Fieldwork Report:

Obesity - Working with Local Communities

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

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Structure of this report

This report contains the following chapters:

The executive summary can be found at the front of the report. This summarises the main overarching themes from the fieldwork.

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 describes the key actors and players involved in establishing a community-wide approach to preventing obesity, including the relationships between and within partner organisations.

Chapter 4 provides discussion on the barriers and facilitators relevant to a community-wide approach to preventing obesity.

Chapter 5 discusses issues of sustainability.

Chapter 6 considers matters of evaluation and cost effectiveness analysis.

Please note that all opinions expressed in this report are those of fieldwork participants, unless otherwise stated.

Executive summary

As part of the Government's obesity strategy work programme, the Department of Health asked the Centre for Public Health Excellence at NICE to produce guidance on working with local communities to prevent obesity. After reviewing evidence, CPHE concluded that there was a gap in the evidence in relation to local community-wide action. Consequently CPHE decided to commission fieldwork to gather information from local public health teams and other relevant parties, about the practicalities of implementing community-wide action to prevent obesity.

This fieldwork was conducted by Word of Mouth. The opinions and experiences described in this report arise from the data obtained in the 35 individual interviews and four discussion groups conducted in this fieldwork process, involving a total of 93 participants.

In reading the report, it should be noted that participants did not tend to have rigid distinctions between interventions at the population level, and the individual level. Both would often be referred to in the same sentence, and issues such as the tensions between long-term strategy and short-term delivery apply to both levels.

Establishing a community-wide approach to preventing obesity: Key actors and players
Fieldwork participants reported that there is potentially a vast range of different actors and agencies to include within a genuinely community-wide approach to preventing obesity. For such a network to be effective, it is thought essential that partners share an overarching vision around obesity prevention, with each organisation "buying in" and feeling a sense of ownership.

At the strategic level, the impetus for a community-wide approach begins with local elected members and senior managers (particularly, but not exclusively, from the NHS and the local authority). If they can provide the basic building blocks, Public Health is best placed to provide investment and hands-on leadership for the network of partners, aided by the Health and Well Being Board, which needs to exert its influence on the Clinical Commissioning Group to ensure investment and "buy in" across community health services.

In order to build the network of partners, it is recommended that local communities and services are viewed from the perspective of individual citizens, to identify the most relevant "touchpoints", i.e. services regularly used and trusted by key groups such as parents. Once signed up as partners, these touchpoints can be leveraged to make every contact count.

Information needs to be shared and relationships developed both "horizontally" across partner organisations, and "vertically" inside individual organisations, via the key level of middle management, such as team leaders in services such as Health Visiting and Adult Social Care, Project Managers in community organisations, etc. Failure to ensure that middle managers and frontline workers share the vision and understand the community-wide approach is perhaps the most common factor limiting the effectiveness of such partnerships.

It is essential that the main delivery organisations (e.g. community projects with Provider contracts) have credibility within their local communities. Community engagement is the key activity in building and developing this credibility.

Facilitators of an effective community-wide approach

After consulting our participants, we concluded that having a central coordination and communications function is to be strongly recommended. This function must engage beyond senior management level in the partner organisations, particularly striving to ensure that middle managers share the vision, and are well informed about the wider network.

Concise briefings on key issues are important for middle managers and frontline staff, to build confidence, capacity and consistency in messaging across the wide range of partners.

Strategy should take an iterative approach, reviewing progress regularly.

Partner organisations should be expected to make an explicit commitment of what they will contribute, and this should be publicised across the network. Those making investment decisions should build on proven success by "backing winners", and concentrate investment where it is most likely to succeed.

Barriers to an effective community-wide approach

Starting conversations about obesity with individual clients/patients is difficult, and there are numerous reasons why staff may not have the confidence or the motivation to do so, even among primary care professionals. It is very important to build confidence and capability amongst customer facing staff in both primary care and community settings, as the credibility of messages from the latter will be seriously undermined if inconsistent with messages from the former.

In terms of population wide primary prevention, the term "obesity" can be off-putting, and engagement with target audiences may be easier if the focus is framed as "healthy lifestyles". This more broadly-based approach may also be more stable in terms of long-term funding.

Financial barriers are significant for many low-income groups, particularly in terms of the cost of transport and accessing services.

Cultural minorities and disabled people face additional barriers in accessing information and services, and their specific needs should be considered carefully when assessing needs.

Participants reported that a significant contribution can be made by volunteers (health champions/peer mentors), but there are concerns that their effectiveness is limited by the willingness of health professionals to make referrals to them.

The prevention of obesity is a long-term objective, but most project funding is short-term. There are complex personal, family and socio-economic causes applying to many obese and overweight people. Both Commissioners and Providers would like to be able to commit to

longer-term contracts for obesity prevention work, in recognition of the considerable time and resources needed to successfully engage with clients with complex needs, for whom positive short-term outcomes are less likely.

Sustainability

Change is inevitable, and what matters is the sustainability of the strategy and the wider network of partners. Underneath the strategy, it is only natural that practices, individuals and organisations will change over time.

The single most important factor in sustainability is the maintenance and development of the shared vision, and this requires effective communication to maintain the engagement, particularly with politicians, middle managers. Frontline staff and organisations that may see themselves as peripheral to the issue of obesity.

A key message in this communication must be the commitment to evaluation and ongoing service improvement.

If pump priming funds (i.e. short-term funds, aimed at stimulating future investment from mainstream sources) are made available to establish the network, plans to transfer responsibilities to mainstream budgets should be built in wherever possible, so that responsibilities are inherited when the initial funds cease. However, in the context of current public expenditure constraints, mainstream incorporation cannot be guaranteed.

It is inevitable that funding streams will change over time, with some diminishing and others growing or emerging. By recognising that obesity is an essential concern for many health and social issues, it should be possible to be flexible and creative in justifying ongoing funds for obesity prevention work, despite such changes.

The community-wide approach should seek to build on existing community assets. This will build capacity in people and institutions that will continue, even if obesity specific funding diminishes. Commissioners need to manage public money carefully, and rightly expect outcomes to be achieved, but they should also consider the fact that at some point in the future, they may be relying on influence and goodwill rather than contractual obligations.

Those participants with longer-term experience of community-wide action strongly recommended that there should be a clear separation of strategic and operational management, using boards/forums with distinctive terms of reference.

Having a strong local brand or identity is important, particularly for workers in the network of organisations, as it is important for them to feel part of a bigger picture.

Evaluation

Most participants thought that evaluation was becoming even more important, as financial constraints increased. Data collection and monitoring were also considered to be useful for project management, keeping all parties focused on goals and service improvement.

People thought about evaluation primarily in terms of individual programmes, projects and interventions. Only the participating Academic attempted to describe an appropriate evaluation design for a community-wide approach to obesity prevention. This involved three layers of population data, covering epidemiological, behavioural and cognitive measures, with a process evaluation running alongside.

A very common complaint throughout this fieldwork, was around the belief that obesity prevention is a long term challenge, with long timescales for return on investment, and yet funding is very often short-term, with unrealistic outcome expectations. Many participants called for more acceptance of intermediate outcomes in commissioning contracts. For example, it was reported that in contracts aimed at moving the long-term unemployed into work, there are accepted "job readiness" milestones. It was suggested that "weight loss readiness" milestones would be appropriate for those working with clients with complex needs.

The example of "job readiness" in employment related community work was cited, with the suggestion that "weight loss readiness" was a similarly legitimate intermediate outcome.

There is clearly tension between Commissioners and Providers on the definition of acceptable "evidence". There were strong views expressed about the use of narrow, quantitative outcome criteria, versus a preference for a broader range of outcome measures including qualitative data. There are rational reasons for these positions, with Providers pursuing a broad range of (sometimes difficult to measure) objectives for the well-being of their communities. In contrast, Commissioners are the guardians of public money, and are wary of "cherry picking", and therefore tend towards a focus on specific quantifiable outcomes. To some extent these are natural tensions in any performance management scenario, but it may be helpful to consider the applicability and acceptability of different types of evidence, in the context of the very limited time and resources available at a local level.

Although most participants reported involvement in evaluations, it seemed that the primary purpose was often contract performance management. There was little evidence of a systematic approach to building a local evidence base. The reasons for this were said to be lack of time and money. Money for evaluation essentially means money taken out of what is available for service delivery. Project timetables and budgets rarely allow for the establishment of robust baselines on which to base evaluations.

Some Providers believed that the burden of data collection, monitoring and reporting has become excessive. This was particularly the case for those receiving funding from multiple sources, and there is frustration at the inconsistency of data required by different funders. One participant with considerable evaluation experience recognised this perspective, and believed that it was partly due to the failure of evaluators to properly brief those collecting the data, to explain the rationale and to address any misunderstandings in what is required.

A number of participants remarked that the evaluation methods typically employed for obesity prevention work tended to ignore clients who had dropped out of the

programme/intervention. This would seem to be a significant gap in the development of evidence.

Cost effectiveness

Few participants seemed to have a clear understanding what was meant by cost effectiveness analysis. When asked whether they undertook such work, participants often responded with very general and subjective comments about value for money and cost management.

Those with more training and experience in evaluation methods were clear in telling us that very little true cost effectiveness evaluation is undertaken. This is primarily because it is a rare and specialist skill. To commission externally is expensive, and if the skills are available internally it is very time intensive. Though not articulated in these words, participants seem to be telling us that cost effectiveness analysis is not justified on grounds of cost effectiveness!

There seems to be relatively little scrutiny of cost effectiveness (as opposed to cost management). Those holding the purse strings at higher levels appear to have limited understanding of cost effectiveness analysis, meaning that there is little pressure to undertake such work.

Among those who understood the principles, there seemed to be a fear that public health investment might be disadvantaged by more exposure to cost effectiveness analysis, due to public health delivering longer-term returns on investment, and the difficulty of attributing cause and effect (relative to clinical treatment).

There was also a concern that truly like-for-like comparisons are difficult to achieve in cost effectiveness analysis. In this view there was a risk of simplistic interpretation, in which differences between programmes and interventions may be caused by underlying socio-economic factors that were not visible in the calculation.

Part A: Background information

1. Introduction

1.1 Policy context

The burden of obesity on society is well documented[1]. Obesity is a major risk factor for a broad range of health conditions. Morbid obesity is responsible for a reduction in life expectancy of between eight and ten years, equivalent to lifelong smoking, and for a poor quality of life among those affected. Obesity is the cause of depression and low self esteem among many of those affected. While obesity affects all groups in society, there is a social class and ethnic dimension, whereby disadvantaged groups and some minority ethnic groups are affected disproportionately. The economic costs[2] of obesity are huge, and are felt both in terms of treating the condition and in lost productivity and welfare payments. Despite significant efforts to tackle obesity – particularly among children – the rates of obesity among children and adults in England are among the highest in the world.

As the scope for this guidance points out, the causes of obesity are complex, and to date policy responses to reduce rates of obesity have been disappointing both in the UK and in the rest of the world. In assessing the evidence of effectiveness of interventions, policy makers have tended to rely on evidence of individual interventions targeted at specific groups: there has been much less attention paid to the interplay and interconnection of a range of approaches – or to the complexities that are involved in planning, organising and delivering these approaches at a local and community-wide level. Much of the scientific literature has focused on interventions targeted at individual behaviour change in relation to diet and/or physical activity. This is because these types of intervention lend themselves more readily to clinical forms of evaluation. However, what is lost as a result is an assessment of the potential of the inter-connection of a range of interventions to prevent obesity.

While there is increasing acceptance among experts that the causes of obesity are complex and take in a wide range of influences – as shown in the list overleaf– there has been little appreciation that the prevention of obesity is likely to require similarly complex and cross-cutting responses that address the inter-connection of the determinants. Appreciating the impact of a broad range of factors on the development of obesity demands an equivalent exploration and understanding of a community-wide response. This is what we understand to be at the core of this present study.

[1] The Foresight Review, 2007

[2] B. McCormick, I. Stone Department of Health, http://www.bis.gov.uk/assets/bispartners/foresight/docs/obesity/161-164.pdf

The range of causes of obesity identified by the Foresight Review 2007

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

1.2 The scope of the guidance to which this fieldwork contributes

This research report will contribute to the development of new NICE guidance on working with local communities to prevent obesity. The fieldwork on which this report was based, was conducted with reference to the definitions set out in the project scope for the guidance development. This can be found on the following link: http://guidance.nice.org.uk/PHG/Wave20/53.

The definition of the population to be covered by this guidance is very straightforward, as it encompasses everyone except those undergoing clinical treatment for obesity.

In terms of activities covered, the focus is on enabling local policy and decision makers to work with their communities, with the aim of reversing obesogenic tendencies in modern life. These decision makers are defined as including "public health commissioners and managers, and those working in local authorities, sports, physical activity and recreational services, the food industry and retailers, the voluntary sector and people living or working in local communities".

From existing evidence, the influential factors for success (or failure) are well known, but the picture is less clear on how these factors can appropriately be brought together to produce effective "packages" at a local level. The key known factors include the following:

- Locally implemented strategies, plans and initiatives, including initiatives run by community and NHS services
- Partnership working (between, for example, primary care, local authorities, local community organisations and local businesses)

- Local services and other local factors such as food, transport, education, planning and media
- Training and development for those involved in local efforts to prevent obesity.

In focusing on "prevention" of obesity, NICE is referring both to primary and secondary prevention, i.e. preventing people becoming obese, and helping obese individuals to achieve a healthy weight.

It should be noted that the project scope does not include national policy, clinical management, prevention of conditions associated with obesity (e.g. type 2 diabetes), location specific interventions, complementary therapy, or definitions around the terms "overweight" and "obese".

It should be noted that, at the time that fieldwork was conducted (October 2011), all agencies involved in community-wide action on obesity were subject to considerable organisational change, and financial challenges. In particular, local government was in the process of significantly reducing its expenditure, with direct consequences for its funding of community groups. In the NHS, Primary Care Trusts (PCTs) were expecting to be abolished in two years time, and the Clinical Commissioning Consortia will inherit the PCTs' responsibilities were still at an embryonic stage. Public Health was in the process of transferring from the NHS into local government, and local Health and Well-Being Boards (designed to remove divisions between the NHS and local authorities) were still in the "early implementation" phase.

