that it was lacking in innovation.
- Voluntary organisations were particularly enthusiastic, but they wanted involvement in the planning and design of interventions and initiatives.
- The term "lay worker" was considered to be open to different interpretation, and several respondents believed that NICE should provide a clear explanation of what was meant by this, e.g. what type of workers?, paid or unpaid?, how it differs from "community champions"?
- The community rooted approach was welcomed by most (though some did question the strength of the evidence base), but certain pitfalls needed to be avoided in planning and commissioning
    - it needed a well thought through commissioning strategy, which avoids short-term, "stop/start" funding
    - if volunteers were to be used, there were significant costs in recruitment and training, and a high turnover of volunteers should be expected
    - the volunteer-based model was believed to be unlikely to work well in more disadvantaged areas
    - the use of lay workers, and particularly volunteers, raised issues of quality assurance, with the risk of greater variability in delivery
    - religious organisations could provide access to some important target groups, but it should not be assumed that they engaged with all members of their particular ethnic/cultural community

    - low-income White (and to some extent African/Caribbean) communities were believed to lack a strong community infrastructure, and a strategy based on delivery through community groups might be less effective with these communities.
    - it could be difficult for outsiders to identify truly credible "Community Champions."
- "Community Champions" should lead a lifestyle consistent with the message they convey, otherwise they risk undermining the message.
- For some participants, particularly those in highly deprived areas, the final two action points seemed inappropriately focused on individual level action - it was suggested that a more population level approach was needed, and that the degree of primary care engagement implied in these action points was unrealistic.
- Participants would welcome guidance on setting, monitoring and evaluating appropriate outcomes for these kind of interventions and initiatives.
- Participants were divided when asked about the impact of recommendation four, with some being very positive, but others believing that it would suffer from poor resourcing, and lack sustainability.
- The broad range of agencies identified as taking action was welcomed, although there was a risk of the list being so long that nobody would take responsibility for leadership.

Recommendation 5 Creating local environments that support healthy food choices

- This recommendation was seen as being clear and relevant, but challenging.
- The wording in this recommendation about 'healthy food' was questioned. It was believed that 'healthy eating' was more appropriate, as the major concern appeared to be more about portion sizes than particular healthy or unhealthy foods.
- The main challenge related to working with private sector food businesses (see overarching issues for more detailed explanation)
    - large businesses were seen as out of reach
    - there was a lack of confidence in engaging with local business
    - relationships were often through Environmental Health, but this department had limited resources
- The use of planning regulations to influence local choices was welcomed, although with some caveats
    - change achieved through planning regulations would be slow in making a significant difference
    - some participants had positive experiences of working with planning departments, but others understood the influence of their local planning departments to be very limited
    - there was a view that legislative change would be needed before significant change could be achieved through the planning system
- It was suggested that some action points, such as those on benefits, eligibility and scheduling of sessions, would be better placed in recommendation three.
- Some participants thought that this recommendation placed too much emphasis on encouraging positive choices, and not enough on restricting negative choices.
- Some participants would have liked to have seen recommendations for legislative change on food labelling and food marketing.
- The idea of introducing voucher schemes to encourage healthier food consumption met with some scepticism - this would require major investment to achieve significant change, and evidence of effectiveness would need to be very clear before local areas would make such commitments.

- There was support for the principles behind this recommendation, but scepticism about whether resources would be made available, whether planning departments had sufficient powers, and whether the private sector would engage meaningfully.
- In terms of who should take action, a number of suggestions were made
    - local authority Health and Well-Being Boards should be specified
    - the commercial sector was felt to be important to some of these actions, and should be mentioned as having responsibility
    - the voluntary sector was specified as taking action, but it was not clear on which elements this sector should take action

Recommendation 6 Creating local environments that support physical activity

- This recommendation was welcomed, but thought to be aspirational in the current funding climate.
- Some participants thought that the recommendation focused too heavily on formal facilities and services, and not enough on informal opportunities/spaces for physical activity.
- The was a major concern around the availability of funding
    - participants believed that it would be difficult to implement the third action point, on accessibility and affordability of leisure services
    - some reported that free and low-cost schemes were currently being withdrawn in their areas, due to financial pressures
    - fears were expressed that GP consortia would not see this sort of work as a priority
- Local leisure services were typically contracted out - NICE guidance should encourage inclusion of public health objectives in the commissioning process
    - in some areas there was poor coordination of physical activity initiatives - "multiple partners with overlapping programs"
    - customer facing staff should receive training to improve their engagement with non-traditional sports participants
    - guidance was needed on the development, monitoring and evaluation of appropriate outcome measures for physical activity initiatives, which could be commonly accepted in both the health and leisure sectors
- There was a tension between the targeting of specific groups with "niche" provision, and the often crude outcome measures currently used by commissioners - for example, single sex and other culturally specific provision were thought to yield poor outcomes (e.g. lower attendance and income).
- "Enabling investment" should be encouraged - for example the training of female lifeguards, the provision of minibuses, etc.
- Some BME communities were very deprived and socially isolated, and the first step towards encouraging them to be physically active should be through groups in their community - it was not realistic to think that they would independently attend mainstream leisure provision in the short term.
- The actions for planning departments were welcomed, although there were concerns around whether sufficient regulatory power existed to ensure effective implementation.
- Community safety was seen as an important issue, facilitating informal physical activity in low-income neighbourhoods, and the reference to this in the first action point was welcomed. Nevertheless, participants were concerned that the anticipated reduced public expenditure on the maintenance of buildings, street lighting, and cleaning up vandalism may lead to increased safety fears.

- The anticipated impact of this recommendation was not great, because although its principles were received positively, there were major doubts over its likely implementation.
- In terms of taking action, participants commented that this recommendation had a very short list, and suggestions for additions included transport planners, voluntary sector organisations providing leisure or catering for specific high-risk groups, and a range of different local authority services including schools with community sports facilities.

Recommendation 7 Training health professionals

- There were significant concerns about the lack of consistency in health behaviour messages. As a result, there was a strong welcome for this recommendation, and particularly the recognition of the need for continuous development, and the focus on cultural sensitivity.
- There was a view that the recommendation seemed very "medically focused", and participants would welcome the extension of the recommendation to lay workers, pharmacy staff, volunteers etc.
- There were concerns about the knowledge of existing, trained health professionals (especially GPs), but the recommendation was not clear in whether this training would apply to those already qualified.
- Some participants requested that the recommendation wording should explicitly emphasise the need for the practical application of the training, and the development and monitoring of associated competencies.
- It was believed that this recommendation should be explicit in calling for health professionals and medical undergraduates to receive training in behaviour change.
- The major barrier to effective implementation of this recommendation was seen as the willingness of commissioners to invest in training, and it was suggested that there is a need to demonstrate the cost effectiveness of health promotion.
- For this recommendation to have impact, there would need to be improvements in the way that services join up, e.g. the ability of health professionals to signpost people to appropriate services.
- There was praise for the potential impact of this recommendation, but scepticism about whether there would be investment in training.
- There was confusion on the need for the commercial sector to take action - did this mean commercial companies employing healthcare professionals, or commercial providers of training?

Recommendation 8 National-level action to promote an environment that supports a healthy diet

- This was considered to be a clear and important recommendation.
- The absence of any mention of alcohol was thought to be a mistake, given not only its calorie content, but also its dis-inhibiting effect on eating behaviour.
- It was suggested that sugar should be included in the first and fourth action points.
- A number of participants queried why there was no reference to data collection in this recommendation, as there was in recommendation nine.
- Some participants questioned the absence of any action on mass media campaigns, with Change4Life seen as an appropriate model, since it combined national mass media with material that could be adapted locally.
- Co-operative working and advocacy with the food industry at a national (and global) level was seen as pivotal to the success of the guidance as a whole, but there was disappointment at the absence of any mention of legislation to make healthier choices easier, and unhealthy choices less easy.

- In terms of impact, the ideas in this recommendation were seen as having great potential, but there was widespread scepticism about the likelihood of the food industry engaging effectively.
- Suggestions for other organisations taking action included the Food Standards Agency and the food industry - note that the reference to "public health agencies in the public and private sector" was considered confusing, i.e. were there any public health agencies in the private sector?

Recommendation 9 National-level action to promote an environment that supports physical activity

- This recommendation was thought to be clear, though a little vague compared to other recommendations, particularly on the first two action points - a clear statement was required to explain how national level action on these points would differ from local action.
- There were concerns over the consistency of messages conveyed about the levels of physical activity required for health gain, with particular misunderstanding around ideal levels, and achievable levels.
- It was acknowledged that negative perceptions of participation in sport could be deep-rooted, and created a barrier to physical activity.
- The third action point discusses evaluation, and this stimulated much discussion
    - a number of participants suggested that the various mentions of monitoring and evaluation throughout the recommendations should be pulled together in a 10th, evaluation-focused recommendation
    - there was believed to be a need for guidance on outcomes, monitoring and evaluation, and it was suggested that the National Obesity Observatory's Standard Evaluation Framework could provide the basis for this
    - this action point calls for national monitoring to determine the success of national level interventions, but it was pointed out that cause and effect could not be attributed in this way, i.e. local interventions also contributed to national change
    - it was suggested that there was a threat to the funding of the Active People survey (which provides local area physical activity measurement), potentially undermining this action point
- The fourth action point calls for assessment of the health impact of all initiatives and interventions - this was considered extremely challenging, and inappropriate at a national level, since most initiatives and interventions were local.
- This was not considered to be a recommendation with significant impact potential, since it overlapped with other recommendations and had little distinctive substance.
- Participants would like to have seen a broader range of organisations with responsibility for taking action, including DCMS, the large community of voluntary organisations engaged in sport and physical activity, planners, transport policy makers - also, the term "organisations with a remit…" was thought to be too vague, and key bodies with such a remit should be specified.

1. Introduction

1.1 Overview

The Centre for Public Health Excellence (CPHE) at The National Institute for Health and Clinical Excellence (NICE) was asked by the Department of Health to develop two sets of public health guidance addressing type 2 diabetes prevention. The first set of guidance covers the prevention of pre-diabetes, and the second set addresses issues around the progression from pre-diabetes to type 2 diabetes. This report describes the methods employed - and the feedback obtained - in relation to the draft guidance on the first of these related projects, i.e. the prevention of pre-diabetes among adults in high-risk groups.

"Pre-diabetes" is defined as raised or impaired glucose levels. NICE recognises that the term "pre-diabetes" is imperfect, but although there is a lack of consensus in the scientific literature about the usefulness of this term, it is frequently used to communicate with patients and the public.

The request from the Department of Health came in May 2009, and after consultation, the project scope was finalised by August 2009. Consultation on the draft guidance took place in late 2010, and the draft guidance was published in November 2010. NICE is committed to thorough consultation in the process of its guidance development. Consequently the draft guidance was then subject to both stakeholder consultation and fieldwork consultation from the end of November to early January 2011. This is a report on the fieldwork consultation conducted with practitioners managers and commissioners. The research was conducted between November 29, 2010, and January 7, 2011.

1.2 Background and scope

Every year 100,000 people are diagnosed with type 2 diabetes in the UK and many more may have the condition (Diabetes UK 2006). It can lead to long-term complications including micro- and macrovascular diseases such as retinopathy, nephropathy and cardiovascular disease. Between 33% and 66% of people with pre-diabetes – raised or impaired blood glucose levels – will go on to develop type 2 diabetes over a period of 3 to 6 years (Diabetes Prevention Programme Research Group 2002; Lindstrom et al. 2003; Pan et al.1997; Ramachandran et al. 2006). During that time they may also be developing other medical conditions such as retinopathy and an increased risk of coronary heart disease (Waugh 2007).

An individual's risk factors for pre-diabetes include: obesity (a body mass index [BMI] of more than 30 kg/m2); high waist circumference measurement (more than 80cm in women and 92 cm in men); a sedentary lifestyle; a family history of type 2 diabetes; a history of gestational diabetes in women; and being over age 40. In addition, certain groups are at greater overall risk of developing pre-diabetes, for example people of South Asian, African-Caribbean and black African descent. . The same is true for those from lower socioeconomic groups, for example, people in social class five are three and a half times more likely than those in social class one to die as a result of diabetic complications (DH 2007b). With rates of obesity on the increase and the population becoming more sedentary (The Health and Social Care Information Centre 2009) type 2 diabetes (and pre-diabetes) is becoming more prevalent.

Diabetes is estimated to account for at least 5% of UK healthcare expenditure. Up to 10% of hospital budgets are used for the care of people with the condition – drug costs alone have been estimated to account for about 7% of the total NHS drugs budget (Waugh et al. 2007). Preventing pre-diabetes among groups at high risk of developing type 2 diabetes could help save some of these NHS resources.

As noted above, this guidance relates to the prevention of pre-diabetes.

The in scope population for this draft guidance was defined as adults aged 18-70, with one or more of the following individual risk factors:

- family history of type 2 diabetes
- history of gestational diabetes
- BMI of 30 kg/m2 or above
- high waist circumference above 80cm (for women) or 94cm (for men).

Groups at greater risk of pre-diabetes including those:

- of South Asian, African-Caribbean or black African descent
- from a lower socioeconomic group (as measured by education and occupation).

The following groups were outside the scope of this draft guidance:

- People who have already been diagnosed with impaired fasting glucose (IFG) or impaired glucose tolerance (IGT). (The second piece of NICE guidance on preventing type 2 diabetes will consider this group.)
- People with diabetes.
- Children and young people aged under 18.
- Adults over 70.
- Pregnant women.
- Adults with other medical conditions who have been prescribed medication which may increase the risk of type 2 diabetes (for example, steroids).

The project scope defined the types of activities that should be covered in the guidance. These include the following:

a) Awareness-raising among health professionals of the increased risk of pre-diabetes faced by some groups. This may include education and training of health professionals and the use of a range of media.
b) Methods to identify communities and individuals at high risk of developing pre-diabetes. This may include: training for health professionals, community-mapping, needs assessment and proactive efforts to find people at risk. It may also include opportunistic screening in primary care.
c) Awareness-raising among high-risk groups of the factors that can lead to pre-diabetes. This may include mass-media campaigns, advertising and social marketing. In addition, it may include community outreach work (for example, in places of worship), use of community leaders to disseminate health promotion messages and the use of culturally appropriate educational materials. It may also include integrated health promotion programmes which could contain several or all of these activities.
d) Methods used to ensure interventions are culturally sensitive and appropriate for groups at high risk of pre-diabetes. This would include getting these groups involved in the interventions and encouraging them to make use of health services.
e) Ways of helping high-risk groups improve their diet, increase their physical activity levels and reach or maintain a healthy weight

It also defined the types of activities that should not be covered in the guidance, and these were specified as follows:
a) Population-level screening to identify pre-diabetes.
b) Diagnostic testing to identify pre-diabetes.
c) The use of body mass index and waist circumference to assess risk in minority ethnic groups.
d) Interventions to prevent the progression from diagnosed pre-diabetes to type 2 diabetes.

e) Treatment and management of diagnosed type 1 and type 2 diabetes.

The full scope document can be found at http://guidance.nice.org.uk/PHG/Wave19/6/Scope/pdf/English

The full draft guidance can be found at
http://www.nice.org.uk/nicemedia/live/12067/51582/51582.pdf

1.3 Structure of the report
This report contains the following chapters:

The executive summary can be found at the front of the report. This summarises both the main overarching themes from the fieldwork, and key feedback on individual recommendations.

Chapter 1 provides an introduction and background information to help the reader understand the context.

Chapter 2 describes the project objectives and fieldwork methods employed.

Chapter 3 provides detailed reporting on both the overarching findings, and those relating to individual recommendations.

Chapter 4 provides discussion on key findings, implementation issues and suggested changes to recommendations.

2 Aims and methodology

2.1 Fieldwork aims and questions

The NICE methods manual for developing public health guidance is very clear about the role of the fieldwork stage in helping to further develop draft guidance:

'The fieldwork phase tests how easy it will be for policy makers, commissioners and practitioners to implement the draft recommendations and how the recommendations will work in practice'.

The general aim is therefore to 'road test' the draft recommendations. This will involve exploring the views of a very wide range of practitioners, with subtly varying perspectives, and drawing out insights that will help to fine tune the recommendations before implementation.

The objectives of the fieldwork stage were clearly set out in the project specification, in terms of examining the relevance, utility and factors affecting implementation. More specifically, the fieldwork needed to examine the following questions:

- What are the views of those working in the field on the relevance and usefulness of these draft recommendations to their current work or practice?
- What impact might the recommendations have on current policy, service provision or practice?
- What factors (for example available time, training) could impact – positively or negatively - on the implementation and delivery of the guidance?
- Do fieldwork participants know of any evidence, either from their own experience and practice or elsewhere, not currently taken into account by the draft recommendations?

2.2 Fieldwork method

Fieldwork was conducted in accordance with the principles set out in the NICE methods manual for public health guidance development. The table below summarises the approach.

Stage 2. Selection of fieldwork areas Two areas of England were selected, with the purpose of reflecting geographical differences and containing significant population proportions from the targeted high risk groups. We were assisted in the selection of areas by advice from the Surya Foundation and the Black & Ethnic Minority Diabetes Association. The areas chosen were: 1. West London 2. Greater Manchester Eligibility for participating in fieldwork was not restricted to these areas, but the main efforts to build a sample of practitioners, managers and commissioners focused in these areas, simply to ensure that the location of the two discussion groups was convenient for the great majority of those invited.
Stage 2. Compilation of a list of relevant potential respondents Desk research using the internet and telephone.
Stage 3. Review early draft of guidance recommendations to be tested This led to refinement of the roles and organisations invited to participate.
Stage 4. Fieldwork 5.1 Fieldwork took place between November 29, 2010, and January 7, 2011. 5.2 Completed fieldwork comprised two discussion groups and 25 interviews.
Online survey **An online survey, inviting responses to each of the 9 recommendations, was made available in early December 2010, and a link sent to relevant professional bodies. A total of 83 people responded to the survey.**

Approximately 180 relevant practitioners, managers and commissioners were identified as potential participants for the fieldwork. Once the final fieldwork design was agreed, these individuals were allocated to the interview/discussion group profile and received letters of invitation.

Letters of invitation were followed up with telephone calls and (where necessary) e-mails, in order to confirm participation and agree appointments for interviews or attendance at discussion groups. Most of the interviews were conducted on the telephone, with just one conducted face-to-face. Discussion groups were conducted face to face, with one held in London and the other in central Manchester.

There were a total of 61 fieldwork participants, with 32 attending the two discussion groups, and 29 taking part in the 25 interviews. In addition, 83 people accessed the online survey.

All interviews were digitally recorded and transcribed, and attempted to cover all nine recommendations, although in some cases individual participants declined to comment on recommendations relating to issues outside their remit. Interview duration varied, with a typical range of between 35 minutes and 60 minutes. Discussion groups had a duration of 90 minutes.

2.3 Fieldwork coverage – types of practitioners and organisations

A total of 61 participants were included in this fieldwork, in either a group discussion or an interview.

Discussion groups
Two discussion groups were attended by a total of 32 participants, with 17 in London and 15 Manchester. The roles of those attending are summarised below. The following job titles of those attending illustrate the range of roles were formed by those at the discussion groups:

Nutrition and Dietetics Manager
Public Health Nutrition Lead
Public Health Development Manager
Physical Activity Referral Service (Manager & Coordinator)
Health Improvement Managers
Health Trainers Programme Manager
Manager of New Deal for Communities Project
Community Engagement Officer
Local Development Framework Officer (Planning)
Physical Activity Outreach Worker
Principal Pharmacist
Consultant Nurse (Diabetes)
Diabetes Specialist Nurse
Assistant Director of Partnerships
Doctoral Researcher
Public Health Strategies
Healthy Activities Coordinator
Specialist Diabetes Dietitian
Long-Term Conditions Commissioning Manager
Chair, Voluntary Sector Organisation
Transition Manager, Voluntary Sector Organisation
Health Trainer
Health Inequalities Manager (Adult Nursing)
Physical Activity Instructor
Health Improvement Officer

Interviews

A total of 29 individuals were interviewed, across 25 different interviews.

	Roles	**Area**
1.	Obesity lead and Head of Partnerships	London PCT
2.	Obesity lead	North West PCT
3.	CVD lead	North West PCT
4.	CVD lead	Midlands PCT
5.	Director of Public Health	North West PCT
6.	Director of Public Health and three senior colleagues*	Midlands PCT
7.	GP	London
8.	GP	London
9.	Community Nutritionist	North West
10.	Community Group	South East
11.	Community Group	North West
12.	BME Specific Media	National organisation
13.	Community Pharmacist	North West
14.	Public Health Manager	London PCT
15.	Physical Activity	London local authority
16.	Physical Activity	North West local authority
17.	NHS Weight Management	North West PCT
18.	Nutrition Adviser (Slimming Business)	National organisation
19.	Maternity	London PCT
20.	Catering	North West
21.	Catering	North West
22.	Practice Nurse	London clinic
23.	Public Health Observatory	National organisation
24.	Director of Commissioning (Long-Term Conditions)	Midlands PCT
25.	Adult Literacy Teacher	London FE College

*The three senior colleagues consisted of a Director of Commissioning (Long-Term Conditions), a Consultant in Public Health, and a Director of Public Health from a neighbouring PCT.

Online survey

We were aware that the number of individual interviews was limited, and that attendance at a discussion group would not be convenient for some of those invited to participate. Consequently we also conducted an online survey, to which we invited everybody in our sample who was not selected for an interview, and not able to attend a discussion group. This was supplemented by invitations sent to relevant organisations which agreed to forward invitations to appropriate members/contacts.

In total 136 individual invitations were sent via email to those not participating through interviews or discussion groups. Indirect invitations were circulated through the following organisations: British Dietetic Association, Royal College of Nursing, Surya Foundation, Black & Ethnic Minority Diabetes Association, South Asian Health Foundation, and the Aga Khan Health Board.

Profile of respondents: a total of 83 people accessed the online survey, although the level of response to individual questions varied considerably. The vast majority of respondents (n=76, 92%) reported that they were employed by the NHS, and the rest employed by local government, the voluntary sector and the private sector.

The majority of respondents included the words 'diabetic dietitian' (n=41) or 'dietitian' (n=20) in their job title, and 67 respondents (82%) reported that they worked in an organisation where either they or the organisation they worked for provided a 'specialist diabetic service'.

Findings from the survey are provided for each recommendation, and are located on the last page of findings for each recommendation.

