FINAL REPORT

A review of effectiveness, including cost effectiveness wherever possible, of commissioned healthy weight-related projects in City and Hackney.

`

Institute for Health and Human Development

www.uel.ac.uk/ihhd

09 June 2009

REPORT AUTHORS

Angela Harden

Emee Vida Estacio

Patrick Tobi

Faye Adams-Eaton

Marcello Bertotti

Shahana Lais

CONTRIBUTORS

Adrian Renton

Gail Barrow-Guevara

Justine Cawley

Alison Trimble

Krystallia Arwodorou

Michelle Bloom

Claire Bowyer

ACKNOWLEDGEMENTS

We would like to thank all the project leads and delivery teams who took part in this study for sharing their valuable insights. We would also like to thank all those service users who gave up their time to share their views with us. Special thanks to David Woodhead, Fiona Bragg and Joy Kahumbu at NHS City and Hackney for their support throughout this project. Thanks also to the finance and administrative team at UEL.

CONTACT DETAILS

a.harden@uel.ac.uk

UEL
Stratford Campus
Romford Road
Stratford
E15 4LZ

Prepared by:

Institute for Health and Human Development

Commissioned by:

NHS City and Hackney

CONTENTS

Executive Summary

Background and aims

Combatting rising levels of overweight and obesity and their subsequent negative impact on health and well-being is an international, national and local priority. Strategies for promoting healthy weight need to encompass efforts to tackle the obesogenic environment as well as individual lifestyles. Before launching new strategies and projects there is a need to take stock of what is already happening. What is required is a clear picture of the kinds of healthy weight related projects that are currently in operation and an assessment of whether these projects demonstrate the characteristics known to associated with effectiveness, acceptability, accessibility and good practice.

The research project described in this report aimed to: identify and map healthy weight-related projects at a local level in the London boroughs of City and Hackney, review project strengths and weaknesses, and develop a set of assessment metrics (including cost where possible) to review and monitor projects in the future. The project was part of a larger programme of work commissioned by NHS City and Hackney, Hackney Council, the Corporation of London and their partners who are seeking to effect a step change in their strategy to tackle obesity and promote healthy weight.

Methods

As many as possible of all the healthy weight-related projects in City and Hackney funded by NHS City and Hackney or their partners were identified and then surveyed. Data were collected on location, organisational set-up, processes and activities, costs, and monitoring and evaluation. In-depth case studies of five projects were undertaken chosen in consultation with NHS City and Hackney. Background documentary material on the projects was reviewed and semi-structured interviews were conducted with project managers, front-line project staff and a small number of services users. A set of assessment metrics was developed which combined a) information from research evidence, national and local strategy on the efftiveness of healthy weight-related interventions with b) the perspectives of project providers and commissioners on effectiveness, coherence and integration and value for money. The assessment metircs were applied to each identified project to assess potential impact and value for money.

Principal findings

A total of 47 projects were identified and 38 (81%) of these repsonded to the survey. There was a balance between primary prevention projects that aimed to facilitate healthy weight in the population as a whole and secondary prevention projects that aimed to facilitate healthy weight amongst individuals referred to projects on the basis of weight, disease or clinical risk factors. Although the majority of projects worked directly with individuals there were a significant number of projects that targeted settings such as schools and nurseries to promote healthy environments. Projects targeted all ages across the life course although the greatest concentration of projects was upon primary aged children and adults. Individually-based projects varied in their capacity from just 14 participants per year to 1,770. Some exceeded their capacity in 2008 whilst others fell significantly below. Survey responses suggest that it is personal circumstances that account for why participants drop out.

The findings of the case studies revealed several barriers and facilitators to success. Key barriers included limited resources for long-term follow-up; personal circumstances of service users; inappropriate or insufficient referrals; lack of support from schools (where applicable); insufficient publicity; availability of venues and facilities; and the weather. Key facilitators included no or minimal cost to service users; inclusivity of projects; safe environments and friendly atmosphere; family bonding; highly-qualified and experienced staff; effective teams; good management and operating systems; and availability of project

review and feedback. The case studies were more likely to identify problems with the project itself as a reason for drop out or low take-up than the survey.