The impact of these changes presented challenges to the fieldwork process. We found that some of the individuals we were recommended to talk to had been made redundant or transferred to different roles, and funding had sometimes been withdrawn for projects which, a few months previously, had been cornerstones of local community-wide action. Contacting people to invite participation was complicated by numerous office moves and changes in e-mail addresses and telephone numbers. Whilst a degree of change is to be expected on any fieldwork project, the extent of change encountered on this fieldwork was exceptional.

Consequently the fieldwork was conducted at a time of great change, and uncertainty about the future. This needs to be borne in mind when reading this report.

2 Aims and methods

2.1 Fieldwork aims and questions

Guidance to tackle obesity at a local level using a "whole system approach" was initiated by NICE in 2009. The work was put on hold in November 2010 and reviewed as part of the Government's obesity strategy work programme. The revised scope has a stronger focus on local, community-wide best practice and will be aimed at local decision makers.
The key questions addressed in the development of this piece of guidance include:

1. What are the essential elements of a local, community-wide approach to preventing obesity that is sustainable, effective and cost effective?
2. What barriers and facilitators may influence the delivery and effectiveness of a local, community-wide approach (including action targeting specific groups)?
3. Who are the key leaders, actors and partners and how do they work with each other?
4. What factors need to be considered to ensure that local, community-wide approaches are robust and sustainable?
5. What does effective monitoring and evaluation look like?
6. Can the cost effectiveness of local, community-wide obesity interventions be established and, if so, what is the best method to use?

In phase 1 of this work, the Programme Development Group (PDG) considered various evidence reviews and heard testimony from a number of experts. The evidence considered in relation to a *whole system approach* to prevent obesity provides a foundation for the development of recommendations about *community-wide* approaches to prevent obesity. However, there was a gap in the evidence considered in relation to local community-wide action in England. In particular, a need was identified for more information to answer questions 3, 4 and 6, specifically around how different teams and organisations can work together to maximise their impact. Consequently it was decided to commission primary, qualitative research with practitioners, managers and commissioners, to supplement the evidence available.

A key objective of the fieldwork was to consider the working relationships and dynamics within and between public health team(s), their commissioners and partners, in order to understand how local teams can work together to maximise their impact on obesity prevention across the community.

The fieldwork took a historical view and considered examples of initiatives or strategies over a number of years. It also sought to elicit participant's views on the implications of proposed structural changes to the NHS and local authorities on community-wide action.

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 Four areas of England were selected for this fieldwork. Areas 1-3 (below) had already been the focus of some case study work, examining strategies and policies, and it was decided to build on this by including them in phase 2. The fourth area was added in order to obtain an understanding of factors applicable to a more rural area, with two tiers of local government. 1. Newcastle 2. Sheffield 3. Barking & Dagenham 4. Lincolnshire 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 on 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. Fieldwork 5.1 Fieldwork took place October 6th - 28th, 2011. 5.2 Completed fieldwork comprised four discussion groups and 35 interviews

Approximately 420 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.

Invitation e-mails were followed up by telephone calls, in order to confirm participation and agree appointments for interviews or attendance at discussion groups. Most of the interviews were conducted on the telephone. Discussion groups were conducted face to face, each with an average of 15 people attending.

There were a total of 93 fieldwork participants, with 58 attending the four discussion groups, and 35 taking part in individual interviews.

All interviews and discussion groups were digitally recorded, and will be kept for 12 months and then destroyed, with client's permission. The majority were subsequently transcribed, though this was not possible in two cases, due to excessive background noise. In these cases, the interviewer produced notes by listening to the recording soon after the event. Interview duration varied, with a typical range of between 30 minutes and 65 minutes. Discussion groups had a duration of 90 minutes.

2.3 Fieldwork coverage – types of practitioners and organisations

A target profile for types of roles and organisations to participate was agreed between NICE and Word of Mouth. Word of Mouth then proceeded to identify relevant individuals in each of the fieldwork areas. Individuals were sent an e-mail invitation to participate, and this was followed up by telephone calls to agree appointments and confirm attendance at discussion groups.

A total of 93 participants were included in this fieldwork, in either a group discussion or an interview.

Discussion groups
Four discussion groups were attended by a total of 58 participants, with 16 in Barking, 19 in Newcastle, 7 in Sheffield and 16 in Lincoln. The roles of those attending are summarised below, and the following job titles illustrate the range of roles performed by those attending:

Manager of Community Disability Project
Public Health Consultant
Manager of Walking for Fitness Project
Manager of Sport & Physical Activity Team (Local Authority)
Physical Activity Coordinator
Planning Policy Officer
Children's Centre Manager
Health Improvement Manager
Modern Matron
Manager of Health & Fitness Project
Head of Health & Well-Being
Manager of Sports Development Team
Strategic Lead, Integrated Family Services
Education & Outreach Ranger, Parks Service
Manager from Learning Disability Charity
Manager of Health Visiting Service
Referral Manager, Physical Activity
Manager of Well-Being Consortium
Chief Executive, Community Health Project
Health Worker, Community Health Project
General Manager, Sport in the Community Project
Joint Health Commissioner (NHS)
Director, Community Health Project
Programme Lead, Children's Health Project

Change4Life Coordinator
Health and Well-Being Coordinator
Community Nutrition Manager
Health Improvement Specialist
Deputy Lead, Sure Start
Health & Fitness Specialist
Adult Weight Management Nurse
Commissioner for Obesity
Chair of Community Health Project
Researcher Public Health Nutrition
Senior Social Marketing Practitioner
Health Improvement Lead (Nutrition)
Deputy Chief Officer, Community & Voluntary Services
Social Marketing Coordinator
Health Improvement Practitioner
Healthy Families Coordinator
Locality Lead, Smoking & Weight Team
Food4Life Coordinator
Public Health Nutritionist (weight management company)
Public Health Manager
Head of Patient and Public Involvement
Health Trainers, Programme Manager
School Improvement Manager
Healthy Schools Manager
Environmental Health Services Manager
Councillor (local authority)

Interviews

A total of 35 individuals were interviewed. The following job titles describe the roles that these individuals performed within their organisations.

Roles
Obesity lead
CVD lead
Director of Public Health
Assistant Director of Public Health
Public Health Consultant
Health Improvement Principal

GP
Community Nurse/Nurse Consultant
Senior member of Clinical Commissioning Consortia
Senior NHS Commissioning Manager
Dietitian/Nutritionist
Senior Manager Health & Well-Being Board
Senior Manager, NHS Health Checks
Senior Manager, Weight Management Organisation
Academic associated with one partnership
Community Pharmacist
Local Authority Councillor
Senior Manager of a Weight Management organisation

The mix of roles/organisations

A total of 93 people participated in the fieldwork. Half of these were NHS employees (47); 17 were local authority employees; 15 were employees of community organisations; there were four community pharmacists, three local authority councillors, three Sure Start managers, two managers from weight management companies, one Academic and one Headteacher.

Part B: Findings

Opinions expressed in this report are those of participants, unless otherwise stated.

3. Establishing a community-wide approach to preventing obesity: Key actors and players

Summary

Fieldwork participants reported that there is potentially a vast range of different actors and agencies to include within a genuinely community-wide approach to preventing obesity. For such a network to be effective, it is thought essential that partners share an overarching vision around obesity prevention, with each organisation "buying in" and feeling a sense of ownership.

At the strategic level, the impetus for a community-wide approach begins with local elected members and senior managers (particularly, but not exclusively, from the NHS and the local authority). If they can provide the basic building blocks, Public Health is best placed to provide investment and hands-on leadership for the network of partners, aided by the Health and Well Being Board, which needs to exert its influence on the Clinical Commissioning Group to ensure investment and "buy in" across community health services.

In order to build the network of partners, it is recommended that local communities and services are viewed from the perspective of individual citizens, to identify the most relevant "touchpoints", i.e. services regularly used and trusted by key groups such as parents. Once signed up as partners, these touchpoints can be leveraged to make every contact count.

Information needs to be shared and relationships developed both "horizontally" across partner organisations, and "vertically" inside individual organisations, via the key level of middle management, such as team leaders in services such as Health Visiting and Adult Social Care, Project Managers in community organisations, etc. Failure to ensure that middle managers and frontline workers share the vision and understand the community-wide approach is perhaps the most common factor limiting the effectiveness of such partnerships.

It is essential that the main delivery organisations (e.g. community projects with Provider contracts) have credibility within their local communities. Community engagement is the key activity in building and developing this credibility.

Introduction

The challenge of getting different partners to work cooperatively towards a common goal requires action at two levels - with local politicians and senior managers at the strategic level, and with middle managers, frontline staff and communities at the delivery level. Both present distinct challenges, though most agreed that the greater challenges are ones of optimising the effectiveness of the delivery level.

"I think there are two tiers in terms of working communities. I think there is a strategic partnership level and then there is a much more …..grassroots level, which actually is much harder for the public sector to engineer"
Obesity Lead

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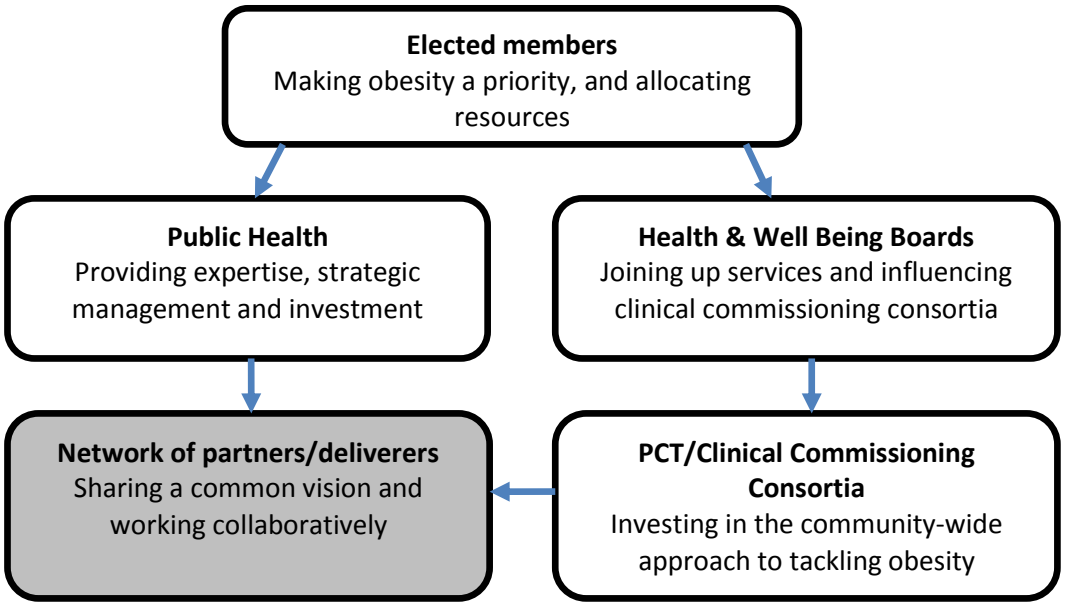
3.1 The strategic level

There are many factors involved in establishing successful community-wide action, but the diagram below summarises the strategic pre-requisites needed to underpin any such approach. This model was not generally explicitly articulated by fieldwork participants, but it was strongly implied by many (particularly senior level) when discussing the essential ingredients of a community-wide approach. Some used a jigsaw analogy to describe the difficulty of putting in place these building blocks, saying that all of the pieces need to be in place at the same time, with each partner feeling ownership of a shared vision.

"If you don't have high level direction and vision, it's probably doomed to failure"
NHS Manager responsible for Health Checks

The agencies in white boxes are "constants", in that these bodies will remain in place for the foreseeable future (although individuals may change, political control may change and Consortia will take over from PCTs). The network partners are presented in a shaded box, to remind us that this comprises multiple partners, and the number and mix of partners can change over time, according to resources available, commissioning priorities, evidence of effectiveness, and other factors.



Although this model may seem simple on paper, the challenge is in ensuring that all elements are working towards common goals, have similar priorities and operate with a shared vision. In reality, there are significant barriers to achieving this cohesion. Participants agreed that the infrastructure needed for an effective community-wide approach takes time to build, and changes in resource allocation, policy priorities and key personnel can all undermine progress at the development stage.

A key requirement is for **elected members** to regard obesity prevention as a major priority, but there are many issues competing for this status, particularly in areas of deprivation. This represents a significant challenge for those seeking to gain political support for the obesity agenda, and to maintain its priority status at times of political instability, whether that be through a change in the majority party, or personnel changes on relevant committees. The localism agenda suggests that local politicians will be granted more freedom to decide their own priorities, and allocate resources accordingly. Obesity is just one of a large number of competing causes, vying for political attention at the local level, and we cannot simply assume that it will always be a priority. Indeed, aspects of the obesity prevention agenda can sometimes be perceived to conflict with other priorities such as economic regeneration. For example, it was suggested that developers can be put off by planning policies that seek to limit certain types of food retailing, or encourage walking over car related travel. In deprived areas, this potentially presents policy makers with a "jobs versus health" dilemma.

"… elected members …might focus on other things like decent neighbourhoods or employment and housing".
Senior Public Health Manager

Alongside elected members, it was thought equally important that there was solid commitment from relevant **senior managers** operating at policy-making levels in the NHS and local authorities.

Health and Well Being Boards are at an "early implementer" stage in most areas of England, but participants reported that they would have a very wide remit, covering many health and social issues. For them to enable the development of effective community-wide action on obesity, two things are necessary: first to give obesity a prominent position in the local health and well-being strategy; and second to exert significant influence on the Clinical Commissioning Consortia, since these Consortia will hold much of the available resources, and will decide priorities for most local health services. At the time of undertaking the fieldwork, it is too early to say how much of a challenge it will be for both of these things to be achieved, though it is clear that the Boards will have very difficult prioritisation decisions to make.

"I think the challenge is that there (are) too many things that we would like to make a difference (to) ….it's very difficult to work out which priority you address so we have high teenage pregnancy levels, we have high incidence of Chlamydia, we have obesity and we have low uptake of immunisations, we have massive financial problems, we have low employment rates. So the issue is not agreeing priorities and outcomes, it's having too many priorities".
Health and Well Being Board Manager

Clinical Commissioning Consortia are also at a very early stage of development, and there was no evidence that they have had a direct influence on any current policy or practice. The impression gained from the fieldwork was that participants were still very unclear on what, if any, differences there would be when PCTs cease to exist, and the Consortia are fully operational. From our limited amount of fieldwork with GPs in Pathfinder Consortia, it does seem that obesity is recognised as a major issue, though perhaps from a perspective that is not entirely consistent with mainstream Public Health thinking - for example the view that prevention work should focus almost entirely on young people, since work with overweight (middle-aged) adults was of dubious value.