2.4 Data analysis

Interviews and discussion groups were digitally recorded and then transcribed. Analysts worked with the transcriptions to identify important themes in the feedback. These themes were then summarised in an analysis grid to enable cross referencing (or mapping) of substantive points with explanatory variables. Direct quotes from participants were recorded verbatim, where appropriate. Issues were sifted and prioritised by importance and salience from the large volume of data on the grid**.**

The online survey was conducted using Survey Monkey, a commercial internet survey tool, and the standard output from this package was used to generate data tables. We were conscious that this survey was not based on a scientifically designed sample frame, and the results from the survey have therefore been interpreted as broadly indicative, and treated as secondary to the qualitative methods used in the main fieldwork interviews and discussion groups.

3 Responses to the draft recommendations

In this chapter we first consider "overarching" feedback, relating to more than one draft recommendation. We then look in more detail at feedback on each of the nine draft recommendations.

3.1 Overarching findings

Public expenditure and NHS reorganisation: most participants made reference to the fact that this guidance was likely to be implemented during an era of reductions in public expenditure and of NHS reorganisation – particularly of primary care and public health. Participants were particularly concerned that the community rooted approach proposed would not appeal to GP consortia, that the supporting social infrastructure (e.g. community groups, leisure services etc) would be cut, and that long-term prevention work will slip down the priority list in a climate of short-term challenges for the NHS.
The balance between local and national responsibilities: many participants believed that the draft recommendations placed too great a responsibility on actions to be take and the local level, and not enough at national level. For example, most local areas will not have sufficient resources to commission mass media campaigns; it was considered unrealistic to expect national and international commercial businesses to engage with people working at the local level in developing and implementing their plans; national legislation would be needed on some issues (e.g. food labelling and planning regulations), but was not mentioned in the recommendations; it was believed that local strategies could best be developed in the context of a national strategy, and yet there was no recommendation for a national strategy.

The age focus of the guidance: participants queried the focus on the age range 18-74, making three different points.

- A family centred approach was preferred in much behaviour change work, and the age restriction was considered unhelpful - for example it appeared to exclude settings that have established engagement with high risk groups, such as Sure Start.
- It was believed that there should be more reference to differing risk levels within the 18-74 age range, with varied approaches according to age segments.
- Work aimed at preventing pre-diabetes among those at the younger end of the range needed to begin with under 18s.

Equality issues: a number of equality concerns were raised by participants.

- There was no mention of disabled people in any of the recommendations, and yet there were clear needs assessment issues for this group, particularly in relation to the targeting of - and conveying messages - to people with learning disabilities and mental health conditions.
- Mobile populations required an iterative approach to needs assessment and strategy development, and their geographical mobility meant that regional or national strategies were needed to supplement local plans.
- Religious organisations could play a very important role in conveying messages to various target populations, but caution was required about assumptions in this area, of the type that "all BME people are automatically religious."
- The community infrastructure (religious and other voluntary organisations) in low-income white working class neighbourhoods was considered to be often underdeveloped, and to an extent this was also true in African/Caribbean communities; focusing an approach that delivers prevention through such infrastructure could inadvertently marginalise these communities.

Making the case for investment: participants recognised that it would be difficult to secure investment for action on this issue in the next few years. It was suggested that the guidance should include advice on constructing a persuasive business case for pre-diabetes prevention work.

Commissioning models and the risk of short-termism: a number of participants identified "stop/start" commissioning as a major problem for work of this nature. This pattern of funding was considered to be inefficient, because investment in developing capacity was wasted when projects closed and trained personnel were lost. This was difficult for voluntary sector organisations to manage, and was frustrating for health professionals who could end up signposting patients to services that no longer exist. The community rooted approach of this guidance was widely welcomed, but would require a well thought through commissioning model, with long-term commitment between funders and those delivering interventions and initiatives.

Action and leadership: most participants wanted to see a wide range of different organisations identified for taking action, but many recognised that there was a risk of nobody taking the leadership role. It would be considered helpful if the "who should take action" section within recommendations clearly specified the body/bodies responsible for leadership, and this should often be the Health and Well-Being Board in the local authority.

Incentives and accountability: some participants said that they could not see strong incentives for action, nor could they see clear lines of accountability for inaction. Consequently they were concerned that the quality of implementation would be poor. One suggestion was that the guidance could recommend a role for local authority Review and Scrutiny committees in monitoring implementation at a local level.

Research and evaluation: there was considerable interest in receiving guidance on research and evaluation, both in terms of improving "consumer insight" (for needs assessment and campaign planning) and in developing appropriate outcome measures to monitor effectiveness and cost effectiveness (for commissioning and performance management). A number of participants suggested that a specific recommendation on this issue be developed, pulling together the various references to research, evaluation and monitoring, that were currently located in different parts of the guidance.

The role of the private sector: participants were not confident in terms of their ability to engage private sector food companies. This view was based partly on a degree of scepticism about private sector motivation (because unhealthy foods can be profitable), and partly due to uncertainty about how to engage these businesses. Large national companies were seen as out of reach for local organisations, and experience of successful relationships with smaller local businesses was rare.

A preference for integrated strategies: most participants would prefer to have an integrated strategy on healthy lifestyles, covering the main long-term conditions (CVD, Obesity, Diabetes, Hypertension etc) and the main lifestyle risk factors (healthy eating, physical activity etc). Independent strategies, such as that proposed for prevention of pre-diabetes, required independent needs assessments and consultations, often on the same issues and with the same stakeholders. In terms of delivery, there were concerns about the practicality of managing staff responsible for delivering several related strategies, and it was considered more cost-effective to pool resources, rather than fragment them.

Style and presentation: some suggestions were made for improving the style and presentation of the recommendations, and these should be understood in the context of the opinion that very few people would read the whole guidance document:

- Some recommendations were closely linked to each other (e.g. five and eight, six and nine), and it would be useful to identify the links by cross referencing within each recommendation.
- Providing more references to related NICE public health guidance, such as that on Obesity, Community Engagement etc.

Views on the draft NICE guidance: overall, the guidance was welcomed by participants. It was believed that NICE guidance was always helpful because of the reputation of NICE, and the certainty that the recommendations were informed by best available evidence. It was believed that this guidance could help to raise the profile of prevention activities in relation to pre-diabetes, and to provide renewed impetus to an issue that was believed to be at risk of becoming de-prioritised, given the changing political and economic climate. However, there was also a general view that the guidance was not imparting any new knowledge, and that much of its contents were in place already. As a result there was a general sense that the potential impact of the guidance overall was likely to be limited.

3.2 Responses to the individual draft recommendations

Recommendation 1 Local joint strategic needs assessments

Who should take action?

Commissioners and providers working in national and local public health services, in partnership with local health commissioners, including GP consortia.

What action should they take?

- Use local, regional and national tools and data from public health reports, the census, indices of deprivation and other sources of high quality data to:
    - identify local communities at high risk of developing diabetes
    - assess their knowledge, awareness, attitudes and beliefs about the risk factors and their specific cultural, linguistic and literacy needs
    - identify what interventions are already being implemented locally and assess their effectiveness
    - make recommendations for future investment and disinvestment.
- Work with local organisations, including the voluntary sector, to gather the views of these communities and ensure they are closely involved in the planning, design, management and delivery of health promotion activities.
- Identify local resources and existing community groups that could help promote healthy eating, physical activity and weight management to these communities.
- Identify successful local interventions and note any gaps in service provision.

Clarity of recommendation

This recommendation was generally found to be clear and understandable.

Relevance and usefulness

Several participants welcomed the recommendation and particularly the inclusion of this level of activity within the JSNA. They felt that the JSNA was the most appropriate local planning document, and would ensure action on pre-diabetes was included in local service planning.

With reference to the item, 'identify what interventions are already being implemented locally and assess their effectiveness', there was a question over whether the JSNA was the correct place to locate discussions about effectiveness of interventions. It was argued that the purpose of the JSNA was about the identification of needs, and that this was not the place for assessment of effectiveness of interventions.

"It's not really the role of JSNA to assess the effectiveness of interventions or to recommend investment or disinvestment, because the JSNA should be focused on identifying needs, and it is then the job of the commissioning strategy to decide how to invest in effective interventions."
Public Health Manager, PCT, London, Interview

There were a number of suggestions that a range of needs assessments and planning documents that aim to tackle long term chronic conditions (including prevention of obesity, cardio vascular disease, hypertension etc) be 'drawn together' to avoid duplication.

"I think it would be very unlikely that you'd have a separate strategy (for the prevention of pre diabetes). In relation to.. lifestyle-related prevention, it would be nonsensical. You might well have some over-arching strategic statements and within a joint strategic needs assessment probably, …. you would have areas that were specifically around diabetes but would very much be linked in to actions that would be integrated (with other issues)....You just wouldn't have them as part of the specific diabetes plan, they would be more of a population plan."
Director of Public Health, PCT, North West, Interview

Factors affecting implementation

Political and economic context: the main factors identified as barriers to implementation of this recommendation were, at a general level, the political and economic environment of reductions in funding and anticipated future reductions in funding for service provision, and the re-organisation of the public health function within the NHS and local government.

"Resources will be the problem, given the cutbacks."
Public Health Manager, PCT, London, Interview

"It (the recommendation) is currently written as though there will be lots of new services introduced, but over the next few years the role of the JSNA is more about mitigating the impact of service reductions, to protect the most vulnerable groups."
Public Health Manager, PCT, London, Interview

At a more specific level, a number of potential barriers to the implementation of this recommendation were identified.

Data – accessing relevant data and lacking engagement capacity to undertake research with at risk groups: a number of respondents commented on the difficulty of accessing relevant data to inform strategic planning. There were concerns that there was currently an over-reliance on routine and quantitative data over what were described as 'softer' engagement data. These softer data were considered to be essential to understanding the needs of the groups at risk, but currently the capability to undertake research was lacking.

"I think perhaps the bit that may not always be happening in JSNAs, and it is very important for this group, is the bit about assessing knowledge, awareness, attitudes and beliefs."
Focus Group, Manchester

"I think the evidence in terms of who to target, who is at high risk.. as far as I am aware that is quite strong evidence. It is more, 'how to do it' that is the problem, 'how to engage people' and I think that is where it is sort of lacking."
Commercial Health and Well Being Organisation,National, Interview

Moreover, there were problems accessing even the routine data.

“There has to be a commitment and an acknowledgement of the need to extract data from GP population registers, but we have had to do it almost by a kind of an agreement with those practices so you would need to overcome that at national level."
Director of Public Health, PCT, Midlands, Interview

Professionals’ commitment and co-operation: another barrier to implementation was identified as the difficulty of gaining commitment from the various interested parties to appreciate the priority that needed to be given to this area.

"One (barrier to implementation) is the over-reliance on routine data and quantitative data rather than the softer engagement data. Another (barrier) is the capacity to do that engagement. And another barrier is getting all the public bodies around the table talking the same language."
Head of Partnerships, PCT, London,Interview

“A potential barrier is getting the GPs and the NHS to work co-operatively with the community, and to stop seeing this approach as generating more work and being more difficult.”
GP, London, Interview

Needs assessments and strategy planning were not viewed as likely to be a priority for the new GP Consortia, which – it was assumed - would have a more short term focus.

"I think this sort of thing so easily gets lost ….in the short term needs.. for your average GP I think the issue is the person in front of you."
GP, London Interview

“Prevention needs to be a priority and it isn't always so. Unfortunately ‘prevention’ often means preventing people with existing high-level needs from going into hospital, rather than preventing the wider population developing high-level needs.”
Community Dietician, PCT, North West, Interview

The concern was also expressed that GPs and the NHS do not work well with voluntary sector, and that the former tend to regard this type of work as creating more work – rather than regard it as a potential solution.

Status of JSNAs: the perception that JSNAs were not generally of good quality and of low status, was considered a barrier to making this recommendation have an impact. However, this recommendation was viewed positively in this regard, in that it was felt that it may help to improve the quality of these reports.

“I don’t think at the moment our joint strategic needs assessments are anywhere near as robust as they might be… (this recommendation) would really help."
Director of Public Health, Midlands, Interview

Whether the necessary information, knowledge, skills and resources exist

Resources to undertake the engagement with communities: several respondents reported that while preparing JSNAs was considered to be part of the current requirements for service planning, they had

important concerns about the lack of resources (human and financial) to ensure that the various elements of the planning would be undertaken.

"The only bits (of this recommendation) that I've got concerns with, is the manpower to do the work… I think doing JSNA is part of our job anyway, but I think it's doing the in-depth work with the local communities - getting their knowledge, awareness, attitudes and beliefs, and doing that in a robust way. You're going to need to make sure you've got the resources available – it's really important."
Obesity Lead, PCT, North West, Interview

There were particular concerns about the availability of resources to ensure that the engagement activities identified in the recommendation could be undertaken.

"Engagement skills and resources: currently these are ring fenced within the PCT, but it's not clear where these will be drawn from in the new structures. Not much mention of engagement in the White Paper, so we assume it will be less of a priority and less well funded in future."
Director of Public Health, PCT, North West, Interview

Data quality and information technologies: concerns were expressed about the capability of the IT systems used by the NHS to collect and analyse the relevant health data, identified in the recommendation.

"At the moment we have got all kinds of different IT systems using different software and so on, they don't talk to each other. One hopes that actually we'll get one system that operates across all the different healthcare providers, GPs, community services, hospitals, so you know we are not constantly re-entering date that somebody else has."
GP, London, Interview

"There will be a shortage of resources and capacity to do this sort of work. I'm not sure if the available data is robust enough. How do you measure success/ improvement in the short and medium-term? Nevertheless it should be possible to do the JSNA, but the hard part is being able to deliver a meaningful strategy over the next few years."
Physical Activity Coordinator, Local Government, London, Interview

Research skills and marketing/social marketing skills: there were also concerns that specific skills in research and in social marketing were lacking. These skills were considered essential to gain meaningful insights into the lives and needs of communities, and to develop and test interventions.

"We certainly found a gap in marketing and social marketing skills… it's still in this sort of fledgling form in many parts of our national health system."
BME/Diabetes Prevention NGO, Focus Group, Hammersmith and Fulham

Potential impact

Responses on the impact this recommendation might have were generally cautious. Several respondents felt that it was possible that it would raise the profile of prevention of pre diabetes (in conjunction with other lifestyle related diseases) if the needs assessments were conducted well, and that it could be used as a tool to influence decision makers.

"Yes it could have impact, if we get the needs assessment right, and it has a strong profile with politicians and health and well-being boards, and links to the public health framework."
Director of Public Health, PCT, Midlands, Interview

Respondents were conscious of the need for a sound evidence base on which to inform the commissioning of services, but were aware too that there were problems about how information is used.

"This (the question about potential impact) is quite a challenge. We are very concerned locally about what decisions get made and about what services should be commissioned, and by having a very good evidence framework, locally we can very much influence... I don't get a sense that much of what we do locally gets used nationally…. Or that there is a sense of bringing together what happens in different places… which is why I was quite pleased to see this coming as a sort of, you know, consultation going out more broadly."
Community Group, South Coast, Interview

Conversely, there were also concerns that occasionally, needs assessments can prove to be unhelpful and wasteful, if they are not conducted well and resourced adequately.

"I think it depends on how well things are done because there are a lot of times when the assessments are just done like a set of procedures, but nothing comes of it - because the quality isn't there. You need the right people to do these things. A good needs assessment can have a lot of benefit. But then there are a lot… I've been involved in ones that literally… I'm sure the documents have never been read and I just think putting needs assessments - making every local authority or whatever, PCT, do a needs assessment has a massive risk of just being rolled out because they have to be done and no good coming of it."
Health Inequalities Lead, PCT, Focus Group, Hammersmith and Fulham

Is action required from other organisations listed?

Several respondents felt that local government, and various sub-divisions of local authorities should be identified specifically.

There was a general sense that the impending organisational re-structuring of primary care and public health will make it more difficult to know in advance who should be involved.

"There's so much change going to take place that it will be a challenge to work out who can do what, under new structures."
Public Health Observatory, National, Interview

When asked which other bodies should take action, participants sometimes interpreted the question in terms of who should be involved, rather than who should take responsibility. Other bodies and professional groups identified included:

- Local authorities
- Children services (because parents engage with these)
- Adult social care services
- Planning, transport, housing, and others who engage with the specific target group
- Local education authority

- Health and well being boards,
- Voluntary sector
- Public Health England
- Dieticians
- Local businesses
- Pharmacists

Online survey responses to recommendation 1

1 Respondents were asked to agree or disagree with a series of statements.

A total of 61 respondents who answered this question:
52 (85%) agreed with the statement 'this recommendation is clear and easy to understand.'
53 (87%) agreed with the statement 'this recommendation is relevant to me in my job.'
48 (79%) agreed with the statement 'this recommendation is useful to me in my job.'
43 (70%) agreed with the statement 'this recommendation will have a positive impact on the prevention of pre-diabetes among adults in high risk groups.'

2 Respondents were asked to rank in order (on a scale from 1-5 where 5 is the biggest), the challenges faced in implementing this recommendation. A total of 60 respondents answered this question.

The order of concern was as follows (scores out of 5):

- Funding 4.68
- Staffing levels 3.33
- Leadership 3.12
- Training 2.57
- Other 1.53

3 Respondents were also invited to add any other comments they had on the draft recommendation. 21 respondents provided comments. These focused on the following concerns:

- That there would be no incentive to implement this recommendation, and no requirement to assess/monitor its implementation.
- That while the recommendation requests a needs assessment be conducted, it does not state what should be done when gaps are found to exist.
- That the list of 'at risk' groups is too narrow, and should include other groups.
- That the recommendation is too vague and would benefit from specific examples of tools and effective interventions.
- That the perceived lack of funding/current climate makes this recommendation low priority

Recommendation 2 Developing a local strategy to prevent diabetes

Who should take action?

Commissioners and providers working in national and local public health services, in partnership with local health commissioners, including GP consortia.

What action should they take?

- Based on the joint strategic needs assessment, develop an overall strategy aimed at preventing diabetes. This should:
    - create local environments that encourage people to adopt a healthier diet and be more physically active
    - target specific at-risk communities
    - provide interventions for individuals who are deemed at particular risk (based on clear criteria about the level of absolute risk which would trigger this provision). (Please see 'Preventing the progression of pre-diabetes to type 2 diabetes in adults' for more on this.)
- Closely link the strategy to local activities and programmes to prevent other chronic diseases (including cardiovascular disease), improve physical activity levels and improve people's diets.

Clarity of recommendation

As with the previous recommendation, this was generally considered to be clear and understandable.

"Very clear. This is a really good recommendation."
Community Group, North West, Interview

The only concern on clarity related to a request that there should be more detailed guidance on how to produce a strategy to prevent diabetes.

"I think it would be quite good to have a sort of 'what should be in a strategy', being clear what the strategy should do, because a strategy means different things to different people. I'm just thinking back to the NICE guidance on obesity; it had a list of things that local authorities should do, and what I did with that NICE guidance was I built a template up. So it included the things local authorities should be doing and then, you know, and I found that really useful."
Obesity Lead, PCT, North West, Interview

Relevance and usefulness

Given the uncertainties about changes in primary care and public health structures and commissioning, the recommendation to produce a local strategy was welcomed as a means of ensuring prevention retained a status of priority.

"With all these changes, it is going to be ages until they have got their act together … so I think people like me get these (NICE) reports and it guides us really in the absence of any commissioning. You think, 'well that's the sort of thing we should be doing then'."
Community Dietician, PCT, North West, Interview

"It is worth doing this, because we shouldn't assume that prevention is taken care of just because people have existing Diabetes strategies and Obesity strategies."
Public Health Observatory, National, Interview

Link to national strategy, re-consider identified groups and access GP held data: another respondent felt that the recommendation was relevant and useful, but that it needed to be more specific. Particular concerns related to ensuring access to good quality data from GPs, linking the local strategy to a national strategy, and to identifying other high risk groups.

"Developing a local strategy is quite hard without the context of a national strategy... why is no national strategy recommended? I would like a family focus and developing pathways e.g. identifying pregnant women with high risk, families with low birth weight children, and families with behavioural issues, encouraging them into lifestyle courses. We need a clear link back to the GP - building a family centred approach is a starting point for any … strategy. This is generally good, relevant and useful, but needs to be more specific, e.g. how do we ensure good quality data from GPs, and role of QOF and expectations around that?"
Director of Public Health, PCT, Midlands, Interview

Some respondents questioned the need for any targeting on high risk groups, when the problems relate to the majority of the population.

"These communities that you would target are the same people that you are targeting for everything else... You are talking about lifestyle (and because) there is such a large proportion of the population affected that you don't always need to identify people at risk."
Director of Public Health, PCT, North West, Interview

Extend the scope to include other lifestyle-related conditions: related to the point above, several respondents felt that there should be a broadening of the scope of the guidance – and of this recommendation in particular – to cover other lifestyle-related conditions, in addition to diabetes.

"It sort of feels a bit narrow sometimes, just talking about diabetes. Because if you're going to prevent diabetes, the sort of interventions you put in place are going to reduce cardiovascular disease, cancer and things like that."
Obesity Lead, PCT, North West, Interview

Factors affecting implementation

Problems relating to implementation of the recommendation included the lack of funding, a history of short term projects and a history of poor co-operation among stakeholders. Several respondents were very concerned about the likely impact of the impending re-organisation of public health and of the reductions in funding.

Impact of perceived cuts to primary care and public health: strategic planning – and developing prevention activities in general - were considered to be likely candidates for being cut in the near future. It was felt that more pressing priorities would take precedence.

"In the current financial climate, (it's important) not to let those things go, be decommissioned or end, and then in three year's time when the dust is settled, the GPs going, 'What we need to commission is the kind of project you were running, oh sorry we made everyone redundant in 2011 when there was no money', and there is a real risk of that at the moment, that things haven't got enough profile to get prioritised or are not evaluated in the way that's recognisable to the Local Authority or public health professionals. Therefore, they will be seen as not cost effective - but they're exactly the kind of thing that do change community behaviour."
Focus Group, Manchester

"Just having the bodies to do it and, it's hardly kind of hitting a 'must-do' priority now. It's something that might happen in the future, so identifying someone to take it on board would be a real challenge."
Health Inequalities Lead, PCT, Focus Group, Hammersmith and Fulham

Lack of co-ordination of relevant personnel and agencies: another perceived barrier to implementation was the generally poor working relationships – and poor co-ordination – of relevant stakeholders who should be involved in strategy development at a local level.