Combining the views of commissioners and project delivery teams with information from the research evidence and national and local strategy, we developed a Value for Money (VfM) metric to measure economy, efficiency and effectiveness. This metric helped to assess, in an explicit and transparent way, the potential impact of projects. The VfM metric was made up of the following 10 criteria: acceptability, multi-component, ongoing, intergenerational, equity promoting, not facility dependent, monitoring and evaluation, coverage, retention, and cost. Projects were assessed within five separate clusters: 1) individually-based projects with weight or disease related entry criteria; 2) individually-based projects without weight or disease-related entry criteria; 3) settings focused projects; 4) dietetic services; and 5) universal national programmes.

CONCLUSIONS AND RECOMMENDATIONS

There are a diverse range of healthy weight-related projects operating in City and Hackney which together target many of the key determinants of obesity identified in both research evidence and national strategy. However, there are some notable gaps such as projects targeting young people, primary prevention projects for adults and older people, and projects which attempt to change the environment itself through for example, transport policy and working with the food production industry.

The following recommendations were made in terms of strengthening existing provision and individual projects, developing the healthy weight programme as a whole, and future mechanisms for monitoring and evaluation:

- ***There is a need to continue to invest in projects from all five clusters identified in this report.*** Although settings-focused projects represent the greatest potential impact, such projects need to be supplemented by more intensive projects that target those who are already overweight and those at risk. Interventions that target the whole population plus targeted interventions to those most in need represent the best strategy for promoting health and reducing inequalities.

- ***Ways of increasing publicity for projects and strengthening referral routes should be explored***. To support projects that experience difficulties with coverage and retention there is a need for greater coherence and integration between individual projects and between projects and other local services and organisations.

- ***There is a need to explore the potential for increasing the number of projects which rely less on fixed facilities and venues.*** Being able practice healthy lifestyles independent of fixed facilities and equipment is an important factor in sustaining behaviour change over the longer term.

- ***Consideration should be given to investing in projects over a longer term***. Funding instability was a factor that impacted on the ability of projects to invest in follow-up activities and planning for the long-term.

- ***There is a need to expand the healthy weight programme in a number of areas which are currently not well served, especially in terms of projects that directly target the obesogenic environment***.

- ***The indicators that make up the VfM metric presented in this report should serve as a common set of outcome indicators which projects should routinely report on in addition to project-specific outcome measures. These can also help inform the direction of future investment.***

1 Introduction

There is currently global, national and local concern about rising rates of overweight and obesity and the consequences of this for individuals, communities and for wider society. Strategies for preventing obesity and promoting healthy weight need to encompass efforts to tackle the obesogenic environment as well as individual lifestyles. However, we do not yet have a detailed picture of the kinds of healthy-weight related projects that are currently in operation in the UK or up-to-date information on how well these projects are working in terms of process, outcomes and costs. The project reported in this document is part of a larger programme of work commissioned by City and Hackney NHS, Hackney Council, the Corporation of London and their partners who are seeking to effect a step change in their strategy to promote healthy weight. The project aimed to identify, describe and evaluate healthy-weight projects operating in the London borough of City and Hackney to help City and Hackney NHS examine what has been achieved to date and identify opportunities for future developments.

1.1 National Trends on Healthy-Weight

Obesity is a global epidemic. In 2003, the World Health Organisation (WHO) estimated that about 1 billion adults were considered 'overweight' of whom about 300 million were obese[1]. International comparisons show that the prevalence of obesity in England is considered the highest in the EU - 15 countries, and one of the highest in the wider cohort of OECD countries[2], with nearly a quarter of adults (aged 16 or over) classified as obese in 2007[3]. If current trends continue, it is expected that 9 out of 10 adults will be either overweight or obese by 2050[4].