> *There are some services that unfortunately will fall by the wayside when it comes to the clinical commissioning….and I think that is going to be an issue going forward. Because in the new world, when GP led commissioners and consortia take the reins, it will be their priorities …. And I think it's going to have a real issue for an equitable service.*
>
> NHS Health Checks Manager

There was widespread agreement that **Public Health** professionals need to provide hands-on leadership of community-wide partnerships, since they have the necessary skill set and the range of appropriate strategic level connections. The move of Public Health into local government, and the link with Health and Well Being Boards were seen to be very positive developments, in this respect.

Ideally, a **network of partners** needs to be built on the basis of senior level support across a range of different stakeholders, beyond local government and the NHS, including third sector organisations, employers, private sector representative bodies, trade unions, hospitals and schools/colleges/universities, within a local area. In reality, building such an alliance is not easy, particularly among those for whom the issue of obesity is "off the radar", and mixed experiences were reported, particularly in terms of the engagement of the private sector, employers and planning departments.

The effective operation of the network partners is discussed in more detail in the following section.

3.2 The delivery level

When asked to specify the key actors and partners that should be included in a community-wide approach to preventing obesity, our participants specified a very long list of potential partners, as shown in the table below.

Key actors and partners in a community-wide approach to preventing obesity
Most commonly mentioned
Primary Care Trusts - and in future Clinical Commissioning Consortia
Health and Well-Being Boards & Children's Trusts
Public Health (often specified as being the leaders)
Local Authorities and their services, including Sports/Leisure, Parks, Social Housing Management, Social Services (Adult and Children's), Planning and Regeneration, Environmental Health, Cultural and Community Services
NHS services, including Commissioners and Community Health services, in particular GPs and their clinics, Dietitians, Health Visitors, District Nurses, School Nurses, Psychologists, Physiotherapists, Occupational Therapists and "Health Professionals" in general
Change4Life campaign
Schools, Further Education Colleges and Universities
Children's Centres/Sure Start and services associated with Early Years
Youth Services including Youth Offending and Teenage Pregnancy services
Employers and Workplace Health services
Weight Management services, including private sector and not for profit sector
Community and Faith groups, including outreach work in these settings
Community Pharmacies
Community leaders, volunteers, health champions and others with credibility in specific communities
Private sector representative bodies, e.g. Chambers of Commerce
Private sector businesses, particularly food businesses and those acting as contractors to the NHS, local authorities and other public sector bodies
Less commonly mentioned
Transport services
Health charities, e.g. Diabetes UK
Media, including online social media
Parents
Carers (including paid carers) for disabled people
Home Start
Celebrity role models (including notable local people)

In the following sections we discuss the key factors in establishing such a network of partners, and making it operate effectively.

3.2.1 Establishing a broad base of partners on which to build a community-wide approach

There was general agreement that hands-on management of the partnership was best led by Public Health, with NHS and local government services as essential partners. This trio

were expected to take the main responsibility of driving forward the obesity strategy and associated community-wide action.

The other services listed above as "most commonly mentioned" were also seen as essential members of any community-wide partnership, but would typically not be expected to provide the coordination and drive. For example, Schools are universally seen as being very important, but few would expect Headteachers to the appropriate people to play a leadership role.

Those in the "less commonly mentioned" list were generally also seen as somewhat more peripheral to the obesity agenda. Having them on board could provide extremely useful assistance, but they were likely to take some persuading. Of course there were exceptions to this classification. For example, Health Charities probably don't need to be persuaded of the importance of the obesity agenda, and some local government services (e.g. Planning) often do need to be persuaded.

In some ways a narrow range of partners may be attractive, as it would be easier to coordinate, and would consist of bodies that should (in principle at least) require less persuasion and support to be active members. However, there were a number of reasons why it was advisable to invest time and effort engaging those with a more "peripheral" relationship to the obesity agenda. First, because they can sometimes provide access to groups that would otherwise be difficult to reach. Second, because they have key strategic powers or skills (e.g. Planners). Third, because in some cases, simply placing the issue of obesity "on the radar" can leverage significant additional contributions from these partners, at relatively little extra cost in terms of time, effort or money.

> *"your local authorities, your hospitals, your universities, your chambers of commerce and the voluntary sector organisations, commercial organisations, really need to have an agreement to work towards a shared agenda".*
> Academic associated with one partnership

3.2.1.1 The private sector

The private sector was often mentioned but seen as the most difficult to engage. This was partly because the issue of obesity is not often "on the radar" for the private sector, but also because of the lack of a central coordinating body with which to engage at a local level. The local Chamber of Commerce is clearly available in most areas, but most local businesses are not closely involved with the Chamber, and its membership contains a very diverse range of businesses. The more appropriate channels through which to engage with the most relevant private sector businesses (e.g. the food industry) are not organised on a local level, so there is no channel for local public/community sector bodies to talk to key decision makers.

Large companies are not organised on a City/Borough/County structure. Small food businesses were seen as very difficult to engage since the competitive pressures on them are intense, and there is little that obesity prevention can ask of them that will not be perceived as increasing their costs or making their consumer offer less attractive. It was noted that some areas of the country had been successful with initiatives such as salt reduction in takeaways and cafes, but this was seen as a comparatively easy message to

convey to small businesses, because salt shakers with smaller holes do not increase costs, nor do they make the basic product less attractive to the consumer. With obesity prevention there are very few, if any, similar "win-win" propositions.

More success was reported in working with private sector companies acting as contractors for the public sector, such as food companies providing catering. A small number of successful "responsibility deals" had been reached, and the number of participants said that they were hoping to identify future opportunities. Nevertheless, there were limits to what could be achieved where income targets applied (e.g. leisure centre vending machines), and reported worries about discouraging private sector investment if an area had a reputation for imposing supplementary planning conditions (whether health-related or not).

3.3 Shared vision and ownership - across partner organisations, and from senior management down to frontline positions

All participants commenting on this matter agreed that a shared vision and shared ownership were extremely important to a successful community-wide approach. Nevertheless, perhaps the most commonly discussed theme across all of our discussion groups and interviews was the challenge of developing and maintaining a shared vision, with shared ownership, across a diverse network of partners - and "vertically" within partner organisations, from senior management to the frontline.

Some participants believe that getting a range of different partners to sign up to a shared vision is fairly straightforward, as long as there is a meaningful process of stakeholder engagement, and monitoring/inspection procedures are in place to keep people focused on the task in hand. People with this view were predominantly Commissioners of services.

Those drawing attention to the difficulties around this theme made a variety of points, which we will consider firstly in terms of (horizontal) cross-partnership relationships, and secondly in terms of (vertical) within-agency relationships. People expressing these reservations were from a mixture of Commissioner and Provider roles, and it was noticeable that some of those from the Provider side displayed some reluctance to discuss these matters in detail in the presence of their Commissioners at discussion groups.

3.3.1 Sharing across the partnership

One of the major concerns was around perceived short-termism. More specifically, this relates to the difficulty of tackling a complex, long-term issue like obesity within a short-term financial/commissioning framework. Providers were typically working on contracts of around 12-24 months,

> *"The project I worked on ….had a target that within two years we would be reducing childhood obesity. How do you do that? In two years! If you look at the evidence, the evidence says, no way. To see return on investment…. could be 20 years".*
> Obesity Lead, previously in a Delivery role

The reason that this was felt to impact on the degree of cooperation and knowledge sharing across partner organisations, was because such working requires good relationships between individuals, and some Providers feel that these relationships do not have time to

develop, and co-operative working/knowledge sharing do not have time to embed in the organisational culture.

This relates to concerns around the Commissioner/Provider relationship which are further discussed below, in section 3.6.

In the light of this view, it is not surprising to find some participants reporting that individual partners worked in isolation. Various reasons were suggested as to why this might be the case, but the common thread was that individual services prioritised their own service specific issues and targets, above those of the wider partnership.

"I think people like to see it as though we are all working together, all sharing the same views, (but) I think sometimes people are doing things in isolation and not sharing the best practice".
NHS Dietitian

To some extent this relates to lack of communication and vision sharing within organisations, particularly at middle management and on the frontline, which is discussed in section 3.2.4. However, amongst some community groups there is an added dimension, in which contracts with specific deliverables are incorporated into cultures based on a more broadly based set of principles. For example, a community group may exist to promote the general well-being and quality-of-life of a particular community. When it takes on a contract to do obesity prevention work, it may come with very specific and time limited targets that may be perceived to fit awkwardly, or even conflict with, the broader principles of the organisation. This is discussed further in section 3.6 on Commissioner/Provider relationships.

As noted earlier in this report, fieldwork was conducted at a time of considerable structural change in local government, the NHS and Public Health. Some participants believed that the associated uncertainty made it difficult to achieve a shared vision and shared ownership.

"I think particularly, at the moment, with the local authorities, staffing cuts and reductions in budgets and relocations of staff etc, I think a lot of that sometimes gets in the way of people maintaining their own enthusiasm and motivation".
Participant in discussion group

A manager reported difficulties in obtaining information from partners, because of the impact of major reorganisation in the area.

"a lot of people …. either took voluntary redundancy or were made redundant, other people have moved to a different building …. so there is a lot of uncertainty at the present time, ….. because they are in a difficult situation".
Senior Public Health Manager

Some participants suspected that competition between organisations was another reason why it could be difficult to achieve a truly sharing partnership, even though this may have been agreed in principle. This problem can apply between Providers who are effectively

competitors for contracts, but also between commissioning organisations. One participant noted that local authority Leisure services were effectively both Provider and Commissioner organisations, and this could potentially cause some tensions.

"some of the…. sports centres want to run (our programmes) and then there's been a few issues recently (and people say) 'if they're doing that, what's the point in having our services …..we're going to be fighting to get patients'".
NHS Dietitian

3.3.2 Sharing within agencies, from senior management to the frontline

A major talking point in many interviews and discussion groups was around the difficulty of ensuring that the shared vision and shared ownership agreed at a strategic level by senior managers, were embedded at all levels within individual organisations. In some cases, we spoke to senior managers who felt confident that this had been achieved in their locality, but also to middle managers and frontline staff in the same area, who complained that they knew little about related work being done in partner organisations.

"you feel as though sometimes ….you don't really know what's going on ….. Last week I heard (specific organisation) are going to be doing (a specific service) and I didn't even know about that, and I asked my manager and she has no idea, (and) her manager has no idea".
NHS Dietitian

"People are doing lots of partnership work, but they wouldn't necessarily see it as (such)…The more senior you are, the closer you feel to the partnership"
Senior Public Health Manager

The latter comment was made in a discussion group at which middle management participants expressed considerable frustration at the lack of information available to them, about closely related work going on in other local organisations, often with the same client groups. The members of this discussion group agreed that some of the best examples of partnership working were to be found in Children's Centres, which provided a natural coming together of various services to meet the needs of common clients, and had been set up with the explicit purpose of joining up related services.

The role of middle management would seem to be crucial to the aim of disseminating partnership knowledge down from senior management to the frontline. A number of participants emphasised the importance of this, in both negative and positive ways.

"Middle management can put the kibosh on anything (if they choose to do so)".
Chief Executive of a Provider organisation

"Middle managers need to be able to communicate the same message, because it's unrealistic to expect that …. strategic leaders will communicate that message down through the organisation without the middle management level also reinforcing it. But, more than that, (middle managers need to) communicate with each other (across organisations)…. and that's the real key to this, in my mind".
Academic associated with one partnership

Note that this latter comment made reference to the importance of middle managers in communication both across and within organisations. This will be discussed further in section 4.1.1 on coordination and communication, and some possible solutions are discussed below, in section 3.8 on Signposting.

3.4 Community engagement

The great majority of participants were keen to emphasise that engaging local communities is an absolutely essential activity. For some Commissioners, evidence of strong roots within the community was a "must have" when awarding delivery contracts to Providers.

Engagement was commonly mentioned as a starting point for community-wide action, but some participants strongly believed that it should be an ongoing process, throughout the lifetime of any such initiative.

> *"We're going out and we're talking to our local areas as well as some communities of interest about health inequality and we're doing consultation with that, and getting ideas from them about what we can do…. What do local people want and what do local areas want".*
>
> Obesity Lead

In terms of what was meant by community engagement, it often seemed to consist of being seen to listen to key local people, who we might describe as "community leaders", or perhaps more accurately as people who are known to be well-connected and have credibility with a specific community. In a minority of cases, more specific activity such as questionnaires, focus groups and established community forums were mentioned. Some participants also pointed out that desk-based analysis of relevant datasets to understand community characteristics, is an important stage in the engagement process.

A number of specific purposes were mentioned in relation to community engagement (sometimes called a scoping study), and it is essentially a two-way process, encompassing elements of both research and social marketing:

> *"One of the services that we are commissioning was through an organisation….to go out to the public and ask them questions, and just give them a feel and tell them about obesity …. So there is actually word out there on the street".*
>
> *NHS Commissioning Manager*

The specific purposes identified by our participants included the following.

Building credibility/legitimacy - Although not always articulated with these words, community engagement is seen as a way of making the project/intervention seem relevant to the target population (i.e. "it's for people like me).

Asset mapping - Engagement is also important for understanding the human, physical and financial resources available to enable or enhance delivery to specific communities. This might include identifying individual "opinion formers" in a community, recruiting potential

volunteers, finding meeting places, contacting relevant groups or projects that can provide access to the target population, etc.

Needs assessment - Local communities differ significantly, even within relatively small geographical areas, and each will tend to have a distinct set of needs. Participants frequently cautioned against the risk of "one size fits all" forms of delivery, and the legitimate way to understand differing needs and priorities, was thought to be through community engagement.

Understanding cultural differences - In ethnically diverse areas there may be the additional challenges of language barriers and cultural differences. In one such area, one of our participants explained how standard healthy eating materials have limited application to the local Bangladeshi population, since they tend to be written from the perspective of more traditional British/Western diets. In the quotation below, another participant drew attention to the fact that the image conveyed by an individual's weight/size can vary according to their culture, and may have implications that are not immediately apparent to health professionals.