"There's an issue of different bodies of people working in silos and not necessarily co-operating on this sort of local strategy."
GP, London, Interview

"I suppose that a lot of this is not things that GPs will commission, a lot of it is going to be down to public health in Local Authorities, and I think the difficulty is that those structures might not be in place in time and, you know, so even if the GPs don't want to commission lifestyle services, gym for free, all that kind of thing - there should be another body doing it. But that won't be in place very quickly."
Focus Group, Manchester

Need for explicit identification of leadership responsibilities: related to this was the sense that the recommendation needed to be more explicit about who should have responsibility for leadership to develop and implement such a strategy.

"The problem is, it is so uncertain at the moment what is happening with public health generally, and I think our experience with our childhood obesity and adult obesity work in the city is that if you don't have a key strategic lead on it, then it becomes quite piecemeal, and so I think what will impact on this is whether or not there is a champion… Obviously different people have different responsibilities but you need to know who the lead is on delivering local work."
Community Group, South Coast, Interview

Whether the necessary information, knowledge, skills and resources exist

Again, the main concern was worry about the human and financial resources available, in the context of reductions in resources to primary care and public health.

"Skills, knowledge and resources currently available, but where will they be after restructuring?"
Public Health Observatory, National, Interview

Other concerns included the question of data quality and access to relevant data. One Director of Public Health remarked that record keeping varies according to risk factor, with clinical factors recorded more systematically, but things like obesity and smoking behaviour much less likely to benefit from accurate records.

Given the landscape of shrinking resources, it was felt that it would be both efficient – as well as sensible from a public health perspective – to include other lifestyle-related conditions within the scope of strategic planning for pre-diabetes.

"Much will come down to prioritisation, so I would prefer a broader integrated strategy, because it becomes a difficult management job to keep adjusting staff training and priorities where new individual strategies come on stream. I mean obviously you've got, what, 5, 6, 7 priority conditions, diseases, that potentially you'll be impacting on with this guidance, another set of guidance, and it's actually about having the workforce that's flexible and knowledgeable enough to switch between priorities."
Physical Activity Coordinator, Local Government, London, Interview,

Potential impact

Broadly speaking, there was a general sense that strategy development was valuable and could help to improve both the quality and profile of prevention activity, mainly by providing a more systematic approach to current activities. At the same time however, there was a sense that it would be difficult – if not impossible – to assess the impact of this recommendation.

"This will have an impact. It would be very interesting to see, when developing the strategy, what the outcomes of that strategy will be, and then how easy it would be to measure those outcomes… so I think (as) with a lot of strategy, it will make a difference, but how we can measure that impact will be harder to establish."
NHS Weight Management, North West, Interview,

Overall, there was a desire to see something more 'disruptive' to bring about the kind of changes required.

"The guidance isn't 'disruptive or radical' enough to bring about desired behaviour change. I think what might enhance this is some call to be more innovative and disruptive in what's put out there, because otherwise, things aren't going to change. 10 years on, we're still debating why didn't people change their behaviour."
BME/Diabetes Prevention NGO, Focus Group, Hammersmith and Fulham

Is action required from other organisations not listed?

Most respondents felt that the same organisations identified at recommendation 1, should be included here too. In particular, local authorities should be included.

"There may need to be a more explicit inclusion of Local Authorities in the broad term national and local public health services."
Focus Group, Manchester

Online survey responses to recommendation 2

1 Respondents were asked to agree or disagree with a series of statements.

A total of 56 respondents who answered this question:
50 (89%) agreed with the statement 'this recommendation is clear and easy to understand.'
50 (89%) agreed with the statement 'this recommendation is relevant to me in my job.'
49 (88%) agreed with the statement 'this recommendation is useful to me in my job.'
43 (77%) agreed with the statement 'this recommendation will have a positive impact on the prevention of pre-diabetes among adults in high risk groups.'

2 Respondents were asked to rank in order (on a scale from 1-5 where 5 is the biggest), the challenges faced in implementing this recommendation. A total of 60 respondents answered this question.

The order of concern was as follows (scores out of 5):

- Funding 4.64
- Staffing levels 3.49
- Leadership 3.04
- Training 2.47
- Other 1.76

3 Respondents were also invited to add any other comments they had on the draft recommendation. 18 respondents provided comments. These focused on the following concerns:

- That there should be a link to other strategies on chronic conditions (CHD, obesity etc)
- That there is too little attention paid to industry, and the benefits to industry of diabetes prevention and obesity prevention.
- That specific information should be provided about how to target high risk groups.
- That the 'provision of intervention for those deemed at particular risk' would include access to a registered dietician for more tailored and specific advice regarding diet
- That new commissioners in GP consortia will not have the skills or expertise to undertake strategy development
- That the perceived lack of funding/current climate makes this recommendation unlikely to be implemented, and that funds would be needed to be attached to ensure it was implemented

Recommendation 3 Conveying messages about lifestyle and the risk of diabetes

Who should take action?

Commissioners and providers working in national and local public health services, in partnership with:

the NHS; local health commissioners and key staff within GP consortia (for example, GPs, practice and community nurses, dietitians, public health nutritionists and those working in ante and postnatal services); community pharmacists; and doctors and nurses working in acute and emergency care

local authorities: education providers and managers of leisure services

voluntary sector: community leaders, voluntary workers and those working for charities and non-profit organisations

those working in the commercial sector.

What action should they take?

- Work with practitioners, role models and peers from the local community to develop consistent, clear and culturally appropriate messages on how to prevent diabetes and giving details of the support services available.
- Ensure information is presented in a format that meets the community's religious, cultural, age, gender, linguistic and literacy needs. Address issues such as stigma and fatalism regarding the development of diabetes and the assumption that weight gain is inevitable in mid and later-life.
- When the opportunity arises, disseminate these messages and information to black and minority ethnic groups and lower socioeconomic communities. Use local newspapers, television and radio channels targeted at specific black and minority ethnic communities. Also make use of local shops and businesses, community workers and groups, educational institutions, workplaces, places of worship and local medical establishments, for example, hospitals.
- Offer communities support to improve their diet and physical activity levels.
- Ensure people at high risk of diabetes know how to access appropriate services.
- Consider running mass-media campaigns to raise awareness of the lifestyle changes that can help reduce the risk of diabetes (where possible and appropriate, utilise established national campaigns). These should highlight the need to reduce the amount of time spent being sedentary and highlight the importance of being physically active and adopting a healthy diet. Messages should aim to increase awareness of what constitutes an effective level of physical activity. They should also increase awareness of the calorie content of standard-portion sizes of energy-dense foods and drinks (such as confectionery, fast foods and sweetened drinks).
- Communication specialists should monitor media and other campaigns promoting the prevention of diabetes. This includes campaigns that generally promote a healthier lifestyle. They should establish relationships with broadcast and Internet-based mass and specialist media to ensure accurate information is communicated on the risks and how to prevent diabetes.

Clarity of recommendation

This recommendation was generally seen as being clear and understandable.

Relevance and usefulness

The recommendation was generally seen as being relevant and useful, although a number of participants noted that the balance of action and responsibility seemed tilted heavily towards the local level, with relatively little being asked of national bodies. These comments often focused on what was perceived to be unrealistic expectations for local mass media campaigns, and the absence of any recommendation for mass media campaigns nationally.

A minority of participants were disappointed that the recommendation did not contain what they considered to be new ideas.

"There was nothing new in here, it's just a list of what we should be doing anyway and what we do all the time."
Director of Public Health, North West, Interview

Factors affecting implementation

Support for community based approaches: the great majority of participants were very keen on the community rooted approach described in this recommendation. They were particularly pleased to see importance attached to community engagement, both in terms of developing messages and delivering them. This was seen as being the key to producing clear, understandable and culturally appropriate messages.

"Community development is the way to go."
Health Improvement Manager, North West, Interview

"(In the) Somalian community there are …. different types of Somalian community, you know there are huge cultural niceties in terms of how you do this. If you really want to get to the fine grain of the different cultures and families that are within these high risk groups."
Director of Public Health, Midlands, Interview

Cultural sensitivity in message development: the importance of community involvement in developing these messages was illustrated by one participant, who cited a "spare tyre" campaign aimed at promoting health checks among people in driving jobs. The metaphor of the "spare tyre" was apparently not well understood among many minority ethnic drivers, particularly those with limited English, who thought the campaign was related to vehicle safety.

Mass media – national and local: the most commonly expressed reservation about this recommendation related to the action point on considering the use of mass media campaigns. This was not thought to be achievable at a local level, and was considered to be a national responsibility. A small minority were sceptical about the effectiveness of mass media campaigns in general, but most did see a role for national campaigns, and sometimes cited Change4Life as a good example of a nationally led campaign designed for local areas to "piggyback" on to.

"The opportunity for mass media campaigns is reduced, certainly over the last two years. I think for me that… falls under the national stuff that comes at the end (recommendations 8 & 9)… Change4Life is a good example of a lot of the resources provided nationally, but they're used locally. I think it's unlikely that a local area is going to be able to put on a mass media campaign"
Public Health Manager, London, Interview

The reservations around the ability to deliver effective mass media campaigns at a local level where not only based on the issue of financial resources. A key concern was whether appropriate media channels existed with a footprint suitable for a local authority or PCT/GP consortia. It was pointed out that Chinese and Asian television channels are highly popular, but operate on a national or international basis. Another participant reported that community radio stations in her area were under tremendous financial pressure, and may not survive.

New media: the absence of any reference to online social media was remarked on by a small number of participants. Some thought that its absence may be due to the lack of firm evidence on effectiveness of this new media, but those mentioning it were all keen to use it. One participant reported that they had conducted a small but remarkably successful campaign on the subject of female genital mutilation in their local area, and this had alerted them to its potential.

Media planning for minority ethnic groups: the third action point of the recommendation encourages the use of, "local newspapers, television and radio channels targeted at specific black and minority ethnic communities", but the media expert interviewed, urged a more sophisticated approach to media planning with such communities. She recommended an integrated campaign at national and local levels, using both mass media and community champions, with "official" (i.e. government or NHS) involvement held in the background, with a view to stimulating a feeling of grassroots "ownership". She added that age makes a big difference to media consumption, with mainstream and online social media being the best way of connecting with younger adults, and more specialist "niche" media having more relevance with older members of communities.

"…. one of the mistakes that's been made in the past is just engaging ethnic media, just making the assumption that all these audiences do is consume ethnic media, and that is not true, mainstream media, social networking, all of the mainstream stuff is out there."

"A fully integrated approach is what is most effective, so you need your local radio, you need your community leaders, you need direct engagement, you need social networking, you need a 360 approach…. I do think mass media is really important, but again anyone of these initiatives on their own (is) weaker than they are together".

"(at a national level) you need to have a bit of "stardust" to something like this…. with all due respect you know to the NHS and …. Government ... (you need something like) a Bollywood Star or a (celebrity) chef."
Head of Social Campaigns, National Media Agency, Interview

Linking messages with behaviour change: some concerns were expressed that recommendation three did not explicitly make the link between conveying messages and giving people (or signposting them towards) behaviour change advice and support.

"It's not just a question of knowing it, it's a question of communicating that in ways that promote change of behaviour...the things that drive them to eat (unhealthily) are deeper than their fear of health problems."
GP, London, Interview

"they have to be able to do something with that information that's effecting their lives."
Obesity Lead, PCT, London, Interview

A more active tone: the third action point in the recommendation also specifies, "when the opportunity arises, disseminate these messages". A number of participants felt that this wording was too passive. They would have preferred a more proactive tone, along the lines of, "seek out opportunities to disseminate these messages". Nevertheless, one community engagement professional from the voluntary sector warned that there was a danger of undermining relationships with some members of the public. The Community Pharmacist interviewed also supported the more opportunistic approach as being appropriate in his role, where customers could take offence at unwelcome advice. It is interesting to note that the two participants supporting the more opportunistic approach were not NHS employees, and those favouring a more proactive approach tended to be in more mainstream NHS roles (e.g. GPs, nurses, health improvement professionals).

"'when the opportunity arises'...to me that kind of says, 'oh when you feel like it'."
Public Health Manager, PCT, London, Interview

"But is that about manners because (for example) hijacking their religious ceremonies is perhaps, you know, going too far, so perhaps ….make the bond and wait to be invited, and that's your opportunity."
Community Engagement Officer, North West, Interview

Consistency of messaging: it was felt to be very important that there be consistency in the messages conveyed. Several participants noted that ensuring consistency is not easy, particularly since optimal advice often changes over time. It was felt to be difficult even for health professionals to keep up-to-date with best practice and the latest knowledge, and even more difficult when considering the involvement of non-health professionals and volunteers.

Other groups: several respondents remarked that this recommendation should make reference explicitly to the needs of disabled people, particularly those with learning disabilities and mental health conditions.

Whether the necessary information, knowledge, skills and resources exist

There was almost universal acknowledgement that financial and human resources would be tight over the next few years, and that this was a potential barrier to effective implementation.

As noted above, there was considerable support for the idea of an integrated "healthy lifestyles" strategy, covering the prevention of diabetes, CVD, obesity and hypertension. Some of those supporting this view had specific concerns around the prospect of managing staff who had to understand and deliver a number of different, but related strategies. This was a particular concern for a couple of participants managing non-health professionals.

The final action point of this recommendation states that, "communication specialists should monitor media and other campaigns…" Some respondents felt that this was achievable within their organisation, although they were not clear how this would be done, nor exactly what the resource implications would be. Others raised concerns about whether this was achievable, especially since communications roles were vulnerable to cutbacks - and in one case had already been cut, leaving just one communications specialist in the PCT.

"I would love to know who 'communication specialists' are."
Commissioner of Antenatal and Postnatal Services, London, Interview

Some participants raised concerns about whether local government and public health were sophisticated in their understanding and use of the mass media. Allied to this, there was some recognition that the sector does not have a good understanding of how to use new media, i.e. online social media.

"sometimes (there is) locally a mis-match between the people who know about media and disseminating messages…and people who know about public health…sometimes they don't talk the same language."

"(social media)… *It's like the trendy thing, but nobody knows quite what to do with it."*
Head of Partnerships, PCT, London, Interview

One GP respondent had experience of broadcasting on local radio, which she felt was highly effective in reaching targeted communities. She noted however, that she had originally been nervous and lacking in confidence when the opportunity first arose. She recommended that media training should be made available for key health professionals, to build their confidence for such opportunities.

One participant said he would welcome advice within the guidance on how to put together a business case to justify investment in prevention of pre-diabetes. Another participant noted that significant investment was more likely if the work was able to communicate messages relating to a range of related lifestyle issues, addressing the "big killers".

Non-health professionals, such as those working in catering, education and the voluntary sector were identified as being often in touch with people from high risk groups, and as having the time and opportunity to talk about health and lifestyle issues. But they were also thought of as people who may lack the knowledge, confidence and resources to maximise these opportunities. It was felt that this could be delivered as a component in other training that they receive, or provided online, such as material for use in lesson planning.

Potential impact

This recommendation was welcomed as having significant potential impact by the great majority of respondents. Nevertheless, this positivity was mainly expressed with a caveat about the availability of resources necessary for it to be implemented.

Is action required from organisations not listed?

The most common remark made about the list of organisations required to take action was that it appeared to be NHS-led. This may reflect the fact that the NHS is the first organisation mentioned, and

several specific jobs within the NHS specified. In comparison, there is relatively little detail attached to the other sectors specified (local authorities, the voluntary sector and the commercial sector). It is clear that participants from a wide range of organisations believed that a broad spread of responsibility was appropriate for this recommendation.

Online survey responses to recommendation 3

1 Respondents were asked to agree or disagree with a series of statements.

A total of 52 respondents who answered this question:
51 (98%) agreed with the statement 'this recommendation is clear and easy to understand.'
47 (90%) agreed with the statement 'this recommendation is relevant to me in my job.'
45 (51%) agreed with the statement 'this recommendation is useful to me in my job.'
43 (83%) agreed with the statement 'this recommendation will have a positive impact on the prevention of pre-diabetes among adults in high risk groups.'

2 Respondents were asked to rank in order (on a scale from 1-5 where 5 is the biggest), the challenges faced in implementing this recommendation. A total of 60 respondents answered this question.

The order of concern was as follows (scores out of 5):

- Funding 4.51
- Staffing levels 3.67
- Leadership 3.04
- Training 2.47
- Other 2.06

3 Respondents were also invited to add any other comments they had on the draft recommendation. 23 respondents provided comments. These focused on the following concerns:

- That there should be an explicit reference to legislation as a means of impacting the food and drinks industry
- Pre-conception care is missing. This is a very important area for the ever growing number of women who are at risk of developing diabetes during pregnancy.
- I think the national campaign should be at the top of the list.

Recommendation 4 Targeting interventions at communities at risk of diabetes

Who should take action?

Commissioners and providers working in national and local public health services, in partnership with:
the NHS: local health commissioners and key staff within GP consortia (for example, GPs, practice and community nurses, dietitians, public health nutritionists and those working in ante and postnatal services); community pharmacists; doctors and nurses working in acute and emergency care; and occupational therapists
local authorities: including commissioners and managers, education providers and managers of leisure services, planning departments and public transport providers
voluntary organisations, community leaders and trained lay workers.

What action should they take?

- Work in partnership to develop physical activity, dietary and weight management interventions that are culturally appropriate for black and minority ethnic groups and lower socioeconomic communities. Identify any skills gaps and train or recruit staff to fill the gaps.
- Identify and address barriers to participation. This includes developing communication strategies which are sensitive to language use and information requirements.
- Use community resources to improve awareness of the key messages and to increase accessibility to the interventions. For example, involve community organisations and leaders at the development stage, use the media, plan events or attend festivals specifically aimed at black and minority ethnic groups. Also involve existing community groups or clubs, such as mother and toddler groups and local football clubs.
- Recruit lay workers from black and minority ethnic groups and from low-income communities to deliver interventions to prevent diabetes among these communities.
- Where necessary, train lay workers in how to plan, design and deliver community-based health promotion activities. Training should be focused, structured and based on proven training models and evaluation techniques. It should give participants the chance to practice new skills out in the community. It should also encourage them to pass on knowledge they have learnt to their peers.
- Lay workers and health professionals should identify '**community champions**' for example, religious and community leaders. They should encourage these champions to promote healthy eating and physical activity and, in particular, to participate in interventions to prevent diabetes.
- Encourage lay workers to recruit other members of their community.
- Ensure lay workers work as part of a wider team led by health professionals. They should be involved in the planning, design and delivery of credible and culturally appropriate messages13. This includes helping people to develop the practical skills they need to adopt a healthier lifestyle for example, by running cookery classes or physical activity sessions. Management and supervision of these activities should be provided by the health professionals leading these teams.
- Commission culturally appropriate weight management programmes either from the NHS or commercial providers. These should be provided in areas where populations at high risk of diabetes live and should be located in community settings (for example, mosques and social clubs).
- Ensure systems or initiatives used to assess individual-level risk in high-risk communities are culturally appropriate.
- Ensure identification and assessment systems or initiatives are linked to effective services and interventions for individuals deemed to be at high risk.

Clarity of recommendation

This was felt to be a long and multi-faceted recommendation, but only a small minority of participants considered it too long. Even these participants could see that splitting up the recommendation might cause other problems.

Given this, the recommendation was generally considered clear and understandable, with one major exception - the term "lay worker" was interpreted differently, by different participants. Some immediately made the connection with Health Trainers, but these were in the minority. Very often participants asked the direct question, "what does the term 'lay worker' mean?" In other cases the interviewer probed on this point, and found much confusion, particularly around whether this role would be paid or unpaid, and whether it referred to allied professionals (e.g. those working in sports centres), or members of the community. Those taking the latter interpretation were unsure about the difference between a "lay worker" and a "Community Champion". It was felt that clarity on what is meant by this term will need to be provided within the recommendation.

Relevance and usefulness

This recommendation was universally thought to be relevant and useful. There was no major criticism of its relevance or utility, although some participants did feel that it tended towards being a statement of good practice, rather than offering anything new. Existing programs such as Healthy Weight, Healthy Lives and Choosing Health were seen to cover very similar ground and to use similar methods.

Factors affecting implementation

Many Public Health participants felt that this recommendation was in line with current best practice, although sometimes they acknowledged that they were not always able to do all of these things. Participants from the voluntary sector were particularly enthusiastic about the recommendation.

"I thought (recommendation four) was better because it goes into more detail about how you actually… (work) with the local communities. And so I was … quite pleased with this bit."
Obesity Lead, PCT, North West, Interview

"This whole strategy would be fantastic if it had resources to go with it."
Healthy Eating Campaigner, NGO, Interview

"Go to the temples. Go to the mosque.... (they) will not say 'no' to you. I have been there already and they don't say no; they're only too grateful."
GP, London, Interview

Collaboration and co-operation: while nobody was opposed to working in partnership more closely with voluntary sector organisations (indeed most were very positive about this), there were some words of caution around the need to plan effectively for this way of working. The concerns were primarily around the commissioning model and the management of services delivered by non-professionals and volunteers. A small number of participants also questioned the evidence base for this approach.

Few participants had been involved directly in setting up or managing service delivery through voluntary sector organisations, but those with relevant experience emphasised the need for a thoroughly thought through, integrated and long-term relationship. The voluntary sector would welcome involvement from an early stage, rather than being brought on board after key decisions have been made.

"(Community partners) have to be integrated organisationally …. with those mainstream services, so they can't just operate in a free floating way…. So they have to link in with the general practices or they have to link in with the midwifery services. If they are just free floating they are just a wasted resource and it's very inefficient....it genuinely has to be a carefully thought through commissioning model (with long-term funding)."
Director of Public Health, PCT, Midlands, Interview

These concerns were reflected on the "contractor" side.

"The commissioning process locally hasn't worked for us as a leisure provider, we've not been commissioned by the PCT or the NHS to deliver any preventative services. We have (been involved) piecemeal, I mean we're talking very small pockets of money, a couple of thousand pound here and there, that's it really…. we've not been involved systematically in the commissioning process around prevention, so we have been like magpies, we've gone off to various different pots of money and small grants here and there to try and get things going."
Physical Activity Provider, North West, Interview

A similar experience was reported by the Coordinator of a BME specific voluntary project in the North West. She complained of short-term, "stop-start" funding, which meant that hard earned skills and relationships were lost, and had to be developed again from scratch at a later date.