Table 1.1 below shows the proportion of body mass index among adults in England as reported in the most recent Health Survey for England.

Table 1.1 Body mass index (BMI) among adults aged 16 and over by region and gender, 2007[3]

	North East	North West	Yorkshire and the Humber	East Midlands	West Midlands	East England	London	South West
Men								
Underweight	1	1	1	2	2	2	1	0
Normal	32	32	27	29	33	35	41	35
Overweight	36	43	45	44	42	41	37	41
Obese	29	22	25	24	23	22	19	22
Morbidly obese	2	2	1	1	-	1	2	1
Women								
Underweight	3	2	2	1	2	1	2	2
Normal	36	39	37	46	42	43	45	41
Overweight	32	36	33	31	33	30	30	34
Obese	24	20	28	19	20	24	21	21
Morbidly obese	5	3	1	4	2	2	2	2

* Using the following BMI definitions: *underweight* (less than 18.5 kg/m^2); *normal* (18.5 to less than 25 kg/ m^2); *overweight* (25 to less than 30 kg/ m^2); *obese* (30 to less than 40 kg/ m^2); *morbidly obese* (40 kg/ m^2).

Obesity has detrimental costs to people's health and wellbeing. It has been associated with chronic conditions such as Type 2 diabetes, coronary heart disease, hypertension, stroke, and several cancers[5]. Being severely obese has also been related with psychological issues such as depression[6]. The total cost to the NHS of overweight and obesity was estimated at £4.2 billion and is forecasted to double by 20507. The NHS Information Centre also estimated that the number of people in England having obesity surgery has risen by 40% in the last year[8]. The cost to the wider economy was estimated at £16 billion per year, and is expected to rise to £50 billion by 2050 if the current trends continue[9].

1.2 Healthy-Weight in City and Hackney

The City and Hackney Joint Strategic Needs Assessment (JSNA) in 2008 reflected a 7% adult obesity rate based on GP records. In Hackney, it was reported that 51% of its residents do not participate in moderate exercise, whereas only 22% of City residents participate in thirty minutes of moderate physical activity at least three times a week.

At the local level, a key driver of change is the prevalence of obesity and overweight among children. Data from 2006/07 indicate that Reception year school children have the highest levels of obesity in the country at 16.0%, and another 14.4% are overweight. In Year 6 pupils, the rates of obesity and overweight were even higher - 24.2% and 16.0% respectively, second highest levels in the country.

High levels of deprivation and the presence of substantial ethnic minority groups are further important local factors to consider. The JSNA reported that Hackney's wards are among the 10% most deprived wards nationally while the Portsoken ward in the City is among the 25% most deprived bracket. Socioeconomic factors are worth noting, considering the trends relating to household income and obesity. As shown in Table 1.2 below, the prevalence of obesity among men in the highest income bracket was about 24%, compared to 27% in the 4th quintile. For women, 49% from the highest income bracket are considered overweight or obese, compared to 63% for the lowest income quintile.

Table 1.2 BMI among adults aged 16 and over by social by household income quintiles and gender, 2007[2]

	Percentages				
	Highest	**2nd**	**3rd**	**4th**	**Lowest**
Men					
Underweight	0	1	1	2	3
Normal	31	36	36	34	35
Overweight	44	40	39	36	42
Obese	24	22	23	27	17
Morbidly obese	1	1	1	1	3
Overweight including obese	69	63	63	64	62
Women					
Underweight	2	1	3	2	3
Normal	49	43	36	37	34
Overweight	29	31	33	34	36
Obese	19	23	26	25	24

	Percentages				
	Highest	**2nd**	**3rd**	**4th**	**Lowest**
Morbidly obese	2	2	3	3	3
Overweight including obese	49	56	62	62	63

Ethnic trends in obesity are also worth considering. Hackney is characterised for its cultural and ethnic diversity with 11% Black African, 9% Black Caribbean, 9 % South Asian, and 7% Charedi. The resident population in City, on the other hand, is predominantly White (83%). This is noteworthy considering that the prevalence of obesity is currently greatest in the Caucasian and Bangladeshi populations[10].