"(Some people from this community) don't realise that actually their child may be overweight or obese. They think they're a healthy weight. It's seen that …. if they're a little bit bigger that's …. a sign of wealth and kind of being healthy".
Community Dietitian

Publicity - Engagement is a two-way process, involving listening to local people, but also an opportunity to spread the word about projects/interventions. In certain communities, word-of-mouth is a very strong and efficient means of communication. Some participants pointed out that, in certain highly deprived areas, statutory bodies and their agencies cannot take it for granted that everyone in the community welcomes advice from "authority", and it can be highly beneficial to channel messages via trusted community networks.

A minority of participants had no comment to make on community engagement, perhaps because it was an area of work considered directly relevant to their roles - it was notable that the participating GPs had little to say on this theme. Amongst the majority, there was an almost unanimous view that community engagement was very important. Nevertheless, we found some evidence that the skills to undertake such work had been lost due to prioritisation of standard programme delivery, and this is something that would seem to be a concern, given the widespread perception of the importance of community engagement.

"We tend not to have …. People who have got the skills to engage communities and get local awareness, find local solutions to what's going on. …. We have lost those".
CVD Lead

3.5 Developing a network of partners: analysing touchpoints and identifying "door openers"

A number of participants commented that early "blue sky" attempts to identify a comprehensive network of partners for a community-wide approach had resulted in an

extremely long list of roles and organisations. The following comment, referring to an earlier planning meeting, illustrates the potential size of the list.

"When we did this, we ran out of space on the paper"
Local Authority Leisure Manager, in discussion group

Whilst many potential partners are quite obvious (e.g. because promoting healthy lifestyles is the raison d'être of the service), other services with a distinct contribution to make can be missed unless a systematic approach is taken. One strongly recommended method was to look at the range of "service touchpoints" from the perspective of a relevant member of the public, whether that be a parent of a young child, or a middle-aged commuter. We should not assume, for example, that the parent attends a children's centre or receives relevant information from their school or GP, but they will have other "service touchpoints" that can make every contact count. This requires thinking outside the obvious public services, as the following examples illustrate:

- School Crossing Patrols are a relevant touch point, since they have the time and opportunity to talk to parents about the child's daily life and parental concerns
- Parental Support Partners/Advisers could be a more appropriate focal point than teachers/headteachers, since they were often more receptive to involvement, and more likely to engage parents on issues around child/family well-being

As noted elsewhere in this report, for many potentially important partners obesity is "off the radar" - or even if regarded as important, it can be one of a very long list of "priorities". In these situations it can be very helpful to identify "door openers" within potential partner organisations. One such example was provided when discussing the difficulty of engaging some local schools, when the obvious channel (e.g. the Headteacher) has proven uninterested.

"Some (schools) are absolutely brilliant, but quite a lot put big barriers up, they won't even let you go in, and it is really really difficult. One way we have found recently is if we go to the parent support partners…. they are there to be the sort of like conduit between school and parents…. It is finding a door to go in…. they get you access to people that you otherwise wouldn't".
Obesity Lead

3.6 Relationships between Commissioners and Providers

Today's public services are commonly structured around the Commissioner/Provider split. For some, this is still a relatively new way of working, but it is clearly going to be in place for the foreseeable future.

To some of our participants the Commissioner/Provider split is a welcome structure, leaving Providers free to concentrate on customer facing delivery, and allowing Commissioners to focus on evidence, needs assessment and objective performance monitoring. Nevertheless, particularly for those Providers more used to support through grants rather than contracts, there are significant reservations. It should be noted that there was some reluctance among Providers to discuss some of these reservations in groups also attended by Commissioners.

From the perspective of some Providers one consequence of this structure is that they do not feel like equal partners in the relationship. At a time of shrinking funding, these Providers are feeling the strain, which manifests itself in a number of ways, including the following:

- The burden of providing multiple update reports for different funders, each with different assessment criteria
- The short-term nature of funding, which can mean that there is little time between completing the set-up phase, and starting the re-tendering phase
- The mismatch between commissioning timetables and employment law, which (in a number of cases) led to staff having to be given redundancy notices while the Provider waited for the results of the re-tender
- The amount of senior time now dedicated to contract tendering, rather than project management and service delivery
- Competition for clients at the delivery level
- Worries about potential opening up of contracts to private sector companies, some of whom will be able to employ the resources of national organisations (or indeed global organisations) - as has happened with employment related contracts

Among some Commissioners there was acknowledgement that the degree of reporting required from external contract Providers could be out of proportion with other "block contract" parts of the NHS.

"We invested I believe about £340k into the walking schemes. We know how many walk, we know where they walk, we know the scheme's (got) 140 volunteers. Contrast (that with the) community health service ….. that's a £60M contract. So, £60M, (but) I don't know what it does. £340k (and) I know what's happening tomorrow".
Senior NHS Commissioner

Commissioners tended to acknowledge these frustrations for Providers, but at least in part saw them as inevitable issues to be dealt with at a time when less money is available, and some providers were adjusting to the contractual culture, with increased accountability. A number of Commissioners pointed out that increased competition could contribute to higher standards.

"(Tenderers) knowing that there will be people with a completely different outlook and a completely different background who are also bidding, and trying to think about what they would be putting in, and so I think you would get a much more well thought out bid"
NHS Commissioner

Nevertheless, some Commissioners believed that it was necessary to allow Providers some flexibility in delivery, rather than always sticking rigidly to contract terms. This debate among Commissioners reflects natural tensions in finding the right balance between keeping Providers focused on agreed outcomes, and accepting that "real-life" does not always fit neatly into contractual definitions.

In one case of apparent inflexibility, the manager of a health focused community project incorporating physical activity facilities, and servicing clients with complex needs around

obesity, reported that the (local authority) Commissioner classed the project as a leisure centre, rather than a health facility. This classification had significant financial implications for the project.

Commissioners also expressed some frustration at the reluctance of many community organisations to work more cooperatively and rationalise, for example by submitting joint bids built on the strengths of individual organisations, and producing administrative efficiencies.

> *"We have had other discussions outside of obesity where we recognise three or four key organisations are doing virtually the same thing, and as commissioners I would like to say well why don't you merge some of your functions or downscale this, because that provider is clear leader on this".*
> Senior NHS Commissioner

It should be noted that we did come across one consortium of community organisations, which had banded together with the intention of jointly bidding for funding/contracts. However, they were not aware of any similar arrangements anywhere else in the country.

In some senses the tensions around the Commissioner/Provider split may be incidental, and perhaps reflect the uncertain and transitional circumstances applying at the time of fieldwork. However, there is a range of views on this, from what might be characterised as a "hard-nosed, contractual focus" through to a more traditional "partnership approach" - though both sides emphasise the importance of effectiveness evidence and good relationships. The following comments illustrate this range of opinion.

> *"there (is) a lot of talking up of the voluntary and community sector offer, trying to look into the detail to unearth the immeasurable outcome…. the soft outcomes".*
> Senior NHS Commissioner

> *"If you have organisations that come together as partners …. then it's much easier, with good evidence, to mainstream activities that are effective…. Where it's client-provider, it's reliant on funding, it's much more difficult to have that (honest and open) conversation".*
> Academic associated with one partnership

3.7 Strategic leadership and operational management

We asked participants whether there was a risk that the day-to-day imperatives of operational management could, in practice, jeopardise the longer term strategic management of community-wide partnerships.

In one area it was reported that the very tight timetable associated with a particular funding stream had pulled senior managers towards a more operational focus than was ideal.

The general view was that this was not a significant problem. Most thought that the commissioning process clearly divides the strategic leadership of the strategy from the delivery. At the local provider level, community groups should have in place an effective

board that looks after the big, long-term issues, leaving operational management to sort out the day-to-day delivery.

3.8 Signposting (Triage)

A number of participants drew attention to the difficulty of effectively signposting clients to appropriate services. This isn't always easy even within the NHS, but it is more complicated in a fragmented network of delivery organisations.

"If you're in the NHS system, you'll be on the NHS data systems. If you're working on exercise programmes, you'll be on (Provider) referral data systems. So we've got this current dilemma of numerous data systems in the NHS, outside the NHS …. (without) the infrastructure behind to help it, because it's intrinsically fragmented.

Discussion group

Given the tendency (noted elsewhere in this report) for frontline staff to often feel ill informed about related services in partner organisations, we were interested to find out what ideas participants had for solving this problem.

One suggestion was based on the "111" non-emergency number currently being piloted in specific parts of England. The suggestion was that a similar system can operate, providing local coordination and direction similar to the model of a bank clearing house.
In one area, where a community-wide approach to preventing obesity was perhaps more long-standing than elsewhere, this had been recognised as a problem some time ago. Partly in order to address this knowledge gap, all members of the community-wide partnership had been equipped with a brochure describing each of the partner services, with contact details and information on the client groups they served.

However, several participants pointed out that this question raises a bigger issue, about the extent to which strategic goals are achievable in the context of short-term funding available for Public Health strategy work.

"I think weight management is a prime example. We are tackling the treatment, but we are not tackling the prevention, so what's happening is more and more people are falling into the category of needing treatment"

NHS Dietitian

3.9 Passionate individuals

It has been suggested that the success of many community-wide partnerships owes much to the hard work and vision of small numbers of individuals who are genuinely passionate about the specific issue. Such individuals, it is claimed, can "make things happen" that would not otherwise happen, though clearly they cannot be designed into the system in the conventional sense, and their efforts can be difficult to replace, should they leave.

It was noticeable that the subject of passionate individuals rarely arose spontaneously in our interviews or discussion groups. In almost all cases, the Interviewer needed to ask directly about this subject. The general consensus was that passionate individuals can make a major contribution to the establishment of community-wide action (though rarely single-

handedly), but that such action is less dependent on them once established, as long as systems are put in place. In short, it was thought that passionate individuals can be very beneficial, but they are not essential.

At a grassroots level, passionate individuals can be very important in engaging local populations, and obtaining attention and resources from policy makers. However, a potential negative was identified, in that such individuals may bring their own agendas, and through the power of their own personality and determination, seek to divert resources in a particular direction. One example was given of an individual with great influence in a specific community organisation, who had a particular focus on autism, and repeatedly sought to influence the use of resources in that direction. Whilst there was no suggestion that this individual's actions were not well intended, and in support of a disadvantaged group, the effect was to disproportionately divert community-wide resources, in a very specific direction.

3.10 Region

The role of regional bodies in contributing to community-wide action seemed to be negligible. In one area, the work of the regional tobacco control partnership was admired as a model, but it was not thought to be realistic for this to be replicated beyond tobacco control. In another area there was some mention of funding being made available by a regional transport body to improve walking routes. However, in general, regional bodies seemed to have minimal relevance to partnership working to prevent obesity, beyond a certain amount of information sharing at a senior management level.

4. Barriers and facilitators to an effective community-wide approach

Summary: facilitators

After consulting our participants, we concluded that having a central coordination and communications function is to be strongly recommended. This function must engage beyond senior management level in the partner organisations, particularly striving to ensure that middle managers share the vision, and are well informed about the wider network.

Concise briefings on key issues are important for middle managers and frontline staff, to build confidence, capacity and consistency in messaging across the wide range of partners.

Strategy should take an iterative approach, reviewing progress regularly.

Partner organisations should be expected to make an explicit commitment of what they will contribute, and this should be publicised across the network. Those making investment decisions should build on proven success by "backing winners", and concentrate investment where it is most likely to succeed.

Summary: barriers

Starting conversations about obesity with individual clients/patients is difficult, and there are numerous reasons why staff may not have the confidence or the motivation to do so, even among primary care professionals. It is very important to build confidence and capability amongst customer facing staff in both primary care and community settings, as the credibility of messages from the latter will be seriously undermined if inconsistent with messages from the former.

In terms of population wide primary prevention, the term "obesity" can be off-putting, and engagement with target audiences may be easier if the focus is framed as "healthy lifestyles". This more broadly-based approach may also be more stable in terms of long-term funding.

Financial barriers are significant for many low-income groups, particularly in terms of the cost of transport and accessing services.

Cultural minorities and disabled people face additional barriers in accessing information and services, and their specific needs should be considered carefully when assessing needs.

Participants reported that a significant contribution can be made by volunteers (health champions/peer mentors), but there are concerns that their effectiveness is limited by the willingness of health professionals to make referrals to them.

The prevention of obesity is a long-term objective, but most project funding is short-term. There are complex personal, family and socio-economic causes applying to many obese and overweight people. Both Commissioners and Providers would like to be able to commit to longer-term contracts for obesity prevention work, in recognition of the considerable time and resources needed to successfully engage with clients with complex needs, for whom positive short-term outcomes are less likely.

Introduction

Participants were asked to express their opinions on facilitators (what worked well in their area), and barriers (what did not work so well). It is noticeable that far more comments were received in terms of the barriers to success, than the facilitators. This may reflect the amount of work yet to be done in optimising local community-wide action, but it possibly also reflects a natural tendency to be highly conscious of the factors that cause problems, and perhaps take for granted things that work smoothly.

4.1 Facilitators of successful community-wide action

4.1.1 Coordination and communication

Central coordination and associated communication were frequently mentioned as strong facilitators. This must involve people below senior management level, and it is particularly important to make middle managers feel that they are part of the bigger picture.

> *"(To give them) an awareness of what's currently going on ….that will complement what (they are) already doing, and it's being part of a bigger agenda within your work"*
>
> Academic associated with one partnership

This could take the form of regular meetings, though it can be difficult for everyone to attend these regularly, so written updates/newsletters are a useful tool, and can be circulated by e-mail at low cost. Another approach is to produce brochures describing the work of all the partners contributing to community-wide action, with contact details and a written commitment of what they promise to contribute. In one area that had lost this central coordination function, the impact was quickly noticed.

> *"Because as I said you (no longer) receive anything to say that ….this is what's happening in your area. It would probably help if there was (something) to say 'This is what you should be doing for this month, this is what you should be doing for that month'."*
>
> Community Pharmacist

One participant did point out that money spent on coordination was money taken away from the frontline, but more commonly participants thought such investment was justified.

4.1.2 An iterative approach, learning over time

In the area with the longest standing policy of community-wide action, there was recognition of the need to learn from experience. Their philosophy was that the strategy needed to be regularly reviewed and built upon in the next commissioning cycle.