Working with volunteers: a number of participants had experience of working with volunteers, and they had concerns around quality assurance and sustainability. They also pointed out that this was not necessarily a "resource light" option.

"We all know that managing volunteers, training volunteers, coordinating volunteer efforts is incredibly time-consuming and resource-intensive."
Physical Activity Development Manager, London, Interview

"(having unpaid volunteers) may make them sustainable from a financial perspective but they are not actually operationally sustainable, because the level of throughput and turnover that you get means that you are spending more money on training new people because it is like a revolving door...and quality assurance is a bit of a problem."
Commissioner of Antenatal and Postnatal Services, London, Interview

Leadership: practical concerns were raised about the challenge for NHS or local government being able to identify credible community leaders/community champions, the role of religious organisations, and ensuring that the personal conduct of "champions" is consistent with the messages they are being asked to convey.

"(Beware of) the assumption that if you are from a BME background you are automatically religious."
Community Engagement Officer, North West, Interview

"I think there is a small danger in approaching community leaders as well, because …. the definition of a community leader (can be) the loudest person in the community."
Focus Group, Manchester

"Does that community leader believe in the concept (of a healthy lifestyle)?"
Owner of Catering Business with African/Caribbean Specialism, Interview

Working with religious organisations: while it should be noted that there was a generally positive feeling about working with religious organisations, one (Asian) participant did sound a note of caution.

"Lots of Muslim communities are feeling quite resentful at the moment towards the Government …. people go to a Mosque or to a Gurdwara to pray , and it feels a bit like we are trying to shoe horn... a message (inappropriately)…. some people within these groups have a very strong faith and would not take kindly to somebody popping up and telling them about diabetes and weight loss ….at that moment."
Head of Social Campaigns, National Media Agency, Interview

Although these notes of caution were expressed about the role of places of worship, nobody doubted that religious organisations had a role to play in reaching members of BME communities, in that they enable very cost-effective population targeting. There was acknowledgement that this resource was not as effective in reaching low-income white communities, and to some extent the same was true of African/Caribbean communities. The relative shortage of similar focal points in these communities was considered a problem.

"the post industrial unemployed, what they have got is the pub and that's it, and very few health workers like going in and working in the pub."
Focus Group, Manchester

Questions about evidence: whilst not opposed in principle, to working more closely with community groups and lay workers, a small number of participants questioned the evidence base for such an approach. One participant said that she had checked the NICE guidance on obesity and this reported "equivocal evidence about using lay workers". Another participant was surprised to see the recommendation text be so specific as to recommend working with toddler groups and football clubs, and asked whether there is evidence around these specific settings.

Targeting versus population level approaches: the final two action points on this recommendation focus on the assessment of individual risk, and the signposting of services for individuals. A small number of participants (tending to be in senior Public Health roles) questioned the degree of focus on individual patients, given that such a high proportion of the population is at risk, particularly in deprived communities, and doubted that the level of engagement that these action points require from primary care would be deliverable. Some believed that there is reason to doubt whether GP Consortia will see this community centred approach as a priority, in the context of financial constraints. This led one participant so far as to suggest that, in her highly deprived area, a more universal approach would be more appropriate. Those inclined towards such views tended to feel that recommendations five and six would be more useful.

"When you have got, in older populations, if you have got 60% of the population that's inactive and 50% of the population that's obese, it's difficult to be targeted and I am not even sure we should be targeted."
Director of Public Health, North West, Interview

One participant from the voluntary sector complained about exclusion of the voluntary sector from the ninth action point, which calls for the commissioning of, "culturally appropriate weight management programmes either from the NHS or commercial providers."

Several participants remarked that this recommendation should include discussion of good practice in targeting disabled people, particularly those with learning disabilities and mental health conditions.

Whether the necessary information, knowledge, skills and resources exist

It was generally thought that the skills and knowledge required to implement this recommendation already existed, since the necessary actions were in line with existing practice, at least in terms of targeting, if not delivery through community groups and community champions to the degree envisaged. However there were significant concerns in relation to the likely availability of the necessary financial and human resources over the next few years, given the context of a real terms reduction in public spending. This view was common to both public and voluntary sector participants.

Challenges – recruitment, training and sustaining: it was felt that a major challenge will lie in identifying, recruiting and training a network of lay workers and community champions. As noted above, there were concerns around the sustainability of this approach, and in relation to quality assurance (i.e. concerned that there would be greater variability in the quality of message delivery, given that it would increasingly be delivered through non-health professionals).

Some respondents felt that the volunteer-based approach would prove to be problematic in more deprived areas, where those with the necessary skills and time were less likely to be looking for unpaid work. This is potentially a serious concern in any guidance aimed at low-income groups.

Several participants noted that there did not seem to be any reference to training for lay workers and community champions. Whilst this is not strictly true (the fifth action point in recommendation four addresses training to some extent), the phrasing "where necessary train lay workers" may be interpreted as suggesting that lay workers may not need any training, and of course, there is no mention of training for community champions.

Participants with roles closer to policy-making often pointed out the challenge they face in defining appropriate outcomes, and measuring performance for work of this nature. Related to this, those closer to the front line complained that targeted provision often suffers because Commissioners tend to judge success in terms of "bums on seats". Since work targeted at specific communities is often "niche" in nature, it can be difficult to deliver large numbers of clients, and this can lead to "stop-start" funding for these kinds of projects. It was suggested that NICE could produce guidance for Commissioners, to address this dilemma.

Potential impact

Opinion about the potential impact of this recommendation was evenly balanced between those who perceived a potentially major positive impact if it were implemented effectively, and those who felt it offered little that was new, and/or questioned the sustainability of the community based approach, particularly in terms of volunteer involvement, future resource availability and commitment from GP Consortia.

Is action required from organisations not listed?

Most participants welcomed the long list of bodies with responsibility to take action, since it reflected the broad range of services that could contribute to this work. However it was felt by some that leadership should be specified within the list, in order to avoid the risk of everybody thinking that somebody else was taking ownership. Some suggested that local authorities should lead, given that their services engage directly with most of the target groups.

Other comments about "who should take action" were quite specific, and tended to be mentioned by just one or two individuals.

- It was noted that the commercial sector was missing from the list, though it is mentioned in the actions
- It should be noted that leisure services are commonly contracted out to arms length bodies, which could be in the private, voluntary or public sectors, and they are not directly controlled by local government - perhaps the focus should be on the local government commissioners, rather than arm's-length providers
- There was a suggestion that Social Housing providers and Children's Services providers (e.g. Sure Start) should be included, because of their high level of engagement with the target groups
- One participant suggested that more clarification should be provided on the role of education providers, since this term covers a wide range of bodies, many of which are not under the control of local authorities, despite being included in this category

Online survey responses to recommendation 4

1 Respondents were asked to agree or disagree with a series of statements.

A total of 47 respondents who answered this question:
43 (91%) agreed with the statement 'this recommendation is clear and easy to understand.'
43 (91%) agreed with the statement 'this recommendation is relevant to me in my job.'
41 (87%) agreed with the statement 'this recommendation is useful to me in my job.'
38 (81%) agreed with the statement 'this recommendation will have a positive impact on the prevention of pre-diabetes among adults in high risk groups.'

2 Respondents were asked to rank in order (on a scale from 1-5 where 5 is the biggest), the challenges faced in implementing this recommendation. A total of 60 respondents answered this question.

The order of concern was as follows (scores out of 5):

- Funding 4.51
- Staffing levels 3.39
- Training 2.95
- Leadership 2.89
- Other 1.92

3 Respondents were also invited to add any other comments they had on the draft recommendation. 14 respondents provided comments. These focused on the following concerns:

- Concerns that funding would not cover the requirements identified and that freezes on recruitment were impacting service provision already.
- Complaints about the short term nature of funding in this area of activity.
- There was a concern that very few culturally appropriate weight management programmes had been assessed for efficacy.
- Ante - and post-natal care should be considered, and the training needs of midwives addressed for tackling obesity of mothers.

Recommendation 5 Creating local environments that support healthy food choices

Who should take action?

Commissioners and providers working in national and local public health services, in partnership with:
the NHS: including public health nutritionists, dietitians, commissioners and procurement teams
local authorities: including commissioners and managers, education providers and managers of leisure services, planning departments and public transport providers
voluntary organisations and community leaders.

What action should they take?

- Increase people's awareness of their eligibility for benefits and wider schemes that will supplement the family's food budget and improve their eating patterns. This includes free school meals, free school fruit and Healthy Start food vouchers. Also consider providing information on how to produce healthier meals and snacks on a budget.
- Work with local food retailers, caterers and workplaces to encourage local provision of affordable fruit and vegetables and other food and drinks that can contribute to a healthy, balanced diet.
- Ensure interventions such as cookery classes are provided at times to suit those with children (or provide a crèche). They should also take place in acceptable and accessible venues such as within children's centres.
- Local planning departments should strive to increase the opportunities available for local people to adopt a healthy, balanced diet by ensuring:
    - large and medium-sized food retail developments are readily accessible locally, either on foot or via public transport
    - planning policies restrict permission for less healthy food outlets in specific areas, for example, near to schools
    - planning policies take into account the needs of, and barriers faced by, particular subgroups14.
- Local authorities and the NHS should encourage local retailers that serve low-income communities to use subsidies (such as voucher schemes) and incentives (such as promotional offers) to promote healthier food and drink options. The aim should be to make the healthier choice the easiest and relatively cheaper choice. The retailers targeted may include street markets and small independent shops.
- Local authorities and the NHS should set an example as employers, by developing policies to prevent obesity, in line with existing NICE guidance and (in England) the local obesity strategy. For example, they should always promote healthier food and drink choices in restaurants, hospitality suites, vending machines and shops for staff and clients. (This could be achieved by using posters, pricing and positioning of products.)

Clarity of recommendation

This recommendation was thought to be clear and understandable. For some participants, some of the action points were unfamiliar areas of work (e.g. working with local retailers and caterers), and one participant felt it would be useful to include appropriate information sources, relevant standards and similar references.

There were some questions about the use of the choice of wording: the term 'healthy food' is used throughout this recommendation, and several respondents felt that the important issue was about 'healthy eating'. They questioned whether there was a value in talking about healthy or unhealthy foods, as the key consideration related to amounts of food eaten, not the definition of it in these terms.

Relevance and usefulness

This recommendation was viewed as being relevant and useful, though some participants regarded certain elements as aspirational, particularly in terms of the ability to influence the commercial sector.

"I agree with it, but it's very challenging."
Health Inequalities Lead, PCT, Focus Group, Hammersmith and Fulham

It was suggested that some of the detailed recommendations, such as increasing awareness of eligibility for benefits and the scheduling of interventions such as cookery classes, would be better placed in recommendation 3.

One participant questioned why there was no mention of encouraging allotments and food cooperatives.

Factors affecting implementation

Most of the discussion on implementation issues related to working with commercial food businesses, and influencing planning policy.

Suspicion about the motives of food and drinks industry: there was suspicion that the encouragement to work more closely with commercial businesses was politically motivated, and scepticism that those businesses had genuine motives for wanting to promote healthier food choices. Some participants expressed the view that unhealthy food is often very profitable, for both large and small businesses.

Scepticism about ability to influence commercial sector practices: some participants had experience of working with local cafes and take-aways, to encourage healthier eating. An example was provided in the North West, where businesses had been persuaded to change their salt shakers, reducing the amount of salt used by consumers. However few participants expressed great confidence in working with commercial businesses. Large-scale national businesses tended to be seen as somewhat inaccessible to local organisations, since they would not have decision-making capabilities at a local level. There were no long-term examples provided to illustrate strong relationships with smaller, local businesses. The most commonly expressed opinions tended towards either scepticism or pragmatic caution, in terms of the ability to significantly influence the commercial sector.

"I am not sure how we can exert leverage on the supermarkets, whether they can be persuaded to…. co-operate."
GP, London, Interview

"I suppose the big thing that was missing for me.. working with local food retailers and caterers, it was how do you actually convince a big food retailer to change, or even a small local retailer to provide affordable fruit and vegetables …. It sounds wonderful in the ideal world."
Commercial Health and Well Being Organisation, National, Interview

The second action point in this recommendation calls for joint working with local businesses to improve the availability of healthy food choices, but one participant pointed out that the most deprived areas are sometimes "food deserts" with few, if any, retailers to work with. Another participant suggested that

smaller supermarket chains like Londis and Costcutter would be better partners than the larger chains, because their "footprint" was better matched with low-income neighbourhoods.

The relationship with local food businesses was often through Environmental Health. Some participants reported strong links between Public Health and Environmental Health, but there is a need to be realistic about the resources that can be made available. Environmental Health departments have limited resources and their priorities are partly driven by statutory duties, restricting the flexibility in resource allocation.

The role of planning: differing views were reported in terms of confidence in the ability to use planning regulations to improve healthy choices - or at least to restrict unhealthy choices. Some participants said that their local Planning departments were very keen to use their influence in this way (Waltham Forest was cited as a leading example), and building political support was sometimes said to be the pre-requisite for this. More commonly, however, it was reported that local Planning departments believed their ability to influence in this way was very limited, without legislative change.

"Now, I've actually approached this with our local authority and I've challenged them to say, you know, would you stop …. a fast food outlet next to the school? And they've said, well ….. the national legislation doesn't cover it and that's what we use, so… it is harder to get your local planning policies changed if the national ones not got (that provision)."
Obesity Lead, North West, Interview

All participants agreed that the effective use of planning regulations to improve food choices was a slow process, since the opportunity to act depends on new applications being received.

One innovative suggestion was made in relation to the potential of "planning gain". This is often used to secure an element of social housing as a condition for a private development, and one participant suggested that it could be used with food retailers to secure investment in healthy food choices in low-income areas. The idea would be for planning permission granted for a large supermarket, on condition that a smaller branch is opened in a low-income/"food desert" area, with the stipulation that it provides healthy food choices.

Voucher schemes: the suggestion of introducing subsidised voucher schemes was met with some scepticism. One GP reported a successful local voucher scheme was currently in operation, but the more common response was negative, particularly in relation to the amount of funding that this would require. It was thought that local Public Health organisations would have to take a policy position on this matter, and it was unlikely that many would decide in favour of voucher schemes, unless clear evidence were available. (Note that this view may change if the private sector could offer financial support for such a scheme, but as noted above, there was also scepticism about the commitment of the private sector to the promotion of healthy eating).

"I just feel it wouldn't be possible on a large enough scale to subsidise food choices."
Director of Public Health, North West, Interview

Call for greater controls on promotion of unhealthy foods: a significant minority of participants would like to have seen a more explicit message about unhealthy choices being made more difficult to exercise. Examples suggested were restrictions on advertising and promotion of unhealthy food, and restrictions on unhealthy food being sold at community events. Those expressing these views believed that the

recommendation was too focused on the promotion of positive choices, and insufficiently focused on the option to restrict negative choices.

Whether the necessary information, knowledge, skills and resources exist

As with other recommendations there were concerns over the availability of human and financial resources to effectively implement this recommendation in the future.

This recommendation requires the development of various relationships which are not well established in all areas. In particular, there is a need to develop relationships with commercial businesses. As noted above, it is not considered realistic for local areas to work closely with large national businesses. The platform for improving relationships with local businesses depends on Environmental Health departments, and there is sometimes a need to develop the existing relationship between Environmental Health and Public Health.

The engagement of local Planning departments with this agenda, and their views on the extent to which they are able to help, seems to vary by area. It was suggested that securing local political support is the first step in achieving a more proactive response from Planning departments.

Potential impact

There was support for the principles behind this recommendation, but significant scepticism about the challenges to be faced in trying to implement it. In particular, these revolve around the likelihood of the private sector showing strong commitment to healthier food choices, and whether the relevant planning regulations are strong enough to achieve the goals set out, in a reasonable timeframe.

Is action required from other organisations not listed?

A number of suggestions and queries were provided about the list of those who should take action on this recommendation.

There was a strongly held view that clear leadership responsibility needed to be defined, and it was suggested that Local Authority Health and Well-Being Boards would be appropriate for this, and that the review and scrutiny functions of local government committees could be helpful.

Some participants asked why the commercial sector was not listed as taking action, despite the fact that a number of action points in the recommendation specify working with commercial businesses.

The voluntary sector is listed as needing to take action, but voluntary sector participants were not clear on which particular action points they were expected to act.

One participant pointed out that Social Service Day Centres feed and engage with large numbers of people in high-risk groups, and should be involved in acting upon this recommendation

Online survey responses to recommendation 5

1 Respondents were asked to agree or disagree with a series of statements.

A total of 46 respondents who answered this question:
45 (98%) agreed with the statement 'this recommendation is clear and easy to understand.'
42 (91%) agreed with the statement 'this recommendation is relevant to me in my job.'
40 (87%) agreed with the statement 'this recommendation is useful to me in my job.'
35 (76%) agreed with the statement 'this recommendation will have a positive impact on the prevention of pre-diabetes among adults in high risk groups.'

2 Respondents were asked to rank in order (on a scale from 1-5 where 5 is the biggest), the challenges faced in implementing this recommendation. A total of 60 respondents answered this question.

The order of concern was as follows (scores out of 5):

- Funding 4.51
- Staffing levels 3.36
- Leadership 3.14
- Training 2.85
- Other 2.38

3 Respondents were also invited to add any other comments they had on the draft recommendation. 13 respondents provided comments. These focused on the following concerns:

- There was strong support for this recommendation but scepticism that it could be enacted locally. Several comments called for national government action – particularly in relation to working with the major food retailers.
- There was a call for ensuring that people eligible for benefits should be able to access these without fear of risking their anonymity.
- There was also a call for hospitals, schools and leisure centres to promote health eating and healthy food choices, and to regulate the use of vending machines.

Recommendation 6 Creating local environments that support physical activity

Who should take action?

Commissioners and providers working in national and local public health services, in partnership with:
local authorities: including local planning departments
the NHS: including commissioning and procurement teams.

What action should they take?

- Local public health services should assess the type of physical activity opportunities needed locally and at what times and where. They should consider social norms, family practices and any fears people may have about the safety of areas where activities are sited (this includes fears about how safe it is to travel there and back).
- Local public health services should map local physical activity opportunities against local needs and address any gaps in provision.
- Local authorities should ensure council-run leisure services are affordable and acceptable to those at high risk of developing diabetes. This includes providing affordable childcare facilities and public transport links. It also includes ensuring the environment is culturally acceptable. For example, local authorities should consider the appropriateness of any videos and music played. They should also consider providing single-sex facilities, exercise classes, swimming sessions and walking groups – for both men and women.
- Local planning departments should ensure:
    - planning policies provide for physical activity in safe locations that are accessible locally either on foot or via public transport
    - the local infrastructure encourages people to be physically active as part of their daily routine (for example, by allowing them to walk to the shops and work)
    - the internal infrastructure of buildings encourages physical activity, for example, by encouraging people to take the stairs rather than the lift.
- Local authorities and the NHS should develop 'active travel' plans for their staff and visitors to encourage them to opt for healthier modes of transport to and from their premises. Walking and cycling can be encouraged by providing showers and secure cycle parking. Signposting and improved decor could encourage them to use the stairs rather than the lift when at work. In addition, people could be encouraged to be active in lunch breaks and at other times, through organised walks and subsidies for local leisure facilities.
- Local public health services should provide information on local, affordable, practical and culturally acceptable opportunities to be more active. If cultural issues affect people's ability to participate, they should work with them to identify activities which may be acceptable. (This may include, for example, single-gender swimming or exercise classes and Asian dance classes.)
- Local public health services should work with local employers to implement, and increase employee's awareness of their eligibility for, 'salary sacrifice' and other schemes that promote physical activity in the workplace.

Clarity of recommendation

This recommendation was generally considered clear and understandable. Nevertheless it should be noted that the term, "salary sacrifice" (in the final action point) was not well understood.

Relevance and usefulness

This recommendation was thought to be relevant and useful by most participants, although considered somewhat aspirational in the current funding climate. Some believed that it focused too much on formal facilities, and not enough on informal and non-sport (e.g. dance) opportunities for physical activity, such as walking, cycling and the creation of open/green spaces within easy reach of neighbourhoods where target groups reside.

Factors affecting implementation

The key concerns around implementing this recommendation related to funding and commissioning.

Availability of resources: the most commonly expressed reservation was the availability of financial resources to achieve these goals, particularly in relation to the third action point, concerning the affordability and acceptability of local leisure services. Participants feared that there would be significantly reduced funding for social objectives within leisure services, in the next few years.

"How practical is this, and are there funds to subsidise some of this activity?"
Physical Activity Development Manager, London, Interview

Changing priorities and re-organisation of primary care and public health: one GP added that the forthcoming re-organisation of the NHS was likely to make it harder for long-term prevention issues to be regarded as a spending priority, at a time of financial constraint. His concern was that GP Consortia may think of "prevention" in terms of short-term factors like reducing hospital admissions, rather than longer-term prevention with less tangible savings.

"Yes I think again (the challenge) is balancing (recommendation six) and the conflict with shorter term aims… GP consortia are just trying to get their head round… what we are suddenly being asked to do. It's quite a job actually to keep your head above the water with what we've got at the moment, let alone taking on any extra work. So I think that's one of the challenges really, how to implement this. "
GP, London, Interview

Several participants mentioned that funding for free/low-cost physical activity in leisure centres was being withdrawn. This included the funding for free swimming for children and over 60s. These schemes were considered to have been effective in reaching target groups, with low-income parents accompanying children to swimming sessions. Note that, as mentioned in the overarching findings, the family-based nature of many physical activity opportunities was not thought to fit well with the exclusion of children from the scope of this guidance.

Some participants said that provision of single sex sessions and other culturally specific facilities incurred additional financial risk. For example, lower attendance at "niche" sessions often results in reduced income, and as noted earlier, it can be more difficult to demonstrate success of an intervention by the

crude measure of the numbers attending sessions tailored around the needs of a minority of the population. A Public Health Manager pointed out that this was less of a risk if the area had a high population from the targeted group, (e.g. Muslim women), but that targeted funding could also help to overcome some of the practical barriers. He cited the example of NHS funding for training female lifeguards, which then ensured that sufficient female staff were available to allow regular women only sessions. Other examples of investment to encourage physical activity among target groups included provision of a minibus and "buddying" (i.e. pairing people to enhance confidence in going for walks, attending the gym or swimming session, etc).

Despite this targeted funding in recent times, those providing physical activity opportunities did not feel that the potential of their services had been employed to maximum effect. One manager of an "arms length" leisure provider expressed his frustration at the difficulty of negotiating the commissioning process.