1.3 Promoting Healthy Weight

In 2001, the Department of Health (DOH) published the White Paper, *Choosing Health, Making Healthier Choices Easier* which set the national agenda for tackling obesity. It was recognised that promoting healthy weight requires a holistic approach that considers various dimensions that influence lifestyle choices. In line with this framework, the *Foresight Report*[11] identified the following core principles for tackling obesity:

- A system-wide approach, redefining the nation's health as a societal and economic issue
- Higher priority for the prevention of health problems, with clearer leadership, accountability, strategy and management structures
- Engagement of stakeholders within and outside Government
- Long-term, sustained interventions
- On-going evaluation and a focus on continuous improvement

Recently in 2008, the *Healthy-Weight, Healthy Lives* cross-governmental strategy for England was released. Immediate plans proposed in this strategy include promoting healthy weight among children, promoting healthier food choices, integrating physical activity into people's lives, creating incentives for better health, and providing personalised advice and support.

As part of its concerted efforts to promote healthy weight, Change4Life, an initiative supported by the Department of Health was set-up. This campaign brings together national, regional and local partners including health care professionals, teachers, charities, government agencies, the media, big businesses and community organisations with the shared aims to prevent people from becoming overweight by encouraging them to eat better and move more. The Change4Life advertising campaign was launched in January 2009 on television, in the press, on billboards and online.

At a local level, City and Hackney NHS developed an *Obesity Strategy* for 2007-2010 with an aim to deliver prevention and weight loss services across the lifespan. Its objectives are to prevent overweight and obesity in children and adults, to support weight loss, and to promote the adoption of healthier lifestyles in those who are already obese. The action plan for this strategy includes:

- Partnership working
- Obesity prevention and treatment in children and young people
- Obesity prevention in adults and older people
- Targeted interventions for risk groups
- Monitoring and evaluation measures

City and Hackney also have a *Nutrition and Health Eating Strategy* which aims 1) to provide a framework for agencies working in City and Hackney around food and health to enable them to improve health, identify the role of nutrition in meeting targets, reduce inequalities in health, and coordinate their activities; and 2) to work in partnership with organisations that may not consider nutrition and healthy eating as part of their remit to develop a holistic strategy to improve the food provision and awareness of healthy eating.

Currently, local action by City and Hackney to promote healthy weight include initiatives that are in-line with the proposed strategy above, such as:

- Health promotion campaigns building on national messages and highlighting local opportunities for physical activity and healthy eating
- Active support for initiation of breastfeeding
- Improved access to affordable fruit and vegetables, including school and nursery based initiatives
- Organisation of healthy eating and associated skill development events
- Physical activity sessions in pre-school, school and other community settings frequented by adults and young people
- Provision of school and pre-school based healthy lifestyle initiatives
- Brief interventions training for front-line staff to enable them to effectively broach and address the issue of overweight and obesity
- Work with partners to develop an environment conducive to healthy lifestyle choices
- Development of local care pathways for the treatment of obesity and overweight

City and Hackney NHS is currently developing a set of ambitious plans to promote healthy weight for the future. In developing this revised strategy, it is essential to examine what initiatives are currently in place, to understand what works and what does not, and to develop indicators to measure effectiveness for future interventions.

1.4 Aims and Research Questions

This project has the following aims:

- to identify and map healthy-weight related projects in the borough of City and Hackney;
- to review the characteristics of healthy-weight projects in City and Hackney including location, organisational set-up, processes and activities, costs, and monitoring and evaluation activities;
- to provide in-depth 'on the ground' perspectives on the context, processes and outcomes of a selected number of projects;
- to develop a set of assessment metrics to review and monitor projects in the future

The following research questions will be addressed in this exercise:

- What are the characteristics of healthy-weight projects in City and Hackney?
- What are the barriers to, and facilitators of, success in these projects?
- How do healthy weight projects in City and Hackney relate to international, national and local recommendations for promoting healthy weight and reducing obesity?
- What are the views of healthy-weight project providers and commissioners on measuring the effectiveness of projects, promoting coherence and integration amongst projects and assessing value for money?
- What is the potential impact and value for money of existing healthy weight projects in City & Hackney?
- How should healthy-weight projects be monitored and evaluated in the future?