4.1.3 Explicit commitment from partners

One of the early lessons learned from the iterative approach described above, was that some partners will join because of the resources it allows them to access, rather than the contribution they can make. Consequently the approach was changed to one in which each

partner was required to make an explicit commitment about what they would contribute, and this information was publicised among the wider partnership network.

"(Some partners were happy with) everybody else coming in and doing all this wonderful stuff for them, but they didn't have to give anything back… there wasn't any …. broad partnership for the community…. So what we did (was to insist that)… if you want to be a partner you have to demonstrate what commitment you are making to that partnership".
Obesity Lead

4.1.4 Workplace initiatives
Employers can be engaged if the right messages are used to attract their interest. The prospect of reducing absenteeism/sick leave is the sort of message that will resonate with this group. Successful initiatives were reported with bus drivers, taxi drivers and SMEs.

4.1.5 Ensuring that frontline staff understand key messages, in concise briefings
As will be noted in more detail below (barriers), frontline staff need to feel confident in raising the issue of obesity, and communicating the right messages. Such staff are not always health professionals, and the briefings they are given need to be appropriate for their roles.

"*Where (frontline staff) haven't been sure about it ….they have asked for…. A4 sheets that say 'What are the ten key messages around food? What are the ten key messages we need to give out about physical activity, and why? ".*
Obesity Lead

4.1.6 "Backing winners" - investing in partners that have proven successful
In any network of partners, some are more likely to be successful than others. This may be due to a variety of reasons, but most often will be the result of greater commitment and capacity. A number of experienced Commissioners reported that, in the long run, the best policy was to invest in those most likely to be successful. This policy will provide examples to others, and reinforce the commitment of successful partners.

4.1.7 Provide a range of service modes
Clients will have different needs and different preferences. Weight management and related services should provide a choice of service modes from which clients can choose, such as group sessions, one-to-one advice, telephone support, etc. Similarly, it was noted that school is an appropriate setting for younger children, but that adolescents would "*hate it*" if expected to address weight management issues at school.

If such choice cannot be provided within an individual provider project, the Commissioner should seek to make a choice available across the network of partners.

4.1.8 Request a small contribution for using the service
One service provider felt strongly that a small financial contribution should be requested from all clients able to pay. In her experience provision of the service for free tends to undermine the perceived value of the service in the eyes of the client. This is a policy that they are experienced in operating in highly disadvantaged neighbourhoods.

4.1.9 Commissioning less obvious services to reach different groups

If possible, Commissioners should reserve a small portion of resources to be spent on services engaging elements of the population that might otherwise not be reached. In one area this took the form of commissioning Arts groups to address weight management with the young people they served, and signpost them to more specific services as appropriate. This was recognised as engaging many young people who would not otherwise be drawn to physical activity services.

4.1.10 NHS Health Checks

A small number of participants commented that NHS Health Checks would be an excellent opportunity for health professionals to raise the sensitive subject of obesity with patients, because the system is designed and equipped to identify risk and communicate its meaning, with a view to developing a plan with them.

> *(With NHS) Health Checks we've actually got an online training package which includes all the (necessary) measurement bits for the risk assessment…. the results come back and the patients are sent another letter to say right we've got your results, these are what they are and this is what they mean for you…. a message they can understand, then ….. the practice nurse or the GP ….goes through it with them and explains… (and agrees with them) a set of realistic guidelines …. how do you think you are going to achieve that, what difference are you going to make to your life to do it? And get them to assign priority".*
>
> NHS Health Checks Manager

Nevertheless, it should be noted that there were concerns about whether appropriate follow-up services would be available, in the future, for those engaged in this manner.

4.2 Barriers to successful community-wide action

4.2.1 Staff confidence in raising the subject of obesity

Probably the most commonly mentioned barrier to success was failing to realise that even experienced health professionals can find obesity to be a very difficult and sensitive issue to raise with patients/clients. There are a number of aspects to this failing:

Many staff are not confident in their own knowledge (see 4.1.5).

Some staff are overweight themselves, and feel self-conscious about raising the issue.

It is an intrinsically difficult message to convey. The implication is that the patient/client needs to make changes that will be unpleasant to them in the short-term (e.g. cutting down on favourite foods, walking instead of driving), but the benefits are longer term.

Although clinical staff understand the longer term importance, some do not see obesity as an immediate priority, relative to sickness:

> *"I would be disingenuous if I said that I wake up at 4 in the morning worrying about obesity. …. I wake up at 4 o'clock in the morning and worry about whether patients are poorly…..*

you've had those conversations a thousand times over and you perceive them not to be heard and not to be listened to, it's difficult, and so I think sometimes people give up"".
Nurse

Consequently there can be a tendency to see difficult conversations about obesity as somebody else's job. The Commissioner quoted below had introduced a special programme of training for clinical staff, to enhance their skills and confidence around these conversations.

"your (own) work force …. should be taking responsibility, (but they are) letting that responsibility go, so it immediately becomes (perceived as) some specialist's job ….so that is a real barrier that (they feel) it is someone else's job"
Senior NHS Commissioner

When primary care clinical staff are not willing or able to address obesity issues with their patients, this causes credibility problems elsewhere in the system.

"I had lots of conversations with parents this summer whose children had been measured as being overweight or very overweight, and they immediately said they'd spoken to their GP or they'd spoken to their practice nurse or they'd spoken to in some cases even their health visitor, school nurse, and they said that their child is fine"
Senior Public Health Manager

There was a perception among a small number of participants that the nature of GP contracts did not incentivise GPs to discuss obesity with patients. Others suggested that health professionals were not well trained in recognising overweight and obesity.

"It's like why put time and effort into that when there are ill people to be dealt with… the GPs (are) very resistant. I mean if (there is no) extra money, ….they (don't) do it. It's simple as"
Community Dietitian

"I did some training and I put up a picture of a child that is obese ….everyone thought she was healthy or just a little bit over. I think that people's perception of what obesity actually is, they just think of America where you see those huge…. Morbidly obese kids eating loads (of fast-food) …. So I think it's a lot to do with perception and obviously they're not realising there's a problem"
Community Dietitian

4.2.2 The connection between GP clinics and the wider community action

There was a commonly expressed belief that GP clinics should ideally be at the centre of community-wide action on obesity, but no participants reported that this was the case in their area. From our interviews with a number of GPs, we concluded that they were quite unaware of obesity prevention work happening in non-clinical settings, and some GPs acknowledged this themselves.

"Maybe there needs to be more awareness amongst GPs as well, that these programmes are running in the community so that we can make patients aware"
GP

4.2.3 Delivering only through the "obvious" channels

Commissioners need to be wary of falling into the trap of concentrating excessively on community settings that seem (rightly or wrongly) obviously relevant and easy to engage. An example was provided of a childhood obesity strategy that was wholly focused in primary schools, only later to be diversified when data revealed that many overweight and obese children were arriving in Nursery and Reception classes.

4.2.4 Negative connotations of the label "obesity"

A number of participants said that they preferred to avoid using the term "obesity", particularly in relation to primary prevention work. There was a belief that some of those most in need of help would "switch off" when confronted with this word. Those putting forward this view would prefer positive terminology such as "healthy lifestyles", or "living healthily".

"*I think that by calling things 'obesity partnerships' we create a bit of a problem because the whole word obesity is an alienating word for many people. Nobody would like to consider themselves obese*."
Member of discussion group

4.2.5 Separate programmes for obesity and other lifestyle issues

A small group of participants wanted to see a more integrated approach to promoting healthy lifestyles, rather than having discrete budgets, teams and communications around the individual topics of diet, exercise, smoking and alcohol. The case for this was articulated in a number of ways. Some argued that an individual topic focus (particularly obesity) had negative connotations for some individuals. Some argued that there was a complex inter-relationship between these issues, within individuals and families. Others argued that separating budgets and delivery mechanisms caused inflexibility and inefficiency, especially when one considers that they are often targeting the same individuals and communities.

"3 or 4 years (ago), we had a very clear obesity programme, tobacco programme, alcohol programme and they were all very separate. I think increasingly we are trying to bring things together …. the people who we are trying reach (would prefer to have) one person telling them about one thing"
NHS Commissioning Manager

4.2.6 Incompatible systems make joined up working difficult to deliver

Some participants reported considerable frustration about the incompatible systems being used by different partners. In one case there were difficulties caused by exercise referral services using a database that could not "talk to" mainstream NHS databases. In another case, the excellent working relationship that Health Visitors had with other services working jointly at Children's Centres could not be optimised, because the Health Visitors had no usable technology in the Centres, thus reducing the time they could spend in that setting. This latter case was particularly frustrating, since the Children's Centres had been set up

with the express purpose of providing a base for more cohesive working across different services.

4.2.7 Financial and other barriers to accessing services

Some of the target groups most in need of services were unable to access them. The cost of transport is very significant for many in the low-income target populations. This was particularly the case in rural areas, where people with very limited financial resources might be expected to make a round trip of 20 miles or more to a service, with the associated expense and cost of the service fee itself.

Fear of crime is a major inhibiting factor in some disadvantaged areas, restricting use of green spaces and walking routes.

These broader economic and social issues were mentioned by a significant minority of participants as major factors limiting the effectiveness of many services.

4.2.8 Cultural differences

Tailoring service provision around the needs and characteristics of cultural minorities continues to present challenges for those working in this area.

In at least one of our fieldwork areas there is a significant minority population from Eastern Europe, and partners found it difficult to find messages that would resonate with this community around smoking, alcohol and high-fat diets.

Some of the Inner-City areas covered in fieldwork had significant populations of Bangladeshi origin, and many of the men worked in the restaurant industry. Those trying to engage this community with messages around healthy eating found it frustrating that most of the available materials were based on British/Western diets, and the working hours of the restaurant industry made it difficult for many of the men to access services.

"*the time when (services are available) may be appropriate for you if you are white working class and you finish at six o'clock, however that is when their day starts, that's when the restaurants tend to be open…. And the women are very often left at home with the children while the husband is out working. So that is inappropriate with the time, and so it is understanding how their cultural system works and accommodating that.*"
Discussion group member

4.2.9 Complex issues underlying obesity, and implications for service delivery

Some participants felt very strongly that the causes of obesity are highly complex and sensitive.

"when somebody is obese, they've other issues as well. It's not just because they are obese".
Community Pharmacist

This Pharmacist went on to explain the difficulty of effectively tackling the subject of obesity with customers in the context of a busy Pharmacy. On the same theme, a Senior Manager from a Community project compared the difficulty of tackling obesity with the challenges

presented by equipping the long-term unemployed for the jobs market place. In the employment related work undertaken by her organisation, the funders understood the complexity of the issues and the size of the challenge, and funding was structured around the concept of "job readiness". Given the complex psychological and economic factors underlying obesity, and the chaotic lifestyles of many of those affected, it was thought appropriate that there should be a similar concept of weight loss readiness built into this work.

"If they can't get the child to go to school, they're not going to be able to get them along to a weight loss programme"
Senior Manager, Community Project

On a similar theme, another participant complained about "rigid models of service delivery" imposed by commissioning contracts. His view was that clients need to be treated as individuals, with personal programmes tailored around their needs. Unfortunately, this is rarely possible on NHS funded programmes, which are largely brief interventions. This participant argued that obesity should more appropriately be regarded as a long-term, chronic condition, with appropriately long-term interventions.

"(Clients say)… you spend 12 weeks engaging me; I'm on board; I'm ready to …. change my lifestyle, and you're telling me that you can't provide the service for me anymore… It doesn't fit well with the individual need. It certainly doesn't fit with patient choice"
Senior Manager, Weight Management Organisation

4.2.10 The association of childhood obesity with safeguarding children
One participant stated that obesity was now a consideration when considering the safeguarding of children. She reported that this had the unfortunate, unintended consequence of making some parents wary of engaging with weight management services.

4.2.11 Health Champions/Peer Mentors and the willingness of health professionals to make referrals to them
Throughout the fieldwork, numerous participants made positive comments about the work done by volunteer Health Champions/Peer Mentors - different areas seem to use different terminology. Nevertheless, the existence of these roles is not an unqualified success, largely because it was noted that health professionals seem somewhat reluctant to refer patients to them.

The fieldwork did not have time to explore this issue in detail. It may be that the professionals have specific causes for concern, or it may be that communication to health professionals about these volunteers has been ineffective (in line with much of what we heard about poor communication with frontline workers).

4.2.12 Including disabled people and those not engaging with the local community
There is evidence to indicate that obesity is more prevalent among disabled people than in the wider population. There are various causal factors underlying this difference, around mobility issues, mental health issues, learning difficulties, economic inactivity and additional barriers faced in accessing services. Despite this, very few participants raised the subject of

disabled people when considering specific target groups, leaving the impression that disability is not a particularly prominent issue in local obesity plans.

" *there is no evidence, no research there on what disabled kids think about being obese, and yet we know that certainly in the adult population, adults with learning difficulties and disabilities are disproportionately more obese, but no-one does anything about it* "
Senior Public Health Manager

One of the greatest challenges is to engage with those who rarely leave their homes to mix with the local community. Many in this situation come from Black and Minority Ethnic communities, facing additional cultural and language barriers. Mental illness, disability and long-term conditions may also contribute to their isolation. Only one participant raised this subject, and they could not suggest a solution. Nevertheless, we should be conscious of the fact that an approach which focuses on local community-wide action, may well struggle to engage with those isolated from local communities.

4.2.13 Long-term strategy but short-term funding

Many participants spoke of the frustration of tackling the intrinsically long-term objectives around obesity, within the framework of short-term funding. Opinion from one area suggested that it could take two years to get the network of local partners working effectively in a genuinely community-wide, cooperative manner, not least because it takes time to develop personal relationships across different organisations, and these relationships are often essential to collaborative working.

"I *think (obesity programmes) need to be there for three to five years to make a difference, and the way in which the work would be carried forward at the end of the funding needs to be clearly identified from the start*"
Senior Public Health Manager

A number concerns were frequently mentioned in relation to short-term funding. First that priorities could change over time to the detriment of obesity prevention strategies, making it harder to keep local alliances together. Second that it was difficult to build capacity with such short-term contracts for Providers, with sometimes less than a year between start-up and re-tendering. Third that short-term funding is poor value for money, because of the need to allow for a set up period at the start, and a running down period at the end, meaning that the service is only fully functional in between. Finally, that unrealistically short term outcomes were demanded because of the commissioning timetable, and without reference to the evidence around outcomes.