I've …been really fighting hard on the prevention agenda, so I've used the NHS guidelines, which are very clear about the savings around prevention, but even though partners and commissioners are aware of this there's still …..a reluctance to take the risk in terms of investing in prevention to a great degree. …. the money needs to come from somewhere. Local authorities aren't going to provide it, it needs to come from government and it needs to come through the NHS….. It needs to be ring fenced, and it needs to be invested appropriately, and it needs to get through to the delivery agents, ...but in the current climate I'm facing a 30% cut from our leisure services department".
Physical Activity Provider, North West, Interview

Outcome measures for physical activity: this manager would very much welcome the development of standard outcome measures for physical activity, which would be commonly accepted by those in the health and leisure professions. Another leisure manager cited the lack of consensus around appropriate outcome measures to have been the main factor leading to the withdrawal of local funding for a successful GP referral service. These physical activity professionals considered the issue of outcome guidance to be a pre-requisite for more effective commissioning practices.

Poor coordination of relevant stakeholders: still on the theme of ineffective commissioning, the same manager complained about lack of coordination in local efforts to promote physical activity. The scenario painted in the quote below possibly has implications for the debate around whether the prevention of pre-diabetes should be the subject of an independent strategy, or integrated with related strategies.

"quite often you've got multiple partners within an area with overlapping programmes, …. Teams within NHS or with a local authority doing something similar, you've got other private partners trying to jump in with things, or national charities coming in, and this is where the efficiencies and the savings can be made, and also the impact can be improved. But again that comes around to local governance and how you're actually managing the commissioning process."
Physical Activity Provider, North West, Interview

A focus on food over physical activity? Some participants believed that engaging the most deprived, low-income BME communities in physical activity was a particularly difficult challenge, and that the emphasis for these groups should be more strongly focused on diet. The key issue, from this perspective, was the availability of time, since some of the most deprived communities are working long hours for low pay, and this is compounded by language barriers and social isolation. One participant summarised this situation,

with specific reference to the Chinese community.

"And they will work, work, work, …. They're scared of going to the swimming pool because they can't buy the ticket, they can't speak English."
Voluntary Sector Manager, BME Community Group, North West, Interview

This participant added that most workplaces were unlikely to facilitate access to these groups, because of concerns about business disruption. She did qualify this by saying that a small number of the better employers may help, as they sometimes do by allowing English language classes to take place in the workplace, but this would not be the norm. The only realistic point of engagement with such marginalised groups is the (ethnically focused) community centre. By working with the community centre in a long-term, jointly planned relationship, it would be possible to deliver some physical activity on site, and to build confidence in marginalised individuals through initiatives like buddying and partnerships with other community groups, such as churches.

Informal physical activity: as noted above, some participants believed that the recommendation should give greater emphasis to informal physical activity opportunities, such as walking, cycling, and provision of open/green spaces in targeted communities, as well as non-sports activity such as dance. Play streets were specifically mentioned as being success in encouraging physical activity among both children and adults. These participants strongly welcomed the inclusion of community safety issues among those to be considered, as these were thought to be major factors inhibiting the confidence of those in low-income neighbourhoods, in terms of walking and other outdoor physical activities/recreation. However some were concerned that public expenditure cutbacks would lead to a deterioration in the maintenance of public infrastructure, with less resources to deal with graffiti and vandalism, and closure of community facilities, possibly leading to increased fear of crime, whether real or perceived.

"(The recommendation mentions) safety of areas, (and) I really welcome inclusion of fear of crime, because that drives behaviour hugely in low income areas, whether it is real or perceived it is a big barrier".
Focus Group, Manchester

Planning: the recommendations for action by Planning departments were welcomed by most participants, one of whom mentioned the Building for Life standards which her local authority applied, but could not enforce. Indeed there was some scepticism on whether the powers existed to ensure that developers listen to Planners, on details such as the location of the stairs and lifts. Nevertheless, the fact that these points would be made in NICE guidance was seen a positive in itself by some, as it would create an opportunity for those promoting physical activity to engage with their Planners.

Changing provision – impact on mapping: finally, one participant warned that mapping local physical activity opportunities was, in his experience, a resource-consuming and difficult task, because provision changes rapidly. He thought that the development of an approved quality standard, with encouragement for leisure providers to sign up to it, would prove more beneficial than trying to take a snapshot of the moving landscape of provision.

Whether the necessary information, knowledge, skills and resources exist

As has been described, there are widespread doubts about the availability of sufficient funding, particularly in relation to the third action point on this recommendation.

There are also doubts over whether Planning departments have sufficient powers to ensure implementation of all elements of the fourth action point.

In terms of skills, there was a strong plea made by a Director of Public Health for the training of Fitness Instructors and Leisure Centre workers to provide a better understanding of cultural issues, and of working with non-traditional sports participants, such as older people. She felt that existing training, such as that provided on sports science degrees, concentrated on elite performance, and neglected the role of physical activity in public health, and particularly neglected engagement with marginalised groups. She reported that her PCT had had to fund in-service training of Leisure Centre staff on these issues, but that this would not be possible in a tightening financial climate, and that the rightful place for such teaching was as part of basic training.

Potential impact

There was little disagreement expressed in terms of recommendation six, but it was regarded as aspirational. On balance, most participants felt that it would have relatively little impact, because it was unlikely to be fully implemented in an era of severe financial constraint.

There were also doubts about the lack of targeting in some elements of this recommendation, particularly around some of the actions for Planners. For example, it was claimed by one participant that encouraging the use of stairs rather than lifts in new developments may raise physical activity levels overall, but would have a negligible impact on high-risk groups.

Is action required from other organisations not listed?

Participants commented that this seemed a very short list of "who should take action". Suggestions for additional organisations to have responsibility on recommendation six included the following:

- Transport planners in regional transport organisations
- The voluntary sector, including bodies delivering physical activity, catering for specific high-risk communities, managing community spaces etc
- Regeneration bodies in the public and voluntary sectors
- Specific local government departments including Leisure/Sports/Parks, Youth services, etc
- Schools with community recreation facilities (e.g. the Extended Schools programme)
- The fitness industry

Online survey responses to recommendation 6

1 Respondents were asked to agree or disagree with a series of statements.

A total of 41 respondents who answered this question:
39 (95%) agreed with the statement 'this recommendation is clear and easy to understand.'
32 (78%) agreed with the statement 'this recommendation is relevant to me in my job.'
30 (73%) agreed with the statement 'this recommendation is useful to me in my job.'
32 (78%) agreed with the statement 'this recommendation will have a positive impact on the prevention of pre-diabetes among adults in high risk groups.'

2 Respondents were asked to rank in order (on a scale from 1-5 where 5 is the biggest), the challenges faced in implementing this recommendation. A total of 60 respondents answered this question.

The order of concern was as follows (scores out of 5):

- Funding 4.59
- Staffing levels 3.14
- Leadership 3.11
- Training 2.75
- Other 2.55

3 Respondents were also invited to add any other comments they had on the draft recommendation. 20 respondents provided comments. These focused on the following concerns:

- There was support for this recommendation but concern that the promotion of physical activity represented a significant challenge in the current economic context.
- The infrastructure of towns and cities was identified as a barrier to the uptake of physical activity, and there were calls for improved community safety to address this.
- The importance of cycling schemes (bike hire, better bike parking, off road safe routes) were mentioned.
- The absence of the fitness industry was identified as an omission from 'who should take action'.

Recommendation 7 Training health professionals

Who should take action?

Commissioners and providers working in national and local public health services, in partnership with:
the NHS: local health commissioners and key staff within GP consortia (for example, GPs, practice and community nurses, dieticians, public health nutritionists and those working in ante and post-natal services); community pharmacists; and doctors and nurses working in acute and emergency care
royal colleges and professional associations, further and higher education training boards, and other organisations responsible for setting competencies and developing continuing professional development programmes for health professionals
local authorities: including education providers and managers of leisure services
voluntary organisations: including community leaders and voluntary workers
those working in the commercial sector.

What action should they take?

- Ensure all health professionals are trained to identify people from communities at increased risk of developing diabetes. They should also be trained to understand the cultural, religious and economic influences on these communities. Ensure they are given time and support to develop and maintain these skills.
- Monitor health professionals' knowledge and awareness using, for example, personal development plans and annual reviews.
- Ensure curricula and continuing professional development programmes for health professionals incorporate the knowledge and skills needed to ensure health promotion interventions are culturally sensitive.
- Ensure medical undergraduate training covers nutrition, physical activity and weight management in relation to the prevention of type 2 diabetes.
- Ensure training is focused, structured and based on proven models and evaluation techniques. It should offer opportunities to practice the new skills out in the community. It should also help health professionals to spread their knowledge among colleagues.

Clarity of recommendation

Generally respondents thought this recommendation was very clear, although there was some uncertainty as to the role of the commercial and voluntary sector.

Relevance and usefulness

This recommendation was considered very relevant to the issue of prevention of pre-diabetes. It was viewed positively because there was widespread concern that current levels of knowledge among some professionals were inadequate.

"It should be part of appraisal or something like that ...because it is a huge problem... a lot of professionals don't understand what obesity does to you."
Obesity Lead, PCT, North West, Interview

Striving for consistency: many participants supported the idea of continuous professional development. They believed that training should be updated regularly, especially on subjects like nutrition advice, in order to understand and counter the myths that evolve over time, and to enable consistent messages to be given out by professionals. It was thought that training should include experienced, qualified medical professionals, because one of the reasons for current inconsistency was that optimal advice has changed over time, and some professionals based advice on training that was now out of date.

"Very relevant, because there is a problem with inconsistent advice being given."
CVD Lead, PCT, North West, Interview

"… everybody should be conveying the same message, because that is not happening, everybody is selling a different message."
Practice Nurse, PCT, London, Interview

One Director of Public Health said that the recommendation was currently aspirational, but such aspirations were important in raising standards. Another participant, while supportive of the recommendation, qualified this support by emphasising that other actions should not be delayed while details of consistency were fine tuned.

"I think it is an important recommendation from a consistency point of view ... but I wouldn't want people to get hung up on it though and to stall action."
NHS Weight Management, North West, Interview

Practical application of training: several participants felt that the recommendation should also include a need for competencies gained from training to be specified and monitored. There was also a view that training needs to equip the professional to put theory into practice.

"Very pleased to see things about undergraduate training… It's great that there's medical undergraduate training covering nutrition and physical activity and weight management. That's fantastic. But there needs to be something that explicitly states that this needs to be applied."
CVD Lead, PCT, North West, Interview

"So there's a line that says 'ensure all health professionals are trained to identify people from communities at increased risk (etc).' And I thought, well, what do they then do after they've identified them? Are we going to also train them in delivering brief interventions?"
Obesity Lead, PCT, North West, Interview

One participant asked why the recommendation made no mention of the relevant work already done by Skills for Health, around such competencies.

Narrow focus on medical professionals: it was suggested by numerous participants that more emphasis be given to the training of non-medical staff and volunteers - such as non-professional pharmacy staff and community lay workers.

"Seems a bit 'Dr limited'."
Director of Public Health, PCT, Midlands, Interview

"It is quite clear (on) medical undergraduate training,.. but it's got voluntary organisations and those working in the commercial sector and again (I'm thinking) ' how would they be trained, how would we work together to do that?'"
Commercial Health and Well Being Organisation, National, Interview

There was a request to ensure that post graduate training was also included in the recommendation.

Many participants believed that the recommendation should be broadened out beyond health professionals, particularly because some at risk groups engage with non-health professionals more effectively than with health professionals. Note that training element of recommendation four ("Where necessary, train lay workers…") was sometimes missed by participants, perhaps because it was not prominent in a fairly long list of actions, nor assertively phrased, and there was confusion around what was meant by "lay workers".

"It's very limited to the health sector. Whereas I think a whole lot of people gain advice and information from other sources…. some people are still terrified of going to their GP."
Physical Activity Coordinator, Local Government, London, Interview

Factors affecting implementation

Funding priorities: concern about the lack of funding allocated to training was the main factor identified as likely to affect the implementation of this recommendation. This was true across the broad range of different sectors participating, and some believed that this reflected a lack of priority for public health and prevention work.

"I agree with all of (the recommendation) but I would say there's very little of it happening. The focus in the health fields is largely on illness still."
Physical Activity Coordinator, PCT, Focus Group, Hammersmith and Fulham

There was a concern that over the past decades training on health promotion had 'fallen off' the curriculum of medical students, because of the emergence of more urgent demands.

"*… we used to have health promotion… a sort of update on the health promotion messages in their annual refreshers, but that's been taken out to deal with something else that's considered more urgent…. it isn't seen as urgent enough because nobody is going to die tomorrow because you haven't done this... I think it needs to be really pushed quite hard."*
Health Inequalities Lead, PCT, Focus Group, Hammersmith and Fulham

In order to address the problem of low priority, some participants thought that there was a need to demonstrate the cost effectiveness of health promotion to commissioners.

"Some good economic models that could show the potential benefits of health promotion, health improvement.... otherwise it's quite hard to persuade healthcare providers to invest in this kind of training."
Assistant Director Partnerships, Diabetic Pathways, PCT, Focus Group, Hammersmith and Fulham

Smarter ways of delivering training: some thought that training should be more embedded into the appraisal system and suggested consideration be given to 'smarter' ways of delivering what was already available.

"I suppose one of the pitfalls of not ring fencing budgets is that people use the training budget for something else, so in terms of policy I think the issue is around providing dedicated resource for training… (we need to look) at smarter ways to deliver your training in house and other things, such as mentoring and supporting staff on the job ... which should be part of their regular appraisals."
Physical Activity Coordinator, Local Government, North West, Interview

Supporting sectors: participants reported that in some sectors, such as education and catering, front-line staff had opportunities to discuss with students/customers about healthy eating on a regular basis. However, it was said that there was little support available in terms of training or advisory materials. In Further Education the most practical means of assisting these workers would be through course materials being made available (e.g. online), and in catering there were opportunities to work with training organisations serving this sector.

Whether the necessary information, knowledge, skills and resources exist

Training on behavioural change: there was a view that there was limited training provided to medical staff on behavioural interventions and that the training provided to medical undergraduates should include specific knowledge on behaviour change. However, it was unclear who would be responsible for making sure this happened across the country.

"I think the key thing really is training people in behaviour change.... I mean (GPs) don't necessarily do particularly well, we are not very specific on the whole about how we encourage people to lose weight. We say, 'oh you need to lose more weight' but we don't give specifics."
GP, London, Interview

"A lot of the work that's happened in London around physical activity is about trying to give GPs and medical staff the capacity to do a brief intervention in a cost effective way about how you raise the topic..... you know, you don't just tell people to change their behaviour."
Community Dietician, PCT, North West, Interview

Some participants would encourage professionals to go beyond giving messages, and to help people change their behaviour. Some PCTs had sent a number of staff on social marketing/behaviour change courses and were adapting materials to be used by professionals in their area.

Training in cultural sensitivity: this was seen as essential in bringing about changes in behaviour among people in high risk groups, but was thought to be lacking in the existing training provision.

"If you don't understand the health belief of that culture then it doesn't matter what you tell them, they're not going to change. So, for instance, in my culture it's believed that you're healthy and you're wealthy if you're round. Now, how are you going to change that? And how are you going to implement some of this if that's what I believe?"
BME/Diabetes Prevention NGO, Focus Group, Hammersmith and Fulham

One senior public health participant identified physical activity staff (e.g. leisure centre workers and fitness instructors) as particularly lacking cultural sensitivity, and as being unfamiliar with social groups not traditionally associated with sport and physical exercise, e.g. older people. Her PCT had funded in-service training for leisure centre workers and cultural sensitivity, but she was clear that funding would not be available for this sort of initiative in the next few years. Hence, she thought it was important that these issues should be incorporated in basic sports science and leisure industry training.

There were suggestions that while training in all forms of cultural difference was impractical for every individual already in post, there should be training about the specific needs and customs of the groups resident in the area covered by the local health service.

"you couldn't really expect everybody to be an expert on every single type of culture … but maybe that should be included once you are in a placement and then be specific for that population..... it is more or less trying to get that process in people's heads. If you are going to interact with Afro Caribbean men you have to understand their lifestyle first before you start doing that."
Practise Nurse, PCT, London, Interview

Another important consideration, was that professionals were perceived as stereotyping people from minority ethnic groups in particular – so that important differences within groups, that may be relevant to the targeting of prevention activities, were frequently missed.

*"I think in the past what we've seen is professionals for simplicity sake saying, 'where is this person from?' Take me and (*another speaker*), we're both Indian, you could put us into the same box but actually I have beliefs that will be completely different. And the segmentation work that you can do to underpin that should be available and that analysis should be done at a national level."*
BME/Diabetes Prevention NGO, Focus Group, Hammersmith and Fulham

Understanding the reasons why people make certain choice was also important.

"In the lower socioeconomic groups, they might feel that it's important to fill up on starchy foods because they can afford them - they're cheaper"
BME/Diabetes Prevention NGO, Focus Group, Hammersmith and Fulham

Potential impact

The main impacts that were identified for this recommendation were as follows: improved knowledge among professionals leading to greater consistency of messaging provided by this group, improved understanding of the needs of different people from the high risk groups, and improved knowledge about how to develop and implement behaviour change interventions.

Nevertheless, there was significant scepticism about whether the necessary funding would be made available for this training.

Is action required from organisations not listed?

Suggestions for additions to the list of organisations focused on the desire to extend the scope of the recommendation beyond health professionals. Thus, there were mentions of those working in children's services (but engaging with high risk adults), lay workers, community champions, pharmacy technicians and those in the leisure/physical activity sector.

One participant questioned whether public health should lead on this recommendation.

"You can't have public health leading on something that you are then going to monitor through PDPs (personal development plans), it's just entirely unworkable."
Director of Public Health, PCT, North West, Interview

Online survey responses to recommendation 7

1 Respondents were asked to agree or disagree with a series of statements.

A total of 46 respondents who answered this question:
44 (96%) agreed with the statement 'this recommendation is clear and easy to understand.'
43 (93%) agreed with the statement 'this recommendation is relevant to me in my job.'
40 (87%) agreed with the statement 'this recommendation is useful to me in my job.'
37 (80%) agreed with the statement 'this recommendation will have a positive impact on the prevention of pre-diabetes among adults in high risk groups.'

2 Respondents were asked to rank in order (on a scale from 1-5 where 5 is the biggest), the challenges faced in implementing this recommendation. A total of 60 respondents answered this question.

The order of concern was as follows (scores out of 5):

- Funding 4.00
- Staffing levels 3.31
- Training 3.20
- Leadership 2.93
- Other 2.69

3 Respondents were also invited to add any other comments they had on the draft recommendation. 12 respondents provided comments. These focused on the following concerns:

- Several respondents lamented the inconsistency of message giving by health care professionals.
- There were calls for consistency of training, and of message giving by professionals, together with requests for examples of how to provide training for different professional groups.
- There were also calls for training on motivational interviewing and behaviour change theory to be included.
- A single comment stated that training had been shown to be ineffective, and that the solution would be to introduce health and fitness practitioners into primary care teams.

Recommendation 8 National-level action to promote an environment that supports a healthy diet

Who should take action?

Commissioners and providers of national and local public health services in the public and private sector.

What action could they take?

Identify and work with a range of commercial partners to promote the provision of healthier food choices. For example:

- Work with food manufacturers to change the composition of prepared foods where needed. This could include reducing the calorie, fat and salt content through product reformulation.
- Work with caterers to help them provide healthier food and drink choices as the default option.
- Work with food retailers to develop pricing structures that favour healthier food and drink choices and to ensure there is a broad range of portion sizes on sale, particularly for energy-dense foods and drinks. The aim is to allow greater consumer choice.
- Work with food manufacturers, caterers and retailers to provide clear, non-ambiguous and consistent nutrition information. This includes prominent displays of calorie content on the front of packaging and the use of clear signage for unpackaged foods.
- Support the development of home cooking resources which give information on the nutritional content of foods prepared at home and offer practical advice on preparing healthier meals. (Resources might include websites offering recipe suggestions.)

Clarity of recommendation

The recommendation was generally considered to be clear. However, it was felt important that there was clear cross-referencing of this recommendation with recommendation five.

One participant said it would be good to mention "nudging" - i.e. what can you change in the environment to make it easier for people to choose the new, healthier "default" option mentioned in second action point.

Relevance and usefulness

Many participants considered this to be a very important recommendation.

Working with the food industry: working with food companies and retailers, to argue the case for healthier foods, was seen as pivotal to the success of all the other recommendations.

"Working with the food companies to reduce the amount of sugar, salt etc in food needs to happen, because it has got a bigger impact in one fell swoop than anything done locally."
Community Food and Nutrition Group, NGO, Interview

Similarly working with retailers to develop pricing structures that favour healthier food was considered essential.

"I couldn't agree more."
GP, London, Interview

Some participants noted the absence of any mention of encouraging legislative change, and thought this was a significant omission.

"If we want to effect a change against decades of trends of reducing physical activity and eating the wrong foods, then there needs to be national legislation. I think that would be a very strong recommendation, obviously highly sensitive, but I do think we're probably at a stage where it needs to be in there.....if you're looking at diet for example, if you're looking at taxation, there needs to be something in there to encourage people to make the right choices."
Physical Activity Coordinator, Local Government, North West, Interview

"It completely steers away from anything that relates to legislation…... it feels quite weak...you would hope we'd have a few more teeth at national level."
Director of Public Health, North West, Interview

The role of planning departments: the rise in the number of fast food outlets was mentioned by several participants who believed that national level action would help local authorities to restrict their growing number.

"I think one of the big areas which is missed in this is the rise in fast food outlets on the street now .... pretty much every other shop is going to be a fast food chicken shop, burger shop. I don't know whether at local authority level there is some sort restrictions on certain outlets."
Physical Activity Coordinator, Focus Group, Hammersmith and Fulham

Echoing their response to recommendation five, some participants said that their local planning departments were very keen to use their influence in this way (Waltham Forest was acknowledged as a leading example), and building political support was sometimes said to be the pre-requisite for this. More commonly, however, it was reported that local planning departments believed their ability to influence in this way was very limited, without legislative change. All participants recognised that change achieved through planning regulations would be slow.

National versus local agenda: this recommendation is clearly labelled as "national", and yet it seemed to require action to be taken by local and private sector public health agencies. This was found to be confusing, and these references may need to be removed or explained.