2 METHOD

The research used a mixed-methods, multi-perspective approach and was conducted in the following three stages:

- A survey to identify and describe healthy-weight projects in City and Hackney
- In-depth case studies of a selected number of projects
- Development and application of assessment metrics to evaluate and monitor projects

The survey aims to provide an overview of the characteristics of healthy-weight projects in City and Hackney and to provide a general impression of the barriers to, and facilitators of, success in these projects. The case studies aim to provide in-depth and contextualised perspectives on the healthy-weight strategy and how it is implemented on the ground. Insights from healthy-weight project providers and commissioners will be combined with a review of evidence to develop the evaluation tool. Integration of information collated from these methods will provide insights into how healthy-weight projects in City and Hackney relate to international, national and local recommendations for promoting healthy weight and reducing obesity and will raise recommendations for future developments in this area.

2.1 SURVEY

Commissioners and service delivery teams from City and Hackney NHS, the local authority and the voluntary sector were approached by the evaluation team. They were asked to generate a list of all existing healthy-weight related projects commissioned by City and Hackney NHS or their partners and to specify the key contact person for each project. Responses were collated in a database to form a directory of healthy-weight projects in City and Hackney (see Appendix 1.1). The key contact person for each project was invited to complete an online questionnaire about their project. The questionnaire requested information in a range of areas including the project location, funding, organisational set-up and processes. Full details of the questionnaire can be found in (see Appendix 6.7). Chapter 3 presents the key findings from this survey.

2.2 CASE STUDIES

Five projects were chosen in consultation with City and Hackney NHS for further in-depth study. Projects were chosen to represent a range of target groups, location and activities. Data were collected through semi-structured interviews with project managers and frontline staff; interviews with service users; and a review of project monitoring and feedback reports and other relevant documentation. A combination of process[12] and outcome evaluation[13] frameworks was used to guide data collection. The aim was to develop rich qualitative and quantitative descriptions of the design, implementation and outcomes of these projects. Interviews with service delivery teams included discussions on the organisational structure, the target audience, project aims and design, implementation, project reach, participant recruitment and experience, and project outcomes. They were also asked to discuss their overall experience of running the project including their recommendations for future developments. Interviews with service users focused on their experiences of the project, how they knew about the project, what motivated them to participate, their relationship with service providers and users, the barriers and facilitators to the project's success and their recommendations for the future.

The five case studies included in this review were:

- Exercise on Referral

- Family Cycle Club
- Healthy Lifestyles
- Personal Bests
- Young at Heart

The findings from the case studies are presented in Chapter 4.

2.3 Assessment metrics development and application

Government strategies, systematic reviews and NICE guidelines were reviewed to inform effectiveness and 'value for money' criteria for healthy-weight projects. An event was organised to bring together commissioners and service delivery teams to discuss initial findings from our research and collect input from them to develop an assessment criteria. In this event, participants formed three discussion groups: a) developing the criteria for effectiveness; b) developing coherence and integration between projects; and c) developing the best arguments for expanding/continuing investment on healthy-weight projects. Groups were given 20 minutes to discuss their topic and five minutes to summarise the main ideas, after which participants were asked to move to another discussion group. There were three rotations for this group work. Further details of how the assessment metrics were developed and applied can be can be found in chapter 5.