4.2.14 The difficulty of achieving consistent "messages" across a diverse range of partners

As has been noted elsewhere in this report, the community-wide approach benefits from including a broad range of partners, ideally operating under a shared vision and feeling shared ownership. Such an approach will include partners for whom health improvement is a core purpose, and others for whom health improvement is not an essential raison d'être. At an individual level, it would also clearly involve people who are highly engaged with the obesity strategy agenda, and others who are less engaged.

This can lead to inconsistent messaging across what is essentially a loose federation, including many independent community organisations, often run by volunteers. An example of the sort of difficulty that can arise was provided by one attendee at a discussion group, who described his experience at a local community fair, organised to promote healthy lifestyles amongst young people.

> *"I've never seen so many sweets and cakes being dished out…(and consequently) if you wanted them to come to your stall, you had to give them sweets."*
> Manager of a Walking Project

5 Sustainability

Summary

Change is inevitable, and what matters is the sustainability of the strategy and the wider network of partners. Underneath the strategy, it is only natural that practices, individuals and organisations will change over time.

The single most important factor in sustainability is the maintenance and development of the shared vision, and this requires effective communication to maintain the engagement, particularly with politicians, middle managers, frontline staff and organisations that may see themselves as peripheral to the issue of obesity.

A key message in this communication must be the commitment to evaluation and ongoing service improvement.

If pump priming funds (i.e. short-term funds, aimed at stimulating future investment from mainstream sources) are made available to establish the network, plans to transfer responsibilities to mainstream budgets should be built in wherever possible, so that responsibilities are inherited when the initial funds cease. However, in the context of current public expenditure constraints, mainstream incorporation cannot be guaranteed.

It is inevitable that funding streams will change over time, with some diminishing and others growing or emerging. By recognising that obesity is an essential concern for many health and social issues, it should be possible to be flexible and creative in justifying ongoing funds for obesity prevention work, despite such changes.

The community-wide approach should seek to build on existing community assets. This will build capacity in people and institutions that will continue, even if obesity specific funding diminishes. Commissioners need to manage public money carefully, and rightly expect outcomes to be achieved, but they should also consider the fact that at some point in the future, they may be relying on influence and goodwill rather than contractual obligations.

Those participants with longer-term experience of community-wide action strongly recommended that there should be a clear separation of strategic and operational management, using boards/forums with distinctive terms of reference.

Having a strong local brand or identity is important, particularly for workers in the network of organisations, as it is important for them to feel part of a bigger picture.

Introduction

A number of participants pointed out that what matters is the sustainability of the strategy, and the shared vision. Changes in circumstances will inevitably happen over time, and it is only natural that some of the component parts (policies, practices, individuals and organisations) of the community-wide partnership will not continue to be part of the picture. This does not necessarily matter, as long as the strategic objectives are still pursued.

Whether asked about establishing community-wide action, or sustaining it, the main answer from our participants was to emphasise the importance of developing a shared vision, into which a wide range of different partners could "buy in" (feel ownership). It is therefore clear that the basic foundations, and the spirit with which the partnership is managed, are the most important factors in sustainability. This is particularly important since most participants recognised that short-term priorities are prone to change over time, and the ongoing shared vision is key to surviving this turbulence.

Alongside this, participants emphasised that sustainability should be factored in from the earliest stages. For example, where funding was made available to improve walking routes, it was essential that the relevant landowners agreed to build-in appropriate maintenance to their future plans. Nevertheless, there was recognition of the fact that no amount of planning for "mainstreaming" (i.e. future incorporation into mainstream budgets) could guarantee that the impact of substantial financial cutbacks would not affect achievement.

Around these overarching factors, a series of more detailed points were raised, and these are discussed in more detail, below.

5.1 Communication

It was commonly thought that the NHS and the local authority would need to be the major drivers in establishing local community-wide action, and yet a number of participants remarked that these bodies are not always very good at telling the wider world about their successes. If centralised funding and coordination cannot be sustained in the longer term, at the very least it was seen to be important that a responsibility for communication across the network should continue.

Such communication was said to be important for maintaining engagement on different levels, for different reasons.

5.1.1 Communicate with local politicians

It was recognised that local politicians (elected Council members and MPs) are subject to requests for support (and funding) from a very wide range of competing issues. As described earlier, local political support is a fundamental building block of community-wide action, and continued engagement at this level is essential in maintaining the relative priority of the obesity agenda against competing demands.

5.1.2 Communicate with middle management and frontline staff

We noted earlier that it is vital to engage middle management and frontline staff if we want community-wide action to be embedded into the culture of everyday working practice. Participants told us that there was a risk that efforts to achieve this would be wasted, if there was a lack of communication and such practices faded away. People at these levels need to continue to feel that they are part of a bigger local picture.

"Communication of what's happening locally isn't filtering down to front-line people…… There's a lot going on, but somewhere along the line we need to be speaking to each other about what's happening in the local area".
Manager of Voluntary Sector Provider

5.1.3 Communicate with organisations that may see themselves as "peripheral"

Not all relevant partners in community-wide action have obesity (or indeed health) as a central purpose of their organisation (e.g. Chambers of Commerce, local authority planners). We noted earlier that the benefit of placing obesity "on the radar" for these agencies, was that they could help to convey messages to those who may otherwise be difficult to reach, and that we could leverage their unique assets. However, precisely because they do see themselves as "peripheral" to the topic, these bodies are at risk of losing focus on obesity, unless they are kept engaged with regular communication.

5.2 Evaluation and service improvement in the context of short-term funding

Whether through the commissioning process or some other mechanism, participants thought that it was important to continue to learn and improve.

A major concern in this respect is the requirement for Providers to achieve significant outcomes within relatively short contract periods. This is particularly difficult when working in highly disadvantaged areas, and dealing with clients with complex needs. As mentioned earlier in this report, there was a plea for recognition of the work involved in achieving "weight loss readiness" - similar to the concept of job readiness, used in employment related contracts.

"If you're funding this for a year, something like that, you won't get sustainable results. We need a more strategic approach and less bits of short term stuff"
Senior Manager, Community Project

Evaluation is discussed further in the following chapter, but one potential solution is to build intermediate outcomes (or "process measures") into contract evaluation criteria to provide at least proxy indicators for assessment.

"Sustainability… starts with agreed partnership from the start. And then it is about being able to mainstream and to be effective and efficient in which activities go forward....being.... ruthless, and saying, well, actually, this didn't work".
Academic associated with one partnership

5.3 Securing future funds by recognising the centrality of obesity in many health and social issues

In one of our fieldwork areas community-wide action had been underway for over 10 years, though the funding streams employed had often changed during this time. This had been possible because obesity has causal relationships and associations with many other issues. By recognising this, both Commissioners and Providers can continue to work towards the shared vision and high-level strategy on obesity, even when direct funding streams shrink.

"if it is seen in …..isolation it won't work, so it has to resonate with everything that we are doing, so you know it has to link with coronary heart disease, it has to link with diabetes, it has to link with infertility"

Manager of Nursing Service

5.4 Building on local assets

In establishing a community-wide approach there are considerable benefits in first identifying local assets, such as community groups strongly rooted and with credibility in the local community, and then investing in them. This increases capacity in the local community, through developing skills and enhancing physical resources. By taking this approach, rather than introducing entirely new community assets, the benefits of the investment remain into the future, even if the original investment cannot be sustained.

Within the framework of the Commissioning model there are some natural tensions in this respect. We found evidence that Commissioners sometimes suspect that Providers are not always fully focused on contractual outcomes. There is some justification for this suspicion, since Providers will admit that not all of their work fits seamlessly with their core values and purpose. Nevertheless, there is a delicate balance to be struck if Commissioners want Providers to embed partnership work into their culture, and continue to focus on obesity in the future when specific funds may reduce, and Commissioners need to rely increasingly on influence and goodwill.

"It does mean it's more about how we can influence people without authority, rather than how we can commission people to do what we want, so it's quite a big change in focus"
Obesity Lead

A related point is that initial investment decisions should favour building on those assets with the greatest chances of sustainability, not least in order to minimise the potential for future service withdrawal from individuals who are often in vulnerable circumstances.

"*..I think the thing that's worse than not putting it in in the first place …. is putting it in for two or three years, starting them on a route of behaviour change and then taking that infrastructure away that was supporting people*."
Obesity Lead

5.5 Focusing investment on schools and young people

A minority view was that investment should be focused mainly on schools and young people. The justification for this lay partly in a belief that (middle-aged) adults were less likely to change ingrained behaviours than were young people. It was also partly in recognition of the fact that rural areas tend to have relatively few community assets other than schools, and these may realistically be the only appropriate resources available.

"…. If we don't get it happening at Primary School and Secondary School these people are becoming fat young adults, and they will continue to do that… The new sports centre which is approximately 10 miles away from most of my patients…. But the reality is that is used by the upper social classes who have got the transport and have got the money to pay for that, rather than some of the people in the lower social class group who really need it more".
GP with prominent role in local pathfinder consortium

5.6 Clear boundaries between strategic management and operational management

Clearly defined and separated responsibilities make for good governance. Some participants reported experiencing blurring across these lines, to the detriment of longer-term objectives. Forums for strategic and operational management should be separated, and though some members will need to have a foot in both camps, each forum should contain individuals with a remit to focus only on one aspect of management.

> "*(There is a) need to have separate forums for strategic management and operational management…. with clear terms of reference…. otherwise they just become one of those things that you should go to*".
>
> Academic associated with one partnership

5.7 Institutional memory: systems need to be in place for storing information and sharing knowledge

When asked about the potential impact of key individuals leaving the partnership, very few participants thought that this posed major risks to the long-term success of community-wide approaches. Indeed the natural turnover in the workforce has positives as well as negatives, with the chance for junior staff to develop, and new ideas to be brought in to organisations.

The main negative aspect of staff change was that strong personal relationships are important to organisational relationships, and these take time to develop.

In all but the very smallest organisations, it was felt that systems should be, and indeed are, in place to enable the retrieval of important information when necessary. A more relevant concern was about the sharing of learning, which was often neglected due to time constraints. However, this was seen to be a very common shortcoming, even in organisations with very stable personnel.

5.8 Having a strong local brand and identity

The great majority of participants said that it was important for delivery agents to be grounded in their local communities, through their work, their history and/or community engagement. The presence of a "brand" can communicate this deeper meaning, and for a number of participants this was thought to be more relevant to workers in the partnership, than it was to the general public.

> *"I guess- it's almost like the brand …. gave everyone a t-shirt to wear. Where everyone was walking around and they thought, I recognise that – like a school uniform".*
>
> Academic connected to one of the partnerships

In this sense, the branding of partnership services is part of the communication that enables people in the partnership to feel part of a bigger, connected picture. Interestingly, in one discussion group comprising largely middle management and frontline workers, all agreed

that a strong local brand was important for obesity prevention, though nobody could say what the identity was, in that particular area.

It is not always necessary to have a specifically local brand. In one fieldwork area the local community had been consulted about the branding of a new obesity related initiative, and concluded that (primarily for reasons of cost effectiveness) it would opt for Change4Life branding rather than develop a distinctive local identity.

Change4Life received a number of favourable comments by participants who appreciated the ability to benefit from a nationally recognisable campaign, and adapt their own local material from the national resource. Only one participant expressed disappointment with the Change4Life campaign resources, regarding them as insufficiently flexible to be used in his particular area.

5.9 Online social media

The use of particular social marketing techniques was not a specific focus of this fieldwork, but a small number of participants remarked on the fact that online social media was becoming more important, particularly when working with young people. There was a feeling that those involved with community-wide action on obesity were not particularly skilled in this field. The general consensus among these people was that online social media tends to be a gap in existing local community-wide approaches to preventing obesity.

6 Evaluation and cost effectiveness analysis

Summary: Evaluation

Most participants thought that evaluation was becoming even more important, as financial constraints increased. Data collection and monitoring were also considered to be useful for project management, keeping all parties focused on goals and service improvement.

People thought about evaluation primarily in terms of individual programmes, projects and interventions. Only the participating Academic attempted to describe an appropriate evaluation design for a community-wide approach to obesity prevention. This involved three layers of population data, covering epidemiological, behavioural and cognitive measures, with a process evaluation running alongside.

A very common complaint throughout this fieldwork, was around the belief that obesity prevention is a long term challenge, with long timescales for return on investment, and yet funding is very often short-term, with unrealistic outcome expectations. Many participants called for more acceptance of intermediate outcomes in commissioning contracts. For example, it was reported that in contracts aimed at moving the long-term unemployed into work, there are accepted "job readiness" milestones. It was suggested that "weight loss readiness" milestones would be appropriate for those working with clients with complex needs.

The example of "job readiness" in employment related community work was cited, with the suggestion that "weight loss readiness" was a similarly legitimate intermediate outcome.

There is clearly tension between Commissioners and Providers on the definition of acceptable "evidence". There were strong views expressed about the use of narrow, quantitative outcome criteria, versus a preference for a broader range of outcome measures including qualitative data. There are rational reasons for these positions, with Providers pursuing a broad range of (sometimes difficult to measure) objectives for the well-being of their communities. In contrast, Commissioners are the guardians of public money, and are wary of "cherry picking", and therefore tend towards a focus on specific quantifiable outcomes. To some extent these are natural tensions in any performance management scenario, but it may be helpful to consider the applicability and acceptability of different types of evidence, in the context of the very limited time and resources available at a local level.

Although most participants reported involvement in evaluations, it seemed that the primary purpose was often contract performance management. There was little evidence of a systematic approach to building a local evidence base. The reasons for this were said to be lack of time and money. Money for evaluation essentially means money taken out of what is available for service delivery. Project timetables and budgets rarely allow for the establishment of robust baselines on which to base evaluations.

Some Providers believed that the burden of data collection, monitoring and reporting has become excessive. This was particularly the case for those receiving funding from multiple sources, and there is frustration at the inconsistency of data required by different funders.

One participant with considerable evaluation experience recognised this perspective, and believed that it was partly due to the failure of evaluators to properly brief those collecting the data, to explain the rationale and to address any misunderstandings in what is required.

A number of participants remarked that the evaluation methods typically employed for obesity prevention work tended to ignore clients who had dropped out of the programme/intervention. This would seem to be a significant gap in the development of evidence.