As currently written, there was perceived to be some ambiguity about who should, and indeed who could realistically, take the actions identified. Participants were clear in saying that much of this responsibility lay at the national level, not least because national and international companies will not want to be dealing with 150+ PCTs/GP consortia.

"It has to be in a national context, because unfortunately the food and drink industry don't need us to, do they? …. So there has to be something national to make them do these things which are not necessarily to benefit their profits."
GP, Focus Group, Hammersmith and Fulham,

“Government communications with the food and drinks federation…. I don’t think you can actually have that much impact on a local food retailer or even the big ones in terms of their type and structures - that has to be done on a very high national level ... on the reformulation of foods"
Commercial Health and Well Being Organisation, National, Interview

Several participants stated that national mass media was needed to underpin local campaigns, along the lines of the Change4Life model. They believed that such campaigns enabled them to do the local work on the back of the national messages. No participants thought that there was any realistic possibility of funding for local mass media campaigns on prevention of pre-diabetes.

"I thoroughly agree that local newspapers and television and radio channels are really really important as are local shops and businesses and any educational institutions, but I would say though that with anything like this, national and mainstream media still does have a massive influence."
BME media planner, Interview

Labelling: the issue of nutrition information and labelling was mentioned by many participants who believed there should be more reference to this subject in this recommendation. Some mentioned that the ‘traffic light system’ should be mentioned, as this was what most people find understandable and the easiest to use.

"I know it’s a bit political, but that’s what the evidence is saying."
Community Dietician, PCT, North West, Interview

"A *lot of the food manufacturers have gone for GDA, guideline daily amounts, which there is research to show that the public find those very confusing. The FSA did a big piece of work and the public actually want the traffic light guides. The food manufacturers don’t want to put red dots on the front of the food."*
BME/Diabetes Prevention NGO, Focus Group, Hammersmith and Fulham,

Several participants highlighted particular issues relating to Asian foods. There was concern about the labelling of imported foods provided in smaller ethnic retailers - that may not be covered by national actions with large manufacturers and retailers.

"Asian supermarkets don’t bother (with labelling), so there has to be some sort of legislation which says all foods must have this (labelling). The whole point is that a lot of that is brought across from abroad... you have to do that on a global level."
BME/Diabetes Prevention NGO, Focus Group, Hammersmith and Fulham

One participant remarked that the emphasis on labelling of processed foods could draw attention from an equally important message, that people should be doing more to create food from scratch and should know the calorie content of the raw ingredients.

"What people need to know is not an individual product and how that compares with a similar product by a different manufacturer, they need more information about food on the whole, about what they should be eating more of …. what foods you should be having more of, the fruit and vegetables, the staples, labelling is only really covering one small portion of everyone’s diet.... You would prefer them to be cooking from scratch and having the knowledge and expertise of how to actually create a meal."
Commercial Health and Well Being Organisation, National, Interview

Alcohol: **s**ome participants wondered why alcohol had not been mentioned. Their concern was that alcohol was important, not just because of the calorie content of alcoholic drinks, but also because of the dis-inhibiting role it plays, effectively encouraging unhealthy eating. There was suspicion that there may have been "political reasons" for its omission.

Sugar: another participant highlighted that sugar should be mentioned in the first and fourth action points. The same participant wondered why there was mention of home cooking resources as it seemed a bit *"out of the blue",* when there was no mention of other specifics.

Young people: although under 18s were not the focus of this guidance, a few participants mentioned the need to do more work in schools, directed from a national level. This fits with the view that was expressed that prevention work should start at an early age, and that any strategy aimed at prevention among young adults, needs to convey messages before the age of 18.

Data collection: unlike recommendation nine there was no mention of data collection and evaluation. A number of participants queried this omission.

Factors affecting implementation

Public scepticism about health messages: some participants voiced concern that there exists a public scepticism about health information, with a common belief that the public is told contradictory things about what is good/bad for their health. There was a view that this recommendation should emphasise the need for *"consistent and credible message"* from all sources.

Working with the commercial sector: many participants believed the work with manufacturers and retailers has to be done at a national - and in some cases at a global - level. Dialogue with industry should be encouraged to persuade it that these changes are important for society, but also important to their industry.

"They (food companies) are being targeted by so many organisations wanting them to carry their cause and, in my experience, they will only take on something that is very relevant to their business."
BME media planner, Interview

"I think it is more communication with the food industry and I think listening to them as well really because a lot of the big manufacturers are changing, they are reformulating foods, yet they can't get involved in discussions because they are almost like... The enemy....they are alienating them at the same time as wanting them to reformulate.... so (we need) communication where they can meet, you know, in the middle."
Commercial Health and Well Being Organisation, National, Interview

"It's got to be a partnership between the private sector and government which include advertising [restrictions] and working with supermarkets to develop a marketing strategy that will encourage the purchase of a healthier products."
Health Inequalities Lead, Focus Group, Hammersmith and Fulham

Regulation and legislation: in addition to persuasion, the following were all identified as important levers to build an environment that supports a healthy diet, and there were calls for them to be included in the guidance. The items mentioned were:

- legislation on reformulation
- labelling
- advertising
- regulating the number of fast food outlets

It was felt that the national guidance could then be used locally to encourage local legislative change and to check that companies (national and local) were abiding by the national legislation. This national context would also help drive the changes suggested in recommendation five.

"There needs to be proper planning at national level. Well, with smoking, the only way we got changes was with legislation... .I certainly think we should legislate ... to reduce the numbers of takeaways in an area. For some of the very deprived families in our area, they have takeaways 3 or 4 nights a week... but until we've got it nationally agreed we haven't got a leg to stand on"
Obesity Lead, North West, Interview

Several participants were not optimistic about the likely implementation of this recommendation. Concerns about the current political climate, coupled with the fact that the food and retail industry were now working within and advising government, led participants to feel that it was unlikely that adequate legislation would be put in place or political pressure exerted to provide an environment supportive of healthy diets.

Whether the necessary information, knowledge, skills and resources exist

Mass media: there was a widespread view that there was not sufficient resource, nor indeed the necessary specialist skills, for mass media campaigns to be run locally, although several participants said local campaigns were needed. Change4Life was suggested as an appropriate example, with national mass media backed up by material available enabling local areas to "piggyback".

Consumer insight: a number of participants mentioned the need for more consumer research to better understand how to help people make healthier choices. The food industry was considered to be much more sophisticated than the health sector, in obtaining customer insight in order to develop products and marketing messages.

"I certainly think it needs the back-up of research around consumer behaviour ... I'm sure that the chocolate makers would say, 'oh that's why we put these two bars in them, we say it's for sharing'.... I've never met anybody who ever shared one of those, you eat them both don't you, and so that works really well for them and looks like they're being really friendly and helpful towards a healthier message, whereas actually what they're doing is selling more chocolate."
Focus Group, Manchester

National level: participants did not feel they were able to comment on the skills at national and governmental level to negotiate and involve the food and retail sector in policy decisions, whilst at the same time seeking to protect the public interest. The perception was that there was not much evidence of

the government securing significant change within the industry in terms of reformulation, marketing or encouraging people to eat more healthily.

Potential impact

There was a general view that this recommendation, if enacted at national level, would have considerable impact. Coupled with recommendation five, it would support individual behaviour changes and was seen as pivotal in preventing pre-diabetes.

"When you look at the countries that have had real success, like the Scandinavian countries, it has been at a national level. This recommendation is very important (more so than local action), and warrants higher profile in the document. It should be brought forward to the front of the document."
Focus Group, Manchester

However, given that the food and retail industry would have to make considerable changes, and the reluctance in the current political climate to introduce legislative changes, there was a view among several participants that this recommendation - whilst being one of the most important - was perhaps the least likely to be actioned at national level.

"It is going to struggle in the changed political environment … for example one of the things that was trying to go through parliament was the idea of having a minimum standard of food in all public institutions. That has just been rejected. There is an awful lot politically about this one that is considered to be unacceptable."
Community Group, South Coast, Interview

Is action required from other organisations listed?

The specification of local public health agencies taking action on this recommendation caused confusion, as it was clearly nationally focused. Similarly, the reference to "national and local public health services in the public and *private* sector raised the question whether there are any public health agencies in the private sector. These references to local agencies and private sector agencies may need to be removed or explained.

It was felt that this recommendation should be more specific about who would be responsible for leadership.

While it was felt that the government had the main role, several participants thought that the private sector should be required to play a more significant role, and to shoulder responsibility.

"I think commercial partners need to take responsibility…. I mean it's a new thing for NICE, isn't it? Because, you know, usually it's about local authorities but, you know, maybe we should be saying in this brave new world, 'this is the NICE guidance for commercial partners'"
Obesity Lead, PCT, North West, Interview

The Food Standards Agency was mentioned as an organisation that should be specifically mentioned on the list.

Online survey responses to recommendation 8

1 Respondents were asked to agree or disagree with a series of statements.

A total of 48 respondents who answered this question:
47 (98%) agreed with the statement 'this recommendation is clear and easy to understand.'
45 (94%) agreed with the statement 'this recommendation is relevant to me in my job.'
43 (90%) agreed with the statement 'this recommendation is useful to me in my job.'
35 (73%) agreed with the statement 'this recommendation will have a positive impact on the prevention of pre-diabetes among adults in high risk groups.'

2 Respondents were asked to rank in order (on a scale from 1-5 where 5 is the biggest), the challenges faced in implementing this recommendation. A total of 60 respondents answered this question.

The order of concern was as follows (scores out of 5):

- Funding 3.82
- Leadership 3.73
- Other 3.27
- Training 2.98
- Staffing levels 2.80

3 Respondents were also invited to add any other comments they had on the draft recommendation. 16 respondents provided comments. These focused on the following concerns:

- The perceived lack of political will from central government and what was described as 'resistance from food manufacturers, retailers and caterers'.
- There were also comments that this recommendation was vitally important, but exceptionally challenging to deliver.

Recommendation 9 National-level action to promote an environment that supports physical activity

Who should take action?

National and local public health services, including data collection services.
Organisations with a remit for increasing physical activity levels or helping to reduce levels of obesity.

What action could they take?

- Ensure the benefits of physical activity – and what constitutes an effective level of physical activity – are made clear to encourage people to be more physically active.
- Support a shift in the population towards being more physically active by encouraging even small changes.
- Monitor the population's overall physical activity levels to determine the success of national-level interventions.
- Assess the health impact of all initiatives and interventions to encourage physical activity.
- Establish national and local systems to ensure action to encourage physical activity is linked to transport policy, the design of new buildings and the wider built environment.

Clarity of recommendation

This recommendation was generally considered to be clear, but there were calls for it to be cross-referenced with recommendation six, and it was perceived to lack detail, compared to other recommendations. Some participants thought that several of the action points were a little vague. It was pointed out that the first action point appears to be about conveying messages, and it was unclear why this was a national action, particularly in the absence of any recommendation for national mass media.

"*Telling us to encourage people to be more active is very vague... The first action point could be in recommendation 3.*"
NHS Weight Management, North West, Interview

Some participants questioned whether bullet points 1 and 2 should be in this "national level action" as these seemed to be concerned with individual behaviour changes. A clear statement was felt to be required outlining what sorts of national level action should be a recommended to support points 1 and 2.

"Not sure about the first two bullet points, as these seem to be about communication rather than influencing the environment – need to expand them to explain better what they are suggesting should be done nationally. Seems as though action points 1, 2, 4, 5 really belong in earlier recommendations, and the only one distinctive from earlier recommendations is the third action point, which could in fact be fleshed out to form a recommendation just about evaluation - encouraging evaluation of physical activity initiatives/interventions, which currently are in not done at all, or done poorly."
Public Health Observatory, National, Interview

The idea that there should be a discrete recommendation focused on data collection, monitoring and evaluation was echoed by several participants. It was perceived that this would have the advantage of drawing together the various mentions of these issues, currently found in different recommendations, and give this important issue and appropriate salience.

"It never does any harm to emphasise evaluation because people always struggle to make room for it."
Public Health Manager, PCT, London, Interview

One participant said there should be more mention of sport, particularly in the final action point.

Relevance and usefulness

One participant stated that there was too much focus on public health, and insufficient recognition of the vast community of (mainly voluntary sector) organisations facilitating physical activity, many of which do not have public health as a raison d'être.

"There's a whole world out there doing this work without any reference to diabetes at all, but still doing it and maybe that needs recognising."
Obesity Lead, PCT, London, Interview

The issue of providing support for the population to make changes was considered essential.

"*If you are not there with the support... it is not going to work."*
Commercial Health and Well Being Organisation, National, Interview

Factors affecting implementation

Confusion about the message: the quality of the evidence underpinning physical activity was questioned by some participants. Participants mentioning this thought that there was confusion around recommendations for the *ideal* levels of activity, and recommendations appropriate to *achievable* levels of physical activity.

Negative image: some participants mentioned the perception of physical activity as being a barrier to implementation.

"We all know why it's important to be involved in physical activity, but for really hard-to-reach groups there may be a negative experience of PE as a child or they didn't get particular support if they had a disability, I think you need to take it right back and promote it as something that's fine. Something that's social."
Sports Development Officer, Local Authority, Focus Group, Hammersmith and Fulham

Transport: legislation was mentioned by a small number of participants.

"People don't respect cycling lanes…….. [that needs] enforcement."
Sports Development Officer, Local Authority, Focus Group, Hammersmith and Fulham

"On transportation, what the government's doing …. It's not going to get people out of their cars."
Physical Activity Coordinator, Local Government, North West, Interview

Monitoring and evaluation: one participant welcomed the recommendation of monitoring physical activity levels, as it may lead to the availability of funds to determine impact.

"And, you know, we need to be able to monitor the impact of what we're doing. If we're trying to promote and support physical activity, we need to be able to see if people are getting more active? Well, we can't, because you have to do local health profiles and local health studies, and we haven't got the resources to do that."
Obesity Lead, PCT, North West, Interview

However the logic of the third action point was questioned, not in terms of the value of measurement, but in relation to the attribution of cause and effect implied by the current wording.

"The action to monitor activity levels in order to determine success of national level actions is not logical - you cannot attribute all change to national policy where there is substantial local action alongside it."
Public Health Manager, PCT, London, Interview

The fourth action point was considered by some to be unrealistic, since the challenge of assessing the health impact of all initiatives and interventions constitutes a massive challenge in terms of resources and methodology.

The participant from a public health observatory stated that the guidance would benefit from reference to the National Obesity Observatory's Standard Evaluation Framework, which has been designed to help of assessing interventions.

Whether the necessary information, knowledge, skills and resources exist

Some of the necessary skills were felt to be available, but getting people to collate robust data was considered to be a challenge.

"Need to mention QOF (Quality and Outcomes Framework) and stuff like that. There is a very easy questionnaire that GPs can use... GP's need a reward for encouraging physical activity… you have to pay them to get them to do something."
Obesity Lead, PCT, North West, Interview

Measurement and evaluation were considered important skills but there were doubts about the current tools and methodologies available to assess impact and effectiveness. Reference to the National Obesity Observatory's Standard Evaluation Framework may be helpful in this respect.

A suggestion by one responded was to highlight what is already available.

"Change4Life has been around for 18 months now, so is there any data that we can draw on to see if that's made a difference?.. And the annual survey done by Sport England – it's into its fourth year now. That will give you an idea of trends in activities by different types of groups".
Assistant Director Partnerships, Diabetes Pathway, PCT, Focus Group, Hammersmith and Fulham

Potential impact

Whilst many participants felt that a national level recommendation on physical activity was important, few thought the recommendation, as written, had enough distinctive substance or innovative ideas**.**

"Not really, it is stating the obvious to quite a large extent."
Public Health Observatory, National, Interview

Is action required from organisations not listed?

Some participants thought that the statement, 'organisations with responsibility for increasing physical activity' needed to be more specific so that these bodies can clearly recognise their responsibility. For example, it was thought that DCMS, Sport England and local authority leisure services/leisure trusts should be specified.

Other suggestions included adding in planners and legislators. Some participants mentioned that the sports media have a responsibility to encourage physical activity, and clearly 'engage' with many people in high-risk groups.

Some thought that there should be recognition of the 2012 Olympics having a role in encouraging physical activity.

Online survey responses to recommendation 9

1 Respondents were asked to agree or disagree with a series of statements.

A total of 42 respondents who answered this question:
41 (98%) agreed with the statement 'this recommendation is clear and easy to understand.'
33 (79%) agreed with the statement 'this recommendation is relevant to me in my job.'
31 (74%) agreed with the statement 'this recommendation is useful to me in my job.'
29 (69%) agreed with the statement 'this recommendation will have a positive impact on the prevention of pre-diabetes among adults in high risk groups.'

2 Respondents were asked to rank in order (on a scale from 1-5 where 5 is the biggest), the challenges faced in implementing this recommendation. A total of 60 respondents answered this question.

The order of concern was as follows (scores out of 5):

- Funding 4.29
- Leadership 3.72
- Staffing levels 2.97
- Training 2.54
- Other 2.33

3 Respondents were also invited to add any other comments they had on the draft recommendation. 12 respondents provided comments. These focused on the following concerns:

- The need to focus the uptake of physical activity at a younger age.
- The need to improve access to sports in school and outside school for young people
- Having 'pathways' in place to follow up and monitor individuals who are referred to physical activity services.
- The view that this recommendation was very broad and ambitious, and that in the current climate unlikely to have significant impact.

4. Conclusions

4.1 Key issues

In general, these draft recommendations were welcomed, by those consulted in this fieldwork study. NICE had a strong reputation for evidence-based advice, and its public health guidance was seen as very valuable in terms of raising the profile of, and making the case for investment in long-term prevention. Participants were clear in asserting that this guidance would be helpful in providing renewed impetus to prevention of pre-diabetes among adults in high risk groups. Nevertheless, there were concerns that the potential impact of the guidance was likely to be limited. This was partly based on issues discussed below, but also on a common view that the draft guidance did not contain a great deal of innovation, and many of the recommended actions were thought to be already in place.

Public expenditure and NHS reorganisation

The timing of this fieldwork coincided with major government announcements that will impact on the landscape within which this guidance is implemented. As fieldwork began participants in all sectors were coming to terms with the implications of the Comprehensive Spending Review, which had been published approximately one month previously. The Public Health White Paper ("Healthy Lives, Healthy People") was published during the first week of fieldwork, and the legislative framework for health care reform ("Liberating the NHS") was published midway through the fieldwork period.

The moving of responsibility for public health planning from primary care trusts to local government was generally considered positively, and was seen to be an opportunity to develop stronger relationships with the various local authority services that currently engage regularly with high risk groups. Similarly, some participants who identified themselves as public health specialists, were keen that the local authority Health and Well-Being Boards should take on lead responsibility for a number of the draft recommendations, and saw the potential for local authority Scrutiny and Review committees to strengthen accountability.

However, the reductions in public expenditure (especially local authority budgets) arising from the Comprehensive Spending Review, and the move towards GP consortia control of local NHS budgets, were perceived to be potential barriers to successful implementation.

There was a widespread belief that the community infrastructure (e.g. community groups, leisure services, community safety, etc) would suffer over the next few years. This led to doubts over whether the community rooted approach promoted in the draft guidance could successfully be implemented at a time when the community infrastructure was weakening. As one public health manager noted, the draft recommendations seemed to assume a significant degree of opportunity to introduce new services and improve existing services, and yet the key challenge during the implementation period would be the mitigation of service reductions. In finalising the recommendations, it may be advisable to consider this context.

There was a consensus that long-term, lifestyle based prevention work had historically struggled to be considered a priority within the NHS and related organisations, although some did add that the situation had improved in more recent years. Almost all participants (including GPs) were concerned that the move

to commissioning through GP consortia would make it harder for long-term prevention initiatives to receive funding priority in competition with more immediate challenges, and there was a risk that a community rooted approach would not appeal to GP decision-makers. Some participants suggested that the guidance should include advice on putting together a business plan to secure investment in long-term, lifestyle based prevention.

The balance between local and national responsibilities

There was a widespread view among participants that the balance of responsibility in the draft recommendations was too heavily weighted towards local areas, and recommendations at national level where insufficient and/or vague. The specific concerns that informed this view related to mass media campaigns, engagement with the commercial food industry, the absence of legislative actions, and the absence of a recommendation for a national strategy.

It was generally accepted that there was a role for mass media campaigns, but almost without exception, participants said that local budgets would not be sufficient to deliver this. Furthermore, there was felt to be a mismatch between the geographical coverage of many appropriate media channels, and the geography of local areas. For example, TV channels that were considered to be highly popular with key, at risk demographic groups within BME communities, tended to be national, or even international. There were also doubts over whether local areas had sufficient specialist communication skills, particularly in new, social media. For these reasons, it was generally believed that the delivery of mass media campaigns by local areas was not achievable.

Although there was scepticism about the motivation of the food industry, there was a recognition that public health professionals should work more closely with the commercial sector in the future. Although few participants were able to cite examples of strong and positive relationships with local businesses, there was acceptance that local public health agencies must take up the challenge to change this situation. However, it was considered unrealistic for local agencies to engage successfully with national and international businesses, and participants were keen to see clearer and more assertive recommendations about the role of national government in this respect. Many believed that these recommendations should have "more teeth", and should include the prospect of legislative change, particularly around food labelling, advertising and the strengthening of planning regulations.

The absence of a recommendation for a national strategy was noted. Some commented that the task of writing a local strategy was more difficult in the absence of a national strategy to provide context and structure. To address this, the final guidance should consider inclusion of a template on which local strategies could be based.

The age focus of the guidance

The fact that the guidance was aimed at adults aged 18-74 was questioned by many participants, on a number of grounds.

First, many of the public health professionals consulted, said that their organisations had a strong preference for family-based interventions, particularly around issues such as healthy eating and physical activity. The 18+ focus of the draft guidance was therefore somewhat problematic for this approach.

Second, it seemed to some that the adult focus on the guidance was unnecessarily restrictive, seeming to exclude children's services, such as Sure Start, through which relevant practitioners engaged with adults in high risk of groups.

Third, the age range 18-74 was considered to be very wide, and there were thought to be significant differences in the level of risk within this range. Some participants would like the guidance to acknowledge this differentiation, and to consider how the recommended actions might be tailored according to age segments.

Finally it was argued that guidance aimed at prevention among young adults needs to start before the age of 18, and that schools had a role to play in educating young people about pre-diabetes.