3 Survey

3.1 Summary

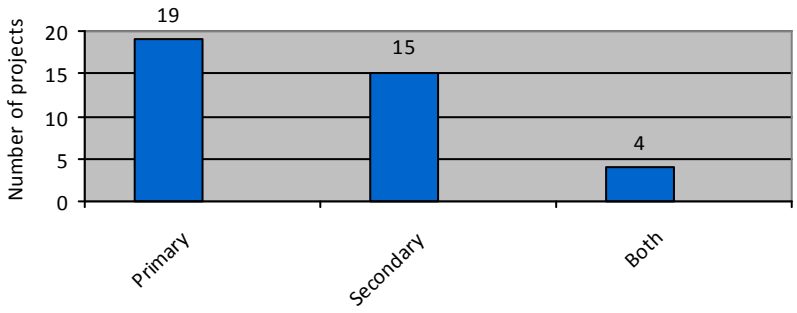
- The 38 projects that responded to our survey represent a highly diverse mix in terms of groups targeted, settings, activities and staff.
- There was a balance between primary prevention projects that aimed to facilitate healthy weight in the population as a whole and secondary prevention projects that aimed to facilitate healthy weight amongst individuals referred to projects on the basis of weight, disease or clinical risk factors.
- Projects were categorised into five distinct clusters: 1) Individually-based projects providing a service for clients referred on the basis of weight or disease-related criteria (N=10); 2) Individually-based projects open to all regardless of weight, disease or clinical risk factor (N=13); 3) Projects targeting settings (N=8); 4) Dietetic services (N=5); and 5) Universal national programmes (N=2).
- Projects targeted all ages across the life course although the greatest concentration of projects was upon primary aged children and adults. A significant number of projects sought to engage the whole family even when their primary focus was on children.
- There were no projects operating in workplaces.
- There was a trend across all projects for a greater focus on changing individuals as compared to direct changes to the obesogenic environment.
- Individually-based projects varied in their capacity from just 14 participants per year to 1,770. Some exceeded their capacity in 2008 whilst others fell significantly below.
- Of the 24 projects providing data the total costs were £1,236,379.
- There appears to be a great willingness amongst projects to monitor and evaluate themselves with nearly all collecting baseline and follow-up data and service user feedback.
- Perceived project impact goes beyond a strict focus on healthy weight. Many respondents to our survey perceived important impacts for participant self-esteem and empowerment.

3.2 Overall Project Approach, target groups and setting

3.2.1 Project approach

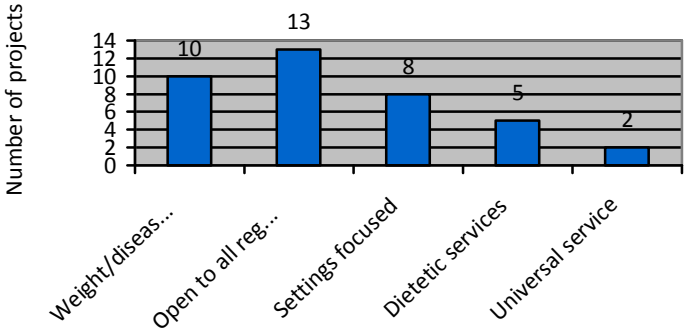
Projects differed in their emphasis on primary and secondary prevention with slightly more projects focused on primary prevention (Fig 3.1). Those categorised as primary prevention were open to all groups regardless of weight, disease or clinical risk factors. Some of these projects did have a particular emphasis on overweight groups but they did not restrict entry into the project on this basis. Those projects categorised as secondary prevention included weight management programmes such as 'Counterweight' and GP exercise referral schemes. Four projects had several strands some of which had a primary prevention focus, some a secondary focus. For example, the 'Child Health Promotion Programme' offers all families screening tests, immunisation and guidance on health choices with additional services to those at risk. Similarly, the 'Be Active/ Keep Healthy Project within the Jewish Orthodox community offers structured exercise programmes for all Jewish young people as well as a weight management programme for those who are overweight.