Summary: Cost effectiveness

Few participants seemed to have a clear understanding what was meant by cost effectiveness analysis. When asked whether they undertook such work, participants often responded with very general and subjective comments about value for money and cost management.

Those with more training and experience in evaluation methods were clear in telling us that very little true cost effectiveness evaluation is undertaken. This is primarily because it is a rare and specialist skill. To commission externally is expensive, and if the skills are available internally it is very time intensive. Though not articulated in these words, participants seem to be telling us that cost effectiveness analysis is not justified on grounds of cost effectiveness!

There seems to be relatively little scrutiny of cost effectiveness (as opposed to cost management). Those holding the purse strings at higher levels appear to have limited understanding of cost effectiveness analysis, meaning that there is little pressure to undertake such work.

Among those who understood the principles, there seemed to be a fear that public health investment might be disadvantaged by more exposure to cost effectiveness analysis, due to public health delivering longer-term returns on investment, and the difficulty of attributing cause and effect (relative to clinical treatment).

There was also a concern that truly like-for-like comparisons are difficult to achieve in cost effectiveness analysis. In this view there was a risk of simplistic interpretation, in which differences between programmes and interventions may be caused by underlying socio-economic factors that were not visible in the calculation.

Introduction

In the rest of this section we consider the detailed comments from participants, firstly for evaluation, and then for cost effectiveness.

6.1 Evaluation

Evaluation was considered by Commissioners to be increasingly important, in an era of tightening financial resources and greater scrutiny of public expenditure. When asked about evaluation, the great majority of participants focused on evaluation of programmes and projects, and only one participant attempted to describe an appropriate evaluation framework for a community-wide approach.

The suggestion is that a multi-layered approach is necessary, along the lines of the following model:

Population	System/organisations
Epidemiological evidence (final outcomes)	Process evaluation to assess compliance with the plan and validity of the logic model
Behavioural evidence (are people changing behaviour?)	
Cognitive evidence (are people's attitudes changing?)	

In this design there is a hierarchy of evidence, with epidemiological evidence at the top, but with recognition of the very long time frames involved in achieving such outcomes - too long to fit into Commissioning timetables. Therefore, in reality, we need intermediate outcomes (cognitive and behavioural evidence) in order to inform Commissioners about progress towards the ultimate objectives.

As noted above, other contributions on the subject of evaluation were more specific to past experiences, and to the evaluation of individual programmes and projects. These are described below, on a theme by theme basis.

6.1.1 Intermediate outcomes (or process measures)

A large proportion of our participants pointed out that the Public Health work often addresses a "complex web of causal factors", and return on investment tends to be long-term. Consequently it is very difficult to prove effectiveness. There was a widespread view that this resulted in Public Health investment being harder to justify than surgical or pharmaceutical investment, which tends to be able to demonstrate relatively quick returns on investment, and be judged against comparatively well defined (if narrow) causal factors, with specific measurable outcomes in the short-term.

A common complaint was that much of the work on obesity is with highly disadvantaged individuals and families, who have complex needs, and often disorganised lifestyles. Providers particularly (but also some Commissioners) were very frustrated at what they saw as simplistic and unrealistic expectations from funders, which failed to recognise the considerable amount of "groundwork" that needs to be done with such clients before they are even ready to start a behaviour change journey.

"The problem is ….measuring outcomes is obviously the ideal, but if you actually look at true quality improvement, if you go to somewhere like Unipart, they do process measures because they know that getting the process measures right is a good proxy for outcome ".

Senior NHS Commissioning Manager

One provider remarked that clients on their healthy eating intervention actually needed to complete the intervention before recognising that their existing diets were not healthy - and yet the intervention was designed on the assumption that this recognition was the starting point. Similar comments were made by those running weight management programmes.

"At week 13 (clients) say, 'Why can't we stay with you?

…..you spend 12 weeks engaging me; I'm on board; I'm ready to …. change my lifestyle and you're telling me that you can't provide the service for me anymore'….
It doesn't fit well with the individual need. It certainly doesn't fit with patient choice".
Senior Manager, Weight Management Provider

One participant worked for a community project with experience in helping long-term unemployed people into work. She reported that Commissioners in that field used evaluation criteria which included the concept of "job readiness", in recognition of the groundwork that needed to be done before somebody was ready for employment. She articulated a view that many would share, when she called for Public Health Commissioners to be more willing to accept similar measures, such as weight loss readiness.

As noted above, some Commissioners are sympathetic to this perspective, but feel they have limited flexibility on such matters. Clearly there is a need to maintain the primary importance of criteria relating to long-term objectives, but Commissioners and Providers alike would welcome guidance on acceptable shorter term, intermediate outcomes.

"It would be really helpful if there was a national template that told us what proxy indicators we should be collecting … We've never had that and it would be really valuable".
Discussion group

6.1.2 Use of soft, qualitative measures in evaluation

The range of data that can be considered as "evidence" is very wide, with what some would characterise as "hard quantitative data" at one end, and "soft qualitative data" at the other end. Our fieldwork included participants with views on most points along the spectrum, though it should be emphasised that nobody was at either extreme end.

Even amongst those with a very clear preference for fixed quantitative measures, there was an acceptance that qualitative data can illustrate and bring to life information that would otherwise be difficult for many to digest. Those favouring more qualitative data (as one participant remarked - "because we're human") did not entirely dismiss the need for statistical evidence. More accessible "evidence" such as case studies was said by some to be particularly important in keeping certain kinds of stakeholders engaged - such as local politicians and the media.

Most providers expressed frustration, not so much at the statistical nature of the evidence that was required from them, but at the narrowness of the criteria. To a great extent there are "philosophical" reasons underlying this frustration. Most Providers are community groups/social enterprises with a remit much broader than prevention of obesity (e.g. the general well-being of a particular community). In contrast, the Commissioners are highly focused on the requirements of the specific contract and the associated funding stream.

Consequently providers frequently complained that Commissioners did not respect the value of broader social returns, such as increasing confidence and social capital, reducing social isolation, etc. Many Commissioners tend to suspect that these factors are raised in order to "cherry pick" positives in a programme that was failing to achieve its agreed aims. Indeed one Commissioner went as far as to say that this was a causal factor in the failure of

some community projects, because the inclination to "cherry pick" reduced the level of management focus on parts of the service that were not performing adequately.

"for things like obesity there's a lot of people who are very good at putting out the results in a way that makes it look as good as it can.... I think it's very easy for projects to hide things that are perhaps a bit less successful".
Commissioning Manager

The mismatch between these perspectives is a difficult one to resolve, and to a great extent it is a natural tension within the Commissioner/Provider relationship, and not restricted to Public Health. It may be helpful if NICE can set out the different circumstances in which different types of data can make an appropriate contribution to the "evidence base".

One Commissioner pointed out that some desirable outcomes are intrinsically difficult to measure, and effectively impossible to measure when budgets are small and timescales are short. Commissioners need to be wary of the unintended consequence of commissioning only easily measurable activity/outcomes, which may be particularly damaging for innovative ideas.

It is also worth noting that, for middle managers in delivery organisations, there is considerable blurring across the concepts of "evidence", "feedback", "engagement" etc. Many of these individuals would not have had formal evaluation training, and there is genuine confusion about what constitutes "evidence". Consequently this is a separate issue to those around the appropriate weighting of qualitative and quantitative data, and very different from the arguments around "cherry picking".

"the focus at community level is around community engagement, not analytical understanding of research"
Senior Manager, Health and Well Being Board

6.1.3 The role of monitoring and evaluation as a project management tool

Some participants said that the collection and reviewing of monitoring data, particularly in a collaborative manner between Provider and Commissioner, focused project managers and provided momentum for delivery agencies. In this sense, monitoring and evaluation has a value independent from performance management criteria.

"*it is your kind of standard framework and check list, and I think building that culture into service delivery is useful even if it is not as robust as you would like it, because it then builds in the skills around assuring continuing quality improvement in the service".*
Obesity Lead

6.1.4 External sources of authoritative evidence

When asked about sources of authoritative evidence on "what works", only a minority of our participants clearly identified bodies such as NICE or the Department Of Health or peer reviewed journals. Those doing so were mainly senior Public Health managers, senior Commissioners or medically trained Clinicians.

A small number of participants said that they would look towards specialist information sources that were available to them, such as the regional Public Health Observatory, or the library/knowledge management centre at the PCT.

Among those mentioning NICE, its guidance was almost always acknowledged to be the best available, though it should be noted that there were critical voices also. One participant criticised what he saw as reluctance to make firm recommendations, whilst another was disappointed in the quality of evidence used to develop guidance.

> "*public health guidance such as public health guidance 27 which is weight management before, during and after pregnancy …. As somebody who leads on maternal obesity, I felt that NICE sat on the fence a little there*"
>
> Senior NHS Commissioning Manager

6.1.5 Building a local evidence base

Many participants told us that they endeavoured to build a local evidence base, but we did not get the impression that there was any systematic process to do this, and we suspect that they were referring to a fairly ad hoc mixture of evaluations, "feedback" and best practice sharing. Indeed, those participants with more training and experience in evaluation tended to be the clearest in articulating the difficulties around building such a base.

The barriers were largely around having the time and money to conduct robust evaluations, particularly when many projects/interventions operated on small budgets and short timescales.

> *" There's very few people that get any additional funding to (evaluate), so you either cut your clinical services down which is not good because that cuts your income down, and then people get a bit miffed because there is a long waiting list… I think most people would be prepared to do a bit more research and monitoring if they were given the sort of time and money to do it really*"
>
> Manager Dietetics Service

The manager of a weight management service provider was critical of the quality of evaluations built into contract requirements, and reported that his organisation regularly offers a more robust evaluation option as part of their tender, but Commissioners don't want to buy it. He felt that, for some Commissioners, evaluation had become "a tick box exercise" and "pretty superficial".

One participant also mentioned that it was difficult to get agreement on the appropriate mix and weighting of qualitative and quantitative measures, and without a commonly accepted hierarchy of evidence, it was difficult to get all parties to sign up to a common approach. In one fieldwork area the local authority and the NHS jointly funded the introduction of a swipe card system for children, which was capable of recording data on food choices in school canteens, and use of local leisure centres. This appeared to be one of the more sophisticated attempts at evaluation reported in our fieldwork, but even so, disagreements between parties led to the NHS withdrawing funding.

Another limiting factor is the lack of local baseline information. Short-term commissioning cycles and limited budgets do not easily allow for the collection of population wide baseline information. National surveys rarely contain adequate sample sizes for use at the local level - Sport England's Active People survey is an exception in this respect. The National Child Measurement Programme was mentioned very favourably by a number of participants, but even this has its limitations, as it is cross-sectional rather than a cohort design (so attribution of local action is difficult to establish), and obviously there is no equivalent data for adults.

One participant reported that the regional PCTs funded a network of university-based research teams, with a remit to develop and evaluate innovative interventions. In his opinion, individual PCTs do not have sufficient resources to carry out such work.

6.1.6 The cost and burden of data collection

Several participants held the view that the burden of data collection, analysis and reporting was excessive, requiring significant resource levels that could otherwise be dedicated to service delivery. This view was predominantly held by Providers, and was said to be fairly common among middle managers and frontline staff. There was sympathy for this perspective amongst a small number of Commissioners.

The burden on Providers seems particularly heavy on those in receipt of funds from multiple Commissioners. There is great frustration at the inconsistency of data requirements across Commissioners.

Our participating Academic was of the view that much of the frustration at middle management and frontline levels could be reduced if evaluators took the time to explain the rationale directly to the data collection staff. In his experience, much frustration was caused by a lack of communication between those designing the evaluation framework, and those completing it. Improved communication could not only persuade frontline staff of the value of the data they collect, but also improve the quality of the data collection.

6.1.7 Omission of "drop-outs" from evaluations

A small number of participants commented on the fact that evaluation requirements often tend to ignore those who do not complete programmes. Clearly these drop-outs are likely to be more difficult to engage for the purposes of evaluation, but they may be able to provide valuable insights on the effectiveness of projects and interventions.

"What we don't do is follow up the drop-outs"
Discussion group

6.2 Cost effectiveness evaluation

There was a lot of misunderstanding among our participants about cost effectiveness evaluation. When asked whether their service/project has undertaken cost effectiveness evaluation, there was a common tendency to respond with general statements that health economists would regard as subjective. Participants said things such as "people lose weight,

so there must be health benefits", “if it's effective, it must be cost-effective" and "we gave money back to the Commissioner, so we are cost effective".

Among those with more formal training and a more sophisticated understanding of evaluation methods (mainly Senior Public Health Managers and some Commissioners), there was widespread agreement that cost effectiveness evaluation was difficult to do, and very few organisations were doing it properly.

"*We would look and say we have spent a small amount of money and had a lot of impact with that one, and we have spent a lot of money there and had very little impact….. But we wouldn’t be doing it in terms of pound per quality*."
NHS Commissioning Manager

Lack of resource is the barrier preventing greater use of cost-effectiveness analysis. A small minority reported that they had the necessary skills in-house, but did not have the time. Others said that they would need external consultancy, which was difficult to find and expensive to commission. The Academic participating in the fieldwork said that he often considered incorporating cost effectiveness analysis into evaluation designs, but rarely did so, because of the opportunity cost, i.e. to fund the cost effectiveness analysis, significant elements of the wider evaluation would need to be dropped.

In these circumstances, participants seemed to be asking "is cost-effectiveness analysis justifiable on grounds of cost effectiveness?"

"I don’t think any PCT has health economics resource. If you want to do it properly you need a Health Economist…. the processes you go through are onerous….(a really robust) approach takes weeks, and when you are (undertaking) engagement with partners, stakeholders, communities, for it to be done properly it is a time consuming exercise....we don’t have the funding for that sort of approach."
Senior Public Health Manager

It should be noted that nobody attempted to suggest a model for reviewing the cost effectiveness of community-wide action to prevent obesity. The very limited number of cost effectiveness evaluations mentioned to us, all related to specific interventions or projects.

6.2.1 Scrutiny of cost effectiveness

True expertise in cost-effectiveness analysis seems to be rare outside specialist academic departments. One senior public health manager reported that her department was now sometimes questioned about cost effectiveness by the local authority, but since the local authority had no detailed expertise in the field, they had been satisfied with a range of more standard evaluation data on inputs and outputs.