Equality issues

Participants made a number of relevant and interesting points on equalities themes, each of which should be considered when finalising the guidance.

The draft recommendations made no mention of disabilities, although there were clear implications for disabled people in most recommendations. For example, any thorough needs assessment would need to consider the barriers faced by disabled people, and this would need to be reflected in strategy development. There were considerations to be made in relation to people with learning disabilities, particularly around the conveying messages. People with mental health conditions (particularly those using medication with weight management implications) also warranted consideration, while those with restricted mobility faced barriers in the physical environment and in accessing leisure facilities.

Some local areas had significant numbers of people from "mobile populations". This applied, for example, to many London boroughs, and to areas in which the traveller community resided. Mobile populations required an iterative approach to needs assessment, and presented distinctive challenges for strategy, conveying messages and targeting. This geographical mobility meant that individual local plans could not accommodate all needs, and the guidance should consider the role of regional and national strategies to supplement local plans.

Religious organisations played a very important role in facilitating access to certain populations, particularly within BME communities. However, there were two notes of caution, in terms of the extent to which these organisations should be used. First, it was suggested that some religious people did not welcome government organisations regularly using places of worship in order to convey messages, and that there may be particular sensitivities in some Muslim communities. Second, there was a need to remember that not everybody with a BME background was "automatically religious", and those not engaging with religious institutions may inadvertently be marginalised.

The community rooted approach encouraged by the draft guidance was widely welcomed, but it was suggested that a move towards partnership with the voluntary sector, religious organisations and other community settings, may inadvertently marginalise communities where such social infrastructure is not strong. This was thought particularly to apply to some low-income White communities, and to some extent, also to some African/Caribbean communities.

Commissioning models and the risk of short termism

As noted above, the community rooted approach promoted in the draft guidance was welcomed, but a significant number of participants warned that this would need a well thought through commissioning model, and long-term relationships between the commissioners and their partners. The concerns held by these participants were based on past experience, in which this kind of arrangement has often been associated with short-term perspectives and short-term financial commitments.

The manager of one BME focused community project reported her frustrations at "stop/start" funding, which led to poor quality investment and difficult management issues. In this scenario there were high levels of start-up costs (e.g. recruitment and training) for projects on which the funding was withdrawn before they could become fully effective, resulting in the loss of expensively developed skills, as staff were made redundant. Related concerns were expressed from the commissioning side, with a Director of Public Health emphasising the need for services delivered through community (and other arms length) groups to be properly integrated with mainstream health services, in order to avoid the risk of inefficiency through "free-floating" projects failing to join up with health services. Both agreed that this scenario risked unintended consequences, such as health professionals signposting patients to services that no longer existed, and thereby undermining confidence amongst both professionals and the public.

Action and leadership

The size of the "who should take action?" list varied across the draft recommendations, but generally participants were happier with longer, more inclusive lists, though some acknowledged that there was a danger of the list being so long that no individual organisation took on leadership responsibility. When asked if any organisations should be added, they often tended to mention all relevant agencies that they would like to see involved. This highlighted the fact that "action" could be interpreted on the spectrum from having specific responsibility, to being consulted or being commissioned. NICE might wish to consider whether the "who should take action" section should be split into categories along the lines of "who should lead?" and "who else should be involved?"

Incentives and accountability

In the forthcoming year of public spending restraint, participants anticipated the challenge of securing investment in long-term prevention work to become more difficult. Some participants were therefore disappointed that the draft recommendations did not seem to include actions that would incentivise action, and make organisations accountable for lack of action. As noted above (under NHS reorganisation) it was suggested that local authority Review and Scrutiny committees could play an important role in this respect.

The role of the private sector

Participants realised that there working with the private sector was important, but were not confident in terms of their ability to engage the food industry. This view was based partly on a degree of scepticism about private sector motivation (because unhealthy foods can be profitable), and partly due to uncertainty about how to engage these businesses.

As noted above ("the balance between local and national responsibilities") national and international companies were seen as out of reach for local organisations. It seemed inconceivable that large retail chains would want to negotiate with 150+ PCTs/GP consortia, and these relationships were clearly seen as the responsibility of national government.

There was recognition of the need to work with local food businesses, but there was little evidence of strong relationships to date. Participants were unsure of how local businesses would respond to an approach. The mechanism for engagement was often seen as being through Environmental Health, but these departments had significant resource constraints, and limited flexibility in their priorities, given that they have a number of key statutory duties.

In developing information to support implementation, NICE may wish to consider including examples of good practice in engaging local food businesses.

Research and evaluation

A significant number of participants suggested that there should be a single, additional recommendation focused on research, monitoring and evaluation. This would bring together the various references to these matters, currently located in different recommendations. The advantage of doing this would be that it would give greater salience to the subject, which was often neglected. There was a need to cover several different elements within this recommendation.

Several participants highlighted the need to obtain greater insight into lifestyle and health behaviour. Some contrasted the excellence with which the food industry conducts consumer research, with what they perceived as much less impressive work by the health sector.

A number of participants emphasised that interventions of the type recommended in the draft guidance would only get significant investment if such health promotion work could demonstrate effectiveness. To this end, the development of appropriate outcomes, and the refining of data collection methods, were seen as essential. The National Obesity Observatory has developed a Standard Evaluation Framework which may help in this respect, and NICE may wish to look at this work, and consider whether it should be referenced in the final guidance.

Following on from the point above, this draft guidance emphasises the need for targeted interventions, tailored around demographic, socio-economic and cultural needs. Some participants pointed out that such "niche" work can appear unsuccessful because commissioners use crude outcome measures (e.g. "bums on seats"), in the absence of more appropriate information. NICE might wish to consider whether the final guidance includes reference to the need for commissioners to take a more flexible, and longer term view on these matters.

In discussions around Joint Strategic Needs Assessments it became clear that there were serious doubts over whether the required robust and appropriate data exist. Those with more experience in such matters reported difficulties in extracting data from IT systems, poor record-keeping (particularly for non-clinical issues) and the absence of resources to obtain "softer" insight on health behaviour.

A preference for integrated strategies

There were significant reservations about the prospect of developing an independent strategy for the prevention of pre-diabetes among adults in high-risk groups. Most participants would have preferred to have an integrated strategy on healthy lifestyles, covering the main related long-term conditions (CVD, Obesity, Diabetes, Hypertension etc) and the main lifestyle risk factors (healthy eating, physical activity etc).

Independent strategies required independent needs assessments and consultations, often on the same issues and with the same stakeholders. This would generate a significant amount of work, and there was doubt over whether appropriate resources would be available in the foreseeable future. The consultation element may leave some stakeholders within the impression that work was being duplicated across strategies.

In terms of delivery, there were concerns about the practicality of managing staff responsible for delivering several related strategies, and it was considered more cost-effective to pool resources, rather than fragment them. For example, the only participant who considered a local mass media campaign to be a realistic possibility, did so with the caveat that it would probably only be justifiable if it addressed "the big killers" (i.e. a number of long-term conditions including CVD, Diabetes, Cancer, etc).

NICE should consider this issue seriously. If there is a strong case for an independent strategy, this should be made clear in the final guidance. Otherwise, the guidance should explicitly acknowledge that an integrated strategy could be appropriate.

Style and presentation

Some suggestions were made for improving the style and presentation of the recommendations, and these should be understood in the context of the opinion that very few people would read the whole guidance document.

It has been noted above (see "Action and leadership") that the "who should take action?" section of the recommendation text is open to different interpretations. We believe that NICE should consider whether the role of leadership should be specified among a long list of action takers.

Some recommendations were closely linked to each other (e.g. five and eight, six and nine), and it would be useful to identify the links by cross referencing within each recommendation.

A number of participants suggested that more references should be provided to related NICE public health guidance, such as the guidance on Obesity, Community Engagement etc.

4.2 Barriers and enablers

In this chapter we consider the issues raised by participants during fieldwork, summarising them into barriers to implementation, and enablers of implementation. These are presented in list format, and more detail and context can be found elsewhere in the report.

Where the barrier/enabling factor applies to a particular recommendation, this is specified. Those without a specified recommendation number apply more broadly.

Barriers to implementation

1. Resources - staff and funds: in the light of reducing public expenditure over the next few years, human and financial resources were considered to be the main barrier to implementation, across all recommendations.
2. Long-term prevention was not seen as a funding priority: this had been the case historically, and no change was expected in the foreseeable future, as public services were likely to prioritise short-term demands.
3. Reduced community infrastructure: the draft guidance emphasises the importance of community engagement and delivery of messages and services in partnership with community organisations; there were major concerns among participants that a wide range of community infrastructure (e.g. leisure services, community safety, voluntary groups) would be adversely affected by public spending constraints, and would therefore have limited capacity to assist with this work. (Recommendations three and four).
4. GP consortia: there was a perception that GP consortia would be less inclined to favour a community rooted approach, and less inclined to prioritise investment in long-term prevention, particularly if in competition with short-term clinical demands; this was a view shared by GPs in the sample.
5. Limits to what was considered to be achievable locally: as noted in the section on overarching findings, there were concerns that the draft guidance was unrealistic in some of the things it expects from local agencies, including mass media campaigns, engagement with the food industry, and effective use of planning regulations.
6. The absence of strong, clear recommendations for national action: many participants were disappointed at the seemingly limited and sometimes vague requirements on national bodies; there were demands for clearer national action on advocacy with national and international food businesses, legislative change (e.g. food labelling, food advertising and planning regulations) and mass media campaigns. (Recommendations eight and nine).
7. The age focus of 18-74: the focus on adults did not fit well with the family centred approach which many agencies prefer using on health behaviour change issues.
8. Reliance on community infrastructure: the community rooted approach promoted in this draft guidance was widely welcomed, but there was a danger that communities with weaker social infrastructure will be inadvertently marginalised by this approach; some White and African/Caribbean communities were thought to be at risk.
9. Lack of innovation: most participants believed that the draft recommendations lacked innovative ideas, and there was a fear that the guidance would fail to stimulate change.
10. Poor data quality, and difficulty accessing relevant data: needs assessments lack high-quality data, because of poor record-keeping, incompatible IT systems and inadequate resources to obtain "softer" consumer insight; the final guidance should include a recommendation that appropriate agencies invest to improve the quality of available data. (Recommendation one).

11. The link between messages and behaviour change: some participants commented that there was a need to go beyond conveying messages and be more specific about linking with support for behaviour change. (Recommendation three and seven).
12. The term "lay worker" required explanation: there was no consistent interpretation of this term, and the final guidance should be explicit on the way it is used in the guidance; similar concerns were found in terms of "community champions". (Recommendation four).
13. Community champions: if community champions did not believe in the message, and did not demonstrate this belief to their community, the message would be undermined. (Recommendation four).
14. Sustainability of using volunteers: it was thought that this approach may work in some areas, but was unlikely to work in more deprived areas. (Recommendation four).
15. Quality assurance when using volunteers: less consistency could be expected from a volunteer-based delivery model. (Recommendation four).
16. Degree of commitment required from primary care: doubts were expressed about whether primary care would be able to deliver action points relating to individual level risk. (Recommendation four).
17. Planning regulations: there were doubts over whether planning departments currently had sufficient powers to deliver the recommended environmental change; even the more optimistic participants believed that change brought about in this way would be slow. (Recommendations five and six).
18. Voucher schemes to encourage healthier eating: it was thought that the evidence base behind this recommendation would need to be very clear before local agencies invested substantial funds in this approach. (Recommendation five).
19. Training for non-medical personnel: participants were disappointed by the medical focus of recommendation seven, wanting it to be broadened out, to incorporate lay workers and other non-medical personnel. (Recommendation seven).
20. Omission of alcohol: this omission was felt to limit the potential impact of recommendation eight. (Recommendation eight).
21. Physical activity levels recommended for health gain: participants believed that there was inconsistent messaging on this issue, often caused by confusion around "ideal" and "achievable" levels. (Recommendation nine).
22. Assessment of health impact: the recommendation that all interventions and initiatives should be assessed for health impact was considered unrealistic, and inappropriate as a national action. (Recommendation nine).
23. National monitoring to determine success of national interventions: this was considered unrealistic, since change could not necessarily be attributed to national interventions alone. (Recommendation nine).

Enablers of implementation

1. NICE guidance adds impetus on this subject: participants welcomed NICE guidance, and believed that it would raise the profile of pre-diabetes prevention.
2. Goodwill from relevant professionals: the community rooted approach promoted in this draft guidance was welcomed by participants, with particular enthusiasm from those in the voluntary sector.
3. Commissioning models: the draft guidance envisaged the delivery of interventions and initiatives through community groups and other arms length organisations, and this required well thought through commissioning models, to encourage positive, long-term relationships. It would be helpful if the final guidance provided recommendations on how to develop such models. (Recommendation two).
4. Integrating pre-diabetes with other lifestyle/prevention strategies: most participants would prefer an integrated strategy incorporating prevention of CVD, Hypertension, and Obesity as well as Diabetes, and this approach was considered much more achievable and efficient. (Recommendations one and two).
5. Providing a strategy template: in the absence of a national strategy, it would be helpful to local agencies if NICE provided advice on the structure and content of a local strategy document. (Recommendation two).
6. Disabled people: the draft guidance would be improved by considering the barriers faced by disabled people. (Recommendations one and four).
7. Mobile populations: the draft guidance would be improved by considering specific issues in relation to Travellers and groups that are resident in one location for only a short time. (Recommendations one and four).
8. Acknowledging the strategy's role in mitigating service reductions: it was felt to be important to acknowledge that there would be few new prevention services developed in the next few years, but that the strategy could still play a valuable role in mitigating the impact of service reductions on vulnerable groups. (Recommendation two).
9. Making the case for investment: the guidance should include advice on how to prepare a persuasive business plan, to secure investment in the prevention of pre-diabetes among adults in high-risk groups.
10. Demonstrating the effectiveness of long-term lifestyle/prevention work: some participants said that a pre-requisite of raising the profile of health promotion interventions and initiatives was the development of commonly accepted outcomes and evaluation methods. NICE should consider incorporating advice on this in the final guidance, and reference to the National Obesity Observatory's Standard Evaluation Framework may assist in this matter.
11. Specifying leadership: each recommendation should clearly specify which organisations are responsible for leadership, as well as a longer list of those needing to take action; local authority Health and Well-Being Boards should be specified as having leadership responsibility on a number of recommendations.
12. Incentives and accountability: the guidance should make recommendations which incentivise organisations to implement recommendations, and make clear how relevant organisations should be held accountable; local authority Review and Scrutiny committees could play a valuable role in this. (Recommendation two).
13. Enabling supporting sectors (e.g. education and catering): provision of training information for catering staff, and lesson planning material for education staff would increase their confidence in

providing healthy eating and physical activity advice to their customers/students. (Recommendations three and four).

14. "Enabling investment": public health agencies should consider how they can facilitate increased physical activity among target groups through enabling investment, such as training female lifeguards and providing transport to facilities. (Recommendation six).
15. Behaviour change training: participants were keen that recommendation seven should be amended to explicitly encourage training in behaviour change methods. (Recommendation seven).

APPENDICES

Discussion guide for interviews and focus groups

	Theme	Notes/probes
3 min	**Introduction of researchers** **On behalf of NICE, thank all for attending** **Housekeeping (group only)** Session duration Toilets Emergency exits/fire assembly Mobile phones, off or silent Rules for the session: everyone has the right to be heard, respect each others opinions and confidentiality Please don't talk over other people - not least because we are trying to record/note discussion Hopefully you have all read the recommendations we sent through, and jotted down some initial thoughts. The purpose of today is for us to discuss those points, interactively, and thereby help us to understand better. If you haven't read the recommendations, don't worry. We will discuss them one by one, starting with a clear description of the recommendation.	
2 min	**Remind people of the scope** (Do not debate the scope or evidence. Scope was consulted on previously. If participants insist on debating these things, suggest they do so via NICE website consultation) The guidance will focus on preventing pre-diabetes among **adults (18-74 years) in high-risk groups.** The guidance acknowledges that the term 'pre-diabetes' and its definition is imperfect in the preamble of the draft document. Participants may wish to express	Take any questions on the scope at this point

	views on this on boarder issues of defining 'disease' (or pre-disease states) These will be noted as for other parts of our discussions but we do ask that participants note that the focus of this session is the use, relevance and implementation of the draft recommendations Facilitators will therefore ensure that sufficient discussion time is reserved to focus on these issues. Note that this is the first of two pieces of guidance the second of which will focus preventing the progression of pre-diabetes to type 2 diabetes. This is currently in an early stage of development and is scheduled to published in May 2012. The draft guidance to be considered today does not therefore cover those already diagnosed with impaired fasting glucose (IFG) or impaired glucose tolerance (IGT), or diagnosed with diabetes. An important point to note is that when developing this guidance, the PDG did not set out to determine the relative effectiveness of interventions such as healthy eating, physical activity and obesity in preventing pre-diabetes per se. The starting point for this guidance was to take interventions already identified as being effective in addressing these risk factors by previous NICE guidance on obesity, physical activity in the environment etc and determine how best to tailor and target them to address the needs of the groups at high risk of developing pre-diabetes. By "high risk groups" we mean those of African/Caribbean, South Asian or Chinese descent, and people in the lower socio-economic groups (as measured by education or occupation) who are at increased risk of developing pre-diabetes as a result of their membership of these groups.. Specific risk factors among individuals include: • family history of type 2 diabetes • history of gestational diabetes • BMI of 25 kg/m2 or above • high waist circumference above 80cm (for women) or 94cm (for men) Finally as we are all aware the forthcoming white paper may result in significant organisational changes. Each recommendation has a 'Who should take action?' section. We would appreciate your thoughts on the recommendations in the context of **current structures** and responsibilities and will make a note of any thought you have on possible implications of future changes. Please be reassured that after the White Paper is published NICE will review the recommendations and revise them if necessary.	
2 min	**Reporting, consent & ethics**	

	I hope you have all brought your signed consent forms. Please pass them to me, or leave them on the front desk. If you do not have the form, you can e-mail them to me following the meeting. Alternatively I have some blank forms that I can give you now. We are recording the discussion so that we can check back later, for accuracy. However only the researchers and transcribers will hear these tapes or read the transcripts from them. These will not be passed to NICE or anybody else. In our report nobody will be named, opinions expressed will be presented in anonymised form. The report should be publicly available on the NICE website from the time the guidance is published. If NICE personnel present: introduce them, emphasising their observer status at the fact that they will respect confidentiality	Please do not attribute anything to particular individuals where discussing today's session with people who are not here.

2 min	**Recommendation 1 Local joint strategic needs assessments** **Who should take action?** Commissioners and providers working in national and local public health services, in partnership with local health commissioners, including GP consortia. **What action should they take?** • Use local, regional and national tools and data from public health reports, the census, indices of deprivation and other sources of high quality data to: – identify local communities at high risk of developing diabetes – assess their knowledge, awareness, attitudes and beliefs about the risk factors and their specific cultural, linguistic and literacy needs – identify what interventions are already being implemented locally and assess their effectiveness – make recommendations for future investment and disinvestment. • Work with local organisations, including the voluntary sector, to gather the views of these communities and ensure they are closely involved in the planning, design, management and delivery of health promotion activities. • Identify local resources and existing community groups that could help promote healthy eating, physical activity and weight management to these communities. • Identify successful local interventions and note any gaps in service provision.	
7 min	**Recommendation 1 discussion** a. Is this recommendation clear, easy to understand? Probe - which aspects clear, which ones less clear? b. Overall, do you think it is relevant and useful? c. What factors might impact (positively or negatively) on implementing and delivering the recommendation in your locality/service. What impact will it have on your current	**Probes** A -How could clarity be improved? B -Which are the more useful & less useful parts of the

	policy practice and provision d. Does the necessary information, knowledge, skills and resources exist to enable you to implement? e. How much impact will it have in preventing pre-diabetes in these high risk groups ? f. Is action required by anybody other than those specified and/or have the right people been listed under 'who should take action'?	recommendation? C,D -Funding, staffing, skills/ training, timescale etc (Ask, 'Are there any other factors/issues which might impact on implementation?') If not, what problems will this cause? E - A lot/a little/nothing? F - Probe: by whom?
2 min	**Summarise recommendation 1 discussion** Note points of consensus and/or disagreement Note any association between particular opinions and particular roles/types of organisation	
	Repeat above process for recommendations 2-9	
	Closing session We have covered the individual recommendations. Are there any opinions on how they fit together as a complete package? Is anything missing? Thinking about Equalities: any issues that have not been raised? (Age, race/ethnicity, gender, sexual orientation, disability and other issues relevant to NICE social value judgements) If that's all, on behalf of NICE I'd like to thank everybody for attending and wish you a safe journey home or back to the office. Briefly reiterate ethics, consent and next steps	

Online questionnaire

NICE: prevention of pre-diabetes among adults in high risk groups

Introduction

Welcome to the NICE survey on 'prevention of pre-diabetes among adults in high risk

groups.' PLEASE READ THIS PAGE

There are 9 draft recommendations in the guidance.

1 Local joint strategic needs assessments
2 Developing a local strategy to prevent diabetes
3 Conveying messages about lifestyle and the risk of diabetes
4 Targeting interventions at communities at risk of diabetes
5 Creating local environments that support healthy food choices
6 Creating local environments that support physical activity
7 Training health professionals
8 National-level action to promote an environment that supports a healthy diet
9 National-level action to promote an environment that supports physical activity

Each page of the survey contains the text of a recommendation, together with a series of questions. We would value your responses to all 9 recommendations. However, if you wish, you can complete the first page, 'About You', and then skip to the recommendation that you wish to comment on by scrolling down and clicking 'next'.

The findings from this survey will be used to inform the final version of the guidance.

Please note that this guidance focuses on prevention of pre-diabetes (i.e. prevention of raised or impaired glucose levels among communities at greatest risk), and is related to a separate piece of NICE public health guidance focusing on preventing the development of type 2 diabetes in individuals with raised or impaired glucose levels.

For the purposes of this guidance, the term ‘pre-diabetes’ is used to refer to raised (but not diabetic) levels of blood glucose. Although there is a lack of consensus in the scientific literature about the usefulness of this term, it is frequently used to communicate with patients and the public.

'High risk groups' are defined as those of South Asian, African, Caribbean and Chinese descent, and lower socio- economic groups (as measured by education or occupation).

The recent public health white papers, 'Equity and excellence' and 'Healthy lives, healthy people' may result in significant organisational changes. We would appreciate your thoughts in the context of current structures and responsibilities. NICE will review the recommendations and revise them if necessary.

The survey should take about about 20 minutes to complete.

If you have questions or technical difficulties completing the survey please contact us at adam@womresearch.org.uk

NICE: prevention of pre-diabetes among adults in high risk groups

About you

Please complete the following questions about you. These will be used to analyse responses.

1. Please tell us what sector you work in. If you work in more than one sector, please select the one that you MAINLY work in

- NHS
- Local government
- Voluntary/charity
- Private sector
- Not working - student/retired etc
- Other

Other (please specify)

2. Your job title - please write in

3. Which of the following best describes the services you/your organisation provides? Tick as many as apply

- [ ] Specialist diabetes service
- [ ] Food, nutrition, diet related
- [ ] Physical activity/sport related
- [ ] Weight management
- [ ] Public health/Health improvement
- [ ] Community engagement
- [ ] NHS Primary Care
- [ ] NHS Commissioning
- [ ] Planning/transport
- [ ] Equalities
- [ ] Environmental health
- [ ] Housing
- [ ] Social care
- [ ] Other

Other (please specify)

Recommendation 1 Local joint strategic needs assessments

Who should take action?
Commissioners and providers working in national and local public health services, in partnership with local health commissioners, including GP consortia.

What action should they take?
• Use local, regional and national tools and data from public health reports, the census, indices of deprivation and other sources of high quality data to:
- identify local communities at high risk of developing diabetes
- assess their knowledge, awareness, attitudes and beliefs about the risk factors and their specific cultural, linguistic and literacy needs
- identify what interventions are already being implemented locally and assess their effectiveness
- make recommendations for future investment and disinvestment.
• Work with local organisations, including the voluntary sector, to gather the views of these communities and ensure they are closely involved in the planning, design, management and delivery of health promotion activities.
• Identify local resources and existing community groups that could help promote healthy eating, physical activity and weight management to these communities.
• Identify successful local interventions and note any gaps in service provision.

Now answer the following questions about the above draft recommendation

1. Please indicate how strongly you agree or disagree with the following statements about the above draft recommendation

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
It is clear and easy to understand	☐	☐	☐	☐	☐
It is relevant to me in my job	☐	☐	☐	☐	☐
It is useful to me in my job	☐	☐	☐	☐	☐
It will have a positive impact on the prevention of pre-diabetes among adults in high-risk groups	☐	☐	☐	☐	☐

2. What do you think will be the key challenges faced in implementing this recommendation?

Rank the following in order from 1 - 5, where 1 is the smallest and 5 the biggest challenge

	1 smallest	2	3	4	5 biggest
Funding					
Staffing levels					
Training					
Leadership					
Other					

Other (please specify)

3. Please use the space below to tell us any other thoughts you have on this draft recommendation, such as equalities implications, resource implications, impact on your current policy and practice, and whether any roles/organisations are missing from the list of "who should take action".

Recommendation 2 Developing a local strategy to prevent diabetes

Who should take action?
Commissioners and providers working in national and local public health services, in partnership with local health commissioners, including GP consortia.

What action should they take?
• Based on the joint strategic needs assessment, develop an overall strategy aimed at preventing diabetes. This should:
- create local environments that encourage people to adopt a healthier diet and be more physically active
- target specific at-risk communities
- provide interventions for individuals who are deemed at particular risk (based on clear criteria about the level of absolute risk which would trigger this provision). (Please see 'Preventing the progression of pre-diabetes to type 2 diabetes in adults' for more on this.)
• Closely link the strategy to local activities and programmes to prevent other chronic diseases (including cardiovascular disease), improve physical activity levels and improve people's diets.

Now answer the following questions about the above draft recommendation

1. Please indicate how strongly you agree or disagree with the following statements about the above draft recommendation

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
It is clear and easy to understand					
It is relevant to me in my job					
It is useful to me in my job					
It will have a positive impact on the prevention of pre-diabetes among adults in high-risk groups					

2. What do you think will be the key challenges faced in implementing this recommendation?

Rank the following in order from 1 - 5, where 1 is the smallest and 5 the biggest challenge

	1 smallest	2	3	4	5 biggest
Funding					
Staffing levels					
Training					
Leadership					
Other					

Other (please specify)

5

3. Please use the space below to tell us any other thoughts you have on this draft recommendation, such as equalities implications, resource implications, impact on your current policy and practice, and whether any roles/organisations are missing from the list of "who should take action".

Recommendation 3 Conveying messages about lifestyle and the risk of dia...

Who should take action?
Commissioners and providers working in national and local public health services, in partnership with:
- the NHS; local health commissioners and key staff within GP consortia (for example, GPs, practice and community nurses, dietitians, public health nutritionists and those working in ante and postnatal services); community pharmacists; and doctors and nurses working in acute and emergency care
- local authorities: education providers and managers of leisure services
- voluntary sector: community leaders, voluntary workers and those working for charities and non-profit organisations
- those working in the commercial sector.

What action should they take?
• Work with practitioners, role models and peers from the local community to develop consistent, clear and culturally appropriate messages on how to prevent diabetes and giving details of the support services available.
• Ensure information is presented in a format that meets the community's religious, cultural, age, gender, linguistic and literacy needs. Address issues such as stigma and fatalism regarding the development of diabetes and the assumption that weight gain is inevitable in mid and later-life.
• When the opportunity arises, disseminate these messages and information to black and minority ethnic groups and lower socioeconomic communities. Use local newspapers, television and radio channels targeted at specific black and minority ethnic communities. Also make use of local shops and businesses, community workers and groups, educational institutions, workplaces, places of worship and local medical establishments, for example, hospitals.
• Offer communities support to improve their diet and physical activity levels.
• Ensure people at high risk of diabetes know how to access appropriate services.
• Consider running mass-media campaigns to raise awareness of the lifestyle changes that can help reduce the risk of diabetes (where possible and appropriate, utilise established national campaigns). These should highlight the need to reduce the amount of time spent being sedentary and highlight the importance of being physically active and adopting a healthy diet. Messages should aim to increase awareness of what constitutes an effective level of physical activity. They should also increase awareness of the calorie content of standard-portion sizes of energy-dense foods and drinks (such as confectionery, fast foods and sweetened drinks).
• Communication specialists should monitor media and other campaigns promoting the prevention of diabetes. This includes campaigns that generally promote a healthier lifestyle. They should establish relationships with broadcast and Internet-based mass and specialist media to ensure accurate information is communicated on the risks and how to prevent diabetes.

Now answer the following questions about the above draft recommendation

1. Please indicate how strongly you agree or disagree with the following statements about the above draft recommendation

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
It is clear and easy to understand					
It is relevant to me in my job					
It is useful to me in my job					
It will have a positive impact on the prevention of pre-diabetes among adults in high-risk groups					

2. What do you think will be the key challenges faced in implementing this recommendation?

Rank the following in order from 1 - 5, where 1 is the smallest and 5 the biggest challenge

	1 smallest	2	3	4	5 biggest
Funding					
Staffing levels					
Training					
Leadership					
Other					

Other (please specify)

3. Please use the space below to tell us any other thoughts you have on this draft recommendation, such as equalities implications, resource implications, impact on your current policy and practice, and whether any roles/organisations are missing from the list of "who should take action".

Recommendation 4 Targeting interventions at communities at risk of dia...

Who should take action?
Commissioners and providers working in national and local public health services, in partnership with:
- the NHS: local health commissioners and key staff within GP consortia (for example, GPs, practice and community nurses, dietitians, public health nutritionists and those working in ante and postnatal services); community pharmacists; doctors and nurses working in acute and emergency care; and occupational therapists
- local authorities: including commissioners and managers, education providers and managers of leisure services, planning departments and public transport providers
- voluntary organisations, community leaders and trained lay workers.

What action should they take?
• Work in partnership to develop physical activity, dietary and weight management interventions that are culturally appropriate for black and minority ethnic groups and lower socioeconomic communities. Identify any skills gaps and train or recruit staff to fill the gaps.
• Identify and address barriers to participation. This includes developing communication strategies which are sensitive to language use and information requirements.
• Use community resources to improve awareness of the key messages and to increase accessibility to the interventions. For example, involve community organisations and leaders at the development stage, use the media, plan events or attend festivals specifically aimed at black and minority ethnic groups. Also involve existing community groups or clubs, such as mother and toddler groups and local football clubs.
• Recruit lay workers from black and minority ethnic groups and from low-income communities to deliver interventions to prevent diabetes among these communities.
• Where necessary, train lay workers in how to plan, design and deliver community-based health promotion activities. Training should be focused, structured and based on proven training models and evaluation techniques. It should give participants the chance to practice their new skills out in the community. It should also encourage them to pass on the knowledge they have learnt to their peers.
• Lay workers and health professionals should identify ‘community champions’ for example, religious and community leaders. They should encourage these champions to promote healthy eating and physical activity and, in particular, to participate in interventions to prevent diabetes.
• Encourage lay workers to recruit other members of their community.
• Ensure lay workers work as part of a wider team led by health professionals. They should be involved in the planning, design and delivery of credible and culturally appropriate messages13. This includes helping people to develop the practical skills they need to adopt a healthier lifestyle for example, by running cookery classes or physical activity sessions. Management and supervision of these activities should be provided by the health professionals leading these teams.
• Commission culturally appropriate weight management programmes either from the NHS or commercial providers. These should be provided in areas where populations at high risk of diabetes live and should be located in community settings (for example, mosques and social clubs).
• Ensure systems or initiatives used to assess individual-level risk in high-risk communities are culturally appropriate.
• Ensure identification and assessment systems or initiatives are linked to effective services and interventions for individuals deemed to be at high risk.

Now answer the following questions about the above draft recommendation

1. Please indicate how strongly you agree or disagree with the following statements about the above draft recommendation

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
It is clear and easy to understand					
It is relevant to me in my job					
It is useful to me in my job					
It will have a positive impact on the prevention of pre-diabetes among adults in high-risk groups					

2. What do you think will be the key challenges faced in implementing this recommendation?

Rank the following in order from 1 - 5, where 1 is the smallest and 5 the biggest challenge

	1 smallest	2	3	4	5 biggest
Funding					
Staffing levels					
Training					
Leadership					
Other					

Other (please specify)

3. Please use the space below to tell us any other thoughts you have on this draft recommendation, such as equalities implications, resource implications, impact on your current policy and practice, and whether any roles/organisations are missing from the list of "who should take action".

Recommendation 5 Creating local environments that support healthy food c...

Who should take action?
Commissioners and providers working in national and local public health services, in partnership with:
- the NHS: including public health nutritionists, dietitians, commissioners and procurement teams
- local authorities: including commissioners and managers, education providers and managers of leisure services, planning departments and public transport providers
- voluntary organisations and community leaders.

What action should they take?
• Increase people's awareness of their eligibility for benefits and wider schemes that will supplement the family's food budget and improve their eating patterns. This includes free school meals, free school fruit and Healthy Start food vouchers. Also consider providing information on how to produce healthier meals and snacks on a budget.
• Work with local food retailers, caterers and workplaces to encourage local provision of affordable fruit and vegetables and other food and drinks that can contribute to a healthy, balanced diet.
• Ensure interventions such as cookery classes are provided at times to suit those with children (or provide a crèche). They should also take place in acceptable and accessible venues such as within children's centres.
• Local planning departments should strive to increase the opportunities available for local people to adopt a healthy, balanced diet by ensuring:
- large and medium-sized food retail developments are readily accessible locally, either on foot or via public transport
- planning policies restrict permission for less healthy food outlets in specific areas, for example, near to schools
- planning policies take into account the needs of, and barriers faced by, particular subgroups14.
• Local authorities and the NHS should encourage local retailers that serve low-income communities to use subsidies (such as voucher schemes) and incentives (such as promotional offers) to promote healthier food and drink options. The aim should be to make the healthier choice the easiest and relatively cheaper choice. The retailers targeted may include street markets and small independent shops.
• Local authorities and the NHS should set an example as employers, by developing policies to prevent obesity, in line with existing NICE guidance and (in England) the local obesity strategy. For example, they should always promote healthier food and drink choices in restaurants, hospitality suites, vending machines and shops for staff and clients. (This could be achieved by using posters, pricing and positioning of products.)

Now answer the following questions about the above draft recommendation

1. Please indicate how strongly you agree or disagree with the following statements about the above draft recommendation

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
It is clear and easy to understand					
It is relevant to me in my job					
It is useful to me in my job					
It will have a positive impact on the prevention of pre-diabetes among adults in high-risk groups					

2. What do you think will be the key challenges faced in implementing this recommendation?

Rank the following in order from 1 - 5, where 1 is the smallest and 5 the biggest challenge

	1 smallest	2	3	4	5 biggest
Funding					
Staffing levels					
Training					
Leadership					
Other					

Other (please specify)

3. Please use the space below to tell us any other thoughts you have on this draft recommendation, such as equalities implications, resource implications, impact on your current policy and practice, and whether any roles/organisations are missing from the list of "who should take action".

Recommendation 6 Creating local environments that support physical acti...

Who should take action?
Commissioners and providers working in national and local public health services, in partnership with:
- local authorities: including local planning departments
- the NHS: including commissioning and procurement teams.

What action should they take?
• Local public health services should assess the type of physical activity opportunities needed locally and at what times and where. They should consider social norms, family practices and any fears people may have about the safety of areas where activities are sited (this includes fears about how safe it is to travel there and back).
• Local public health services should map local physical activity opportunities against local needs and address any gaps in provision.
• Local authorities should ensure council-run leisure services are affordable and acceptable to those at high risk of developing diabetes. This includes providing affordable childcare facilities and public transport links. It also includes ensuring the environment is culturally acceptable. For example, local authorities should consider the appropriateness of any videos and music played. They should also consider providing single-sex facilities, exercise classes, swimming sessions and walking groups – for both men and women.
• Local planning departments should ensure:
- planning policies provide for physical activity in safe locations that are accessible locally either on foot or via public transport
- the local infrastructure encourages people to be physically active as part of their daily routine (for example, by allowing them to walk to the shops and work)
- the internal infrastructure of buildings encourages physical activity, for example, by encouraging people to take the stairs rather than the lift.
• Local authorities and the NHS should develop 'active travel' plans for their staff and visitors to encourage them to opt for healthier modes of transport to and from their premises. Walking and cycling can be encouraged by providing showers and secure cycle parking. Signposting and improved decor could encourage them to use the stairs rather than the lift when at work. In addition, people could be encouraged to be active in lunch breaks and at other times, through organised walks and subsidies for local leisure facilities.
• Local public health services should provide information on local, affordable, practical and culturally acceptable opportunities to be more active. If cultural issues affect people's ability to participate, they should work with them to identify activities which may be acceptable. (This may include, for example, single-gender swimming or exercise classes and Asian dance classes.)
• Local public health services should work with local employers to implement, and increase employee's awareness of their eligibility for, 'salary sacrifice' and other schemes that promote physical activity in the workplace.

Now answer the following questions about the above draft recommendation

1. Please indicate how strongly you agree or disagree with the following statements about the above draft recommendation

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
It is clear and easy to understand					
It is relevant to me in my job					
It is useful to me in my job					
It will have a positive impact on the prevention of pre-diabetes among adults in high-risk groups					

2. What do you think will be the key challenges faced in implementing this recommendation?

Rank the following in order from 1 - 5, where 1 is the smallest and 5 the biggest challenge

	1 smallest	2	3	4	5 biggest
Funding					
Staffing levels					
Training					
Leadership					
Other					

Other (please specify)

3. Please use the space below to tell us any other thoughts you have on this draft recommendation, such as equalities implications, resource implications, impact on your current policy and practice, and whether any roles/organisations are missing from the list of "who should take action".

Recommendation 7 Training health professionals

Who should take action?
Commissioners and providers working in national and local public health services, in partnership with:
- the NHS: local health commissioners and key staff within GP consortia (for example, GPs, practice and community nurses, dietitians, public health nutritionists and those working in ante and post-natal services); community pharmacists; and doctors and nurses working in acute and emergency care
- royal colleges and professional associations, further and higher education training boards, and other organisations responsible for setting competencies and developing continuing professional development programmes for health professionals
- local authorities: including education providers and managers of leisure services
voluntary organisations: including community leaders and voluntary workers
- those working in the commercial sector.

What action should they take?
• Ensure all health professionals are trained to identify people from communities at increased risk of developing diabetes. They should also be trained to understand the cultural, religious and economic influences on these communities. Ensure they are given time and support to develop and maintain these skills.
• Monitor health professionals' knowledge and awareness using, for example, personal development plans and annual reviews.
• Ensure curricula and continuing professional development programmes for health professionals incorporate the knowledge and skills needed to ensure health promotion interventions are culturally sensitive.
• Ensure medical undergraduate training covers nutrition, physical activity and weight management in relation to the prevention of type 2 diabetes.
• Ensure training is focused, structured and based on proven models and evaluation techniques. It should offer opportunities to practice the new skills out in the community. It should also help health professionals to spread their knowledge among colleagues.

Now answer the following questions about the above draft recommendation

1. Please indicate how strongly you agree or disagree with the following statements about the above draft recommendation

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
It is clear and easy to understand					
It is relevant to me in my job					
It is useful to me in my job					
It will have a positive impact on the prevention of pre-diabetes among adults in high-risk groups					

2. What do you think will be the key challenges faced in implementing this recommendation?

Rank the following in order from 1 - 5, where 1 is the smallest and 5 the biggest challenge

	1 smallest	2	3	4	5 biggest
Funding					
Staffing levels					
Training					
Leadership					
Other					

Other (please specify)

3. Please use the space below to tell us any other thoughts you have on this draft recommendation, such as equalities implications, resource implications, impact on your current policy and practice, and whether any roles/organisations are missing from the list of "who should take action".

Recommendation 8 National-level action to promote an environment that suppo...

Who should take action?
Commissioners and providers of national and local public health services in the public and private sector.

What action could they take?
Identify and work with a range of commercial partners to promote the provision of healthier food choices. For example:
• Work with food manufacturers to change the composition of prepared foods where needed. This could include reducing the calorie, fat and salt content through product reformulation.
• Work with caterers to help them provide healthier food and drink choices as the default option.
• Work with food retailers to develop pricing structures that favour healthier food and drink choices and to ensure there is a broad range of portion sizes on sale, particularly for energy-dense foods and drinks. The aim is to allow greater consumer choice.
• Work with food manufacturers, caterers and retailers to provide clear, non-ambiguous and consistent nutrition information. This includes prominent displays of calorie content on the front of packaging and the use of clear signage for unpackaged foods.
• Support the development of home cooking resources which give information on the nutritional content of foods prepared at home and offer practical advice on preparing healthier meals. (Resources might include websites offering recipe suggestions.)

Now answer the following questions about the above draft recommendation

1. Please indicate how strongly you agree or disagree with the following statements about the above draft recommendation

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
It is clear and easy to understand					
It is relevant to me in my job					
It is useful to me in my job					
It will have a positive impact on the prevention of pre-diabetes among adults in high-risk groups					

2. What do you think will be the key challenges faced in implementing this recommendation?

Rank the following in order from 1 - 5, where 1 is the smallest and 5 the biggest challenge

	1 smallest	2	3	4	5 biggest
Funding					
Staffing levels					
Training					
Leadership					
Other					

Other (please specify)

3. Please use the space below to tell us any other thoughts you have on this draft recommendation, such as equalities implications, resource implications, impact on your current policy and practice, and whether any roles/organisations are missing from the list of "who should take action".

Recommendation 9 National-level action to promote an environment that suppo...

Who should take action?
National and local public health services, including data collection services.
Organisations with a remit for increasing physical activity levels or helping to reduce levels of obesity.

What action could they take?
• Ensure the benefits of physical activity – and what constitutes an effective level of physical activity – are made clear to encourage people to be more physically active.
• Support a shift in the population towards being more physically active by encouraging even small changes.
• Monitor the population's overall physical activity levels to determine the success of national-level interventions.
• Assess the health impact of all initiatives and interventions to encourage physical activity.
• Establish national and local systems to ensure action to encourage physical activity is linked to transport policy, the design of new buildings and the wider built environment.

Now answer the following questions about the above draft recommendation

1. Please indicate how strongly you agree or disagree with the following statements about the above draft recommendation

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
It is clear and easy to understand					
It is relevant to me in my job					
It is useful to me in my job					
It will have a positive impact on the prevention of pre-diabetes among adults in high-risk groups					

2. What do you think will be the key challenges faced in implementing this recommendation?

Rank the following in order from 1 - 5, where 1 is the smallest and 5 the biggest challenge

	1 smallest	2	3	4	5 biggest
Funding					
Staffing levels					
Training					
Leadership					
Other					

Other (please specify)

5
6

3. Please use the space below to tell us any other thoughts you have on this draft recommendation, such as equalities implications, resource implications, impact on your current policy and practice, and whether any roles/organisations are missing from the list of "who should take action".

Your views on the questionnaire

1. Please answer the following questions

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
The questionnaire was clear about its purpose					
The questionnaire was easy to use and to complete					

2. Please use the space below for any other comments on the questionnaire?

5

6

Consent form

Consent to participate

NICE Fieldwork on the prevention of pre-diabetes among adults in high risk groups
This letter explains important details about the fieldwork in which you have verbally agreed to participate. Please read the letter and sign to indicate consent at the end.

As part of the NICE public health guidance process, we are carrying out fieldwork in order to find out your views as a practitioner/commissioner/manager so that NICE's recommendations are relevant, appropriate, useful, feasible and implementable. NICE is an independent organisation and is responsible for providing national guidance on promoting good health and preventing and treating ill health.

Interviews will last about 30-45 minutes, discussion groups will last about 90 minutes.

We will record the discussion, for reference when reporting. Recordings will be handled in accordance with best practice, with transcripts held securely and destroyed after five years.

The report produced will be used by NICE to produce a final version of its recommendations, and will be published on the NICE website. Your identity will not be revealed in the research or any final products. We may quote you, but all comments will be anonymised.

We will provide you with a copy of the draft NICE guidance prior to the appointment.

If you have any questions regarding this research or your rights as a participant, you can contact the project manager, Graham Kelly, at Graham@womresearch.org.uk

Your signature indicates that you have read and understood the information provided above, that you willingly agree to participate, that you understand you may discontinue participation at any time without being required to give a reason and without penalty, and that you have received a copy of this form.

Please fill in the details to indicate consent

Your name……..

Your signature……..

Your organisation……

Date……