Figure 3.1: Distribution of projects (N=38) according to focus on primary or secondary prevention



Extending the above classification of projects further, projects clustered into five broadly distinct categories (Figure 3.2). The first category was individually-based projects providing a service for clients referred on the basis of weight or disease related criteria. The second category was individually-based projects that were open to all regardless of such criteria. The third category were projects focused on facilitating the creation of healthy settings included those targeting early years settings such as Happy@Home, Happy in Hackney and the Nursery Fruit Scheme, the Hackney Healthy Schools Programme for all primary and secondary schools and those targeting communities such as the refurbishment of Community Kitchens and Neighbourhood Maps. The fourth category was the dietetic services which ran a number of healthy weight related projects including one to one weight management clinics, professional training for those delivering weight management projects, and education and awareness raising. The dietetic services included projects that could fall under any of the preceding categories. The fifth category covered the two national universal programmes running in City and Hackney: the Child Health Promotion Programme and the National Child Measurement Programme and school health services.

Figure 3.2: Distribution of projects (N=38) according to type of project

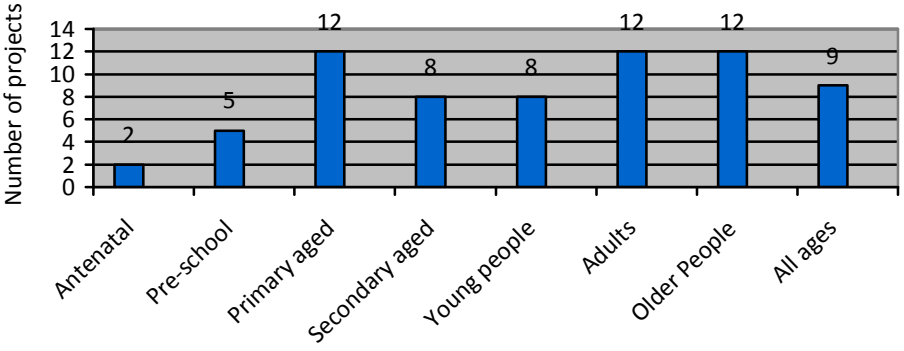


3.2.2 TARGET GROUPS

There were projects covering all age categories across the life course although children of primary school age, adults and older people appear to be the best served (Figure 3.3). There were, however, only four projects that solely focused on older adults (Chinese Cardio Project; Counterweight; Healthwise; and Young at Heart). There was only one project that catered specifically for older children and young people (Youth in Progress).

Those projects classified as targeting all ages included those that focused on working with whole families, such as STA Bikes who run a family cycle club, those providing an antenatal and early years service and those that were focused on the community as a whole such as the refurbishment of community kitchens project, East London Food Access and Neighbourhood Maps.

Figure 3.3: Distribution of projects (N=38) according to age category*

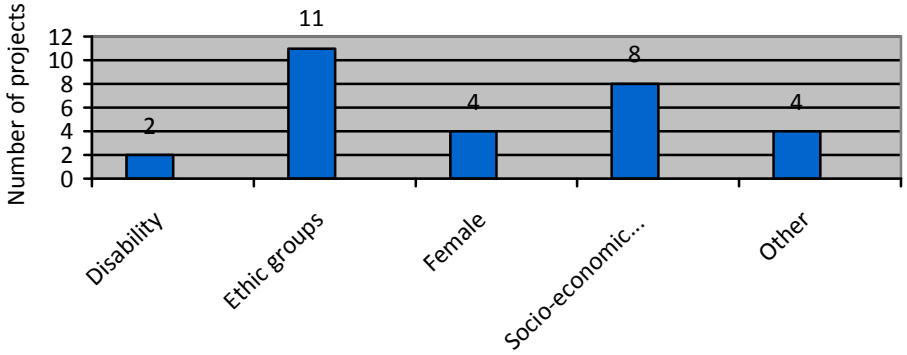


*N does not add up to 38 as projects could cover more than one age catergory

A total of 17 projects aimed to target groups based on other socio-demographic variables. The most