"All we can describe to the councils at the moment …. Is that ‘this is how we have spent our money, this is why we decided to spend it in this area, and this is what the outcomes are at the moment’"
Obesity Lead

6.2.2 The difficulty of proving the cost-effectiveness of community projects

Another participant with a relatively sophisticated understanding of cost effectiveness remarked that, as far as he was aware, there was a lack of evidence on the cost effectiveness of community-based interventions. Since other evaluations were understood to point to the value of community-based interventions, there seems to be a reluctance to expose such work to the rigours of cost-effectiveness analysis.

"I'm not so sure about the cost effectiveness of community based programmes, because I don't think there's enough evidence to support it one way or the other"
CVD Lead

The implied reluctance to apply cost-effectiveness analysis relates to wider reservations about the relative difficulty of evaluating public health work (compared to clinical treatment), because of difficulties around long-term return on investment, and the attribution of cause and effect across the complex web of social and economic determinants. In the current financial climate, there are particular pressures on long-term investments.

"If there's a weight management programme that we need to put £100k into but the return on that would be reduced healthcare utilisation in 10 years' time, that wouldn't pay for today's investment. So we're having to focus on interventions that make a difference now."
Health Checks Manager

Given this focus on short-term savings, one Obesity Lead was concerned that cost effectiveness evaluations would potentially undermine the case for public health investment. For example, one likely factor to include in a cost effectiveness review of obesity prevalence work would be cost of diabetes treatment over the next few years. Current obesity prevalence work cannot be expected to impact on diabetes treatment costs over this timescale, and realistically (given the limited scale of current investment) it is unlikely to do more than reduce the rate of increase in these costs, even in the longer term.

6.2.3 The danger of simplistic analysis

One senior public health manager recommended caution in the way that cost effectiveness analysis is interpreted and acted upon. He was aware of other PCTs that had stopped funding projects on the basis of cost comparison analysis, and he wondered whether they had truly achieved "like-for-like" comparisons. He knew that there were geographical variations affecting service delivery within his own PCT, such as greater availability of volunteers in some areas, and less in others. One particular area had historically received significantly fewer volunteers (which he put down to socio-economic and demographic factors), and consequently tended to fare relatively badly in cost comparisons.

"Some areas are more expensive than others… high levels of deprivation…. volunteering is quite poor in some areas compared to others…. so those factors come into play and we start to add them and begin to weigh them, you can see why some of the costs are different….. If you're going to tackle health inequalities, it's going to probably cost you more to change behaviours in some communities…. because you're starting at such a low base"

His conclusion was that common sense needs to be applied to the interpretation of such data, in the recognition that findings on cost effectiveness may in reality be proxies for underlying factors that are not explicit in the calculation.

6.2.4 Awareness of cost effectiveness models

A minority of participants claimed to be aware of standard models for cost effectiveness reviews, though few were able to specify a name/organisation. NICE was most commonly specified, but we must consider the fact that participants may have been influenced by the fact that this fieldwork was being conducted on behalf of NICE. The only other organisation specified as offering a standard model was the World Health Organisation.

It should be noted that a small number of participants did state that they knew of specific university departments that could provide such advice on request.

6.2.5 Social Return on Investment

Two participants reported that their community projects had undertaken Social Return on Investment studies. These were thought to be useful but quite onerous to conduct even in a relatively "cut down" version, and it seemed that they were unlikely to be repeated on a regular basis.

7 Discussion

In this chapter the author highlights issues that he believes would benefit from further research and discussion. The thoughts below are based on data from the fieldwork, but the selection and interpretation of these particular issues is based on the judgement of the author.

Whether talking about the establishment of community wide action, its sustainability or evaluation, a recurring theme was the mismatch between the long-term challenge and the short-term reality. This manifested itself most clearly in the complaints from Providers and some Commissioners about the difficulty of proving effectiveness on contracts sometimes as short as 12 months, particularly when working with clients with complex needs. Notwithstanding the fact that Commissioners will naturally seek to set stretching targets in order to get the best value for public money, there is a debate to be had around whether commonly used outcome measures are "blunt tools", and whether more can be done to develop and legitimise intermediate outcome measures, as used by Commissioners of services aimed at helping the long-term unemployed into the jobs market.

Participants thought that achieving a shared vision around community-wide action on obesity prevention with mutual ownership should be possible in all areas - though it won't always be easy. The greater challenge was generally thought to be the dissemination of the vision down through the partner organisations, to spread the feeling of ownership to middle managers and frontline workers. This was commonly thought to be the key to both effectiveness and (to a great extent) to sustainability, if the shared vision could become part of the organisational culture. To achieve this requires investment of time and resources in local coordination and communication.

Each local area will need to think about how it brands community-wide action. The evidence from our fieldwork suggests that a strong local identity is important, not least in order that frontline workers can see the relationship between their own work, and those of other organisations, thus feeling part of the bigger picture. Partnerships will need to consider whether they use the term "obesity". Some participants felt strongly that this term was off-putting to many people, whilst others pointed out that a broader focus on a concept such as "healthy living" also offered more flexibility in accessing funding on related issues.

Each community has its own existing asset base, which will rarely be evenly spread around the area. Some participants strongly recommended a quite ruthless approach to prioritising investment in areas with the existing infrastructure most likely to facilitate successful outcomes. In practice, this requires difficult decisions to be made, possibly marginalising neighbourhoods that already lack investment. Nevertheless, the exhortation to "back winners" is difficult to ignore, particularly in an era of financial restrictions, in which the need to demonstrate return on investment is likely to become even more important.

Particularly when working in highly disadvantaged communities, the credibility of local Providers was seen as essential. This credibility is achieved through community engagement, the importance of which was repeatedly emphasised by participants. Community engagement was seen as a strength of voluntary sector organisations, which

were strongly rooted in their communities, but some Commissioners noted that voluntary Providers often seemed resistant to high-quality evidence and well-defined, quantitative outcome measures. In contrast, some Commissioners noted what they perceived as the analytical sophistication of some private sector organisations, often with the greater resources of a national company. With private sector providers likely to play a growing role in the delivery of public services over the foreseeable future, Commissioners will need to make difficult judgements about the relative importance of local community credibility, versus the different value offered by private sector contractors.

As funding becomes more difficult to find, the notion of a broadly based collaborative partnership, in which some partners contribute to the obesity prevention agenda without public sector funding, becomes more attractive. This will require a flexible, and iteratively improved strategy, in which some partners contribute what is appropriate and realistic for them. It will also require more emphasis on persuasion and influence, rather than specification and commissioning.

A decentralised, evolving approach of this nature presents evaluators with a considerable challenge, in terms of study design and attribution across a diverse community-wide initiative, particularly when one considers the general lack of consensus around appropriate outcome measures, and the absence of reliable baseline data in most areas. Robust evaluations of community-wide approaches may, in reality, prove too difficult and expensive, and evaluators may need to confine their studies to specific elements of the approach. We would recommend that one element worthy of increased evaluation, is the experience of those dropping out of obesity prevention programmes.

We found very few attempts at robust cost effectiveness analysis (as opposed to straightforward analysis of expenditure). Few organisations have the relevant skills to conduct, or resources to commission such studies, and among those that do have the skills, it is generally not considered a priority given the considerable investment of high skill resource that it requires. This situation seems unlikely to change in the foreseeable future, since these techniques do not seem to be demanded by those holding the purse strings at a local level.

APPENDICES

Appendix 1: Discussion guide for interviews and focus groups

Time	Theme
3 min	**Whole group** **Introduction of researchers** **On behalf of NICE, thank all for attending** **Housekeeping (group only)** Session duration, Toilets, Emergency exits/fire assembly. Mobiles 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 Just to remind you, we are here to talk about how organisations work together to produce successful community-wide action, with the aim of tackling obesity. We want to talk about issues such as who needs to be involved, what helps and what hinders such initiatives, their sustainability, how we can judge their achievements, and how we can judge their cost effectiveness. We are interested in your opinions and experiences, whether that relates to the past, the presence or the future Also, please note that the particular focus of this session, is on how community-wide action can work at a local level. We are not focusing on national policy or national action. It's about working together to produce community-wide action at county level, district level, community specific level or even neighbourhood level.
2 min	**Whole group** **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. Please do not attribute anything to particular individuals when discussing today's session with people who are not here. In our report nobody will be named, opinions expressed will be presented in anonymised form. Ohe report should be publicly available on the NICE website from May 2012, when the draft guidance goes out for consultation. **If NICE personnel present**: introduce them, emphasising their observer status at the fact that they will respect confidentiality

20 min	**Key question 1 (whole group). What are the essential elements of a local, community-wide approach to preventing obesity that is sustainable, effective and cost effective?** • Start with unprompted exploration of experiences and views on the question **Probe as necessary with…** • Who is involved and what roles do they play? • What does an effective obesity prevention system or culture look and feel like at the local and community-wide level? • How important is planning? How is it done? How is this translated into action? • What activity/support is available from regional level? • How do the various sectors connect –transport/ education/ leisure/ private business/ NHS/ local authorities/3rd sector/ media • What resources in their experience are essential – physical, human, organisational, financial? • Is there a strong governance structure? What makes it strong/weak? a. Governance = management structure, policies, processes, oversight, etc • The role of engagement with the local/target population - how can we learn from them, get them to help develop creative solutions, innovations? • Nature and extent of local community involvement/volunteers <u>If partnership mentioned…</u> • Established formally (e.g. legal agreement between partners) or informally? • How do partners connect/communicate/co-ordinate – on day-to-day basis Summarise discussion Note points of consensus and/or disagreement Note any association between particular opinions and particular roles/types of organisation
10 min	**Key question 2: What barriers and facilitators may influence the delivery and effectiveness of a local, community-wide approach (including action targeting specific groups, e.g. low income, BME & faith groups, disabled people, specific neighbourhoods)?** • Start with unprompted exploration of experiences and views on the question **Probe as necessary with…** • What works well and why? • What does not work so well, and why not? • Consistency/predictability of funding • Do those delivering (front-line staff) understand the goals/outcomes? <u>If partnership mentioned</u>… • Central coordinating team, located together, versus diffuse network? • Is there "competition" between partners, e.g. over future funding, roles, responsibilities etc? If so, can this be positive, or is it negative? • Team dynamics - how might this impact on effective working Summarise discussion Note points of consensus and/or disagreement Note any association between particular opinions and particular roles/types of organisation
10	**Key question 3. Who are the key leaders, actors and partners and how do they work**

min	**with each other?** • Start with unprompted exploration of experiences and views on the question **Probe as necessary with…** • The role of "passionate individuals" - some say they can be essential to effective community-wide action - discuss • Who else is involved, what roles do they play, e.g. discrete areas of responsibility? • Who leads the activities, what authority do they have, and who is accountable? • Consistency/predictability of funding • Is strategic leadership separated from operational management? (E.g. do long-term goals suffer because short-term issues dominate agendas?) • How easy/difficult for partners to agree shared goals/outcomes… How easy/difficult? Summarise discussion Note points of consensus and/or disagreement Note any association between particular opinions and particular roles/types of organisation
10 min	**Key question 4. What factors need to be considered to ensure local, community-wide approaches are robust and sustainable?** • Start with unprompted exploration of experiences and views on the question **Probe as necessary with…** • Impact of fluctuations/insecurity in funding? • Impact of staff development, staff turnover? • Developing knowledge base/institutional memory - how can this be done despite staff turnover and organisational change • Political and senior management support (achieving it, sustaining it) • Partners being committed, sharing "ownership" • Local communities/volunteers being committed, sharing ownership • Value of developing a strong local identity/brand • Are plans for sustainability factored in from the outset? Summarise discussion Note points of consensus and/or disagreement Note any association between particular opinions and particular roles/types of organisation
10 min	**Key question 5. What does effective monitoring and evaluation look like?** • Start with unprompted exploration of experiences and views on the question **Probe as necessary with…** • How do they know whether their actions are effective and/or cost effective? • Are research, monitoring & evaluation valued by community level decision-makers? • What is understood by "evidence", e.g. priority given to DH, NICE etc, compared with "informal evidence" • What priority is attached to evidence based guidance – in the form of guidance from DH, NICE and other national agencies concerned with obesity prevention? • What factors are likely to ensure this form of guidance is enacted? • What priority is attached to ideas and proposals that are not evidence based – e.g. untested or tested and failed interventions and policies? • What influences/pressures lead to repeating failed/less efficient approaches (if this occurs)? • What effort is devoted to building an evidence base at the local and community-

	wide level? • Is evaluation planned from the start? • Does baseline data exist? • Is there time/resource together it? • Do they have expertise in evaluation methods? Summarise discussion Note points of consensus and/or disagreement Note any association between particular opinions and particular roles/types of organisation
10 min	**Key question 6. Can the cost effectiveness of local, community-wide obesity interventions be established and, if so, what is the best method to use?** • Start with unprompted exploration of experiences and views on the question **Probe as necessary with…** • Is cost effectiveness understood, as different to effectiveness? • What priority is attached to cost effectiveness (as opposed to effectiveness of interventions)? • What factors are considered when assessing cost effectiveness of different approaches? • Are the various models that have been developed in the last few years (eg Cabinet Office, NEF) understood/used? If 'yes' – have they used them? What works well/poorly with these approaches? If 'no' – why not • What are the key factors to be evaluated when assessing cost effectiveness? • Knowledge/expertise in cost effectiveness evaluation? Understanding of models e.g. Cabinet Office, NEF… If so, what works well & not so well? Summarise discussion Note points of consensus and/or disagreement Note any association between particular opinions and particular roles/types of organisation
3 min	**Move back into whole group setting**
10 min	**Review of the breakout groups discussions (whole group)** • Breakout facilitators summarise - invites comment, questions & supplementary points • What is missing?… Is there anything we have not covered?
2 min	**Closing session** 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. Remind people about the opportunity to register as a stakeholder (see note at top of page 1).

Consent form

Consent to participate

National Institute for Health and Clinical Excellence (NICE)
Fieldwork on "Obesity - working with local communities"

This document explains important details about the fieldwork in which you have agreed to participate. Please read the letter and sign to indicate consent at the end.
NICE is an independent organisation and is responsible for providing national guidance on promoting good health and preventing and treating ill health. 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 in order to help NICE develop guidance that is evidence based, useful, and implementable. For more information about the guidance being developed on 'Obesity – working with local communities' see http://guidance.nice.org.uk/PHG/Wave20/53
Interviews will last about 30- 60 minutes, and the workshops 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.
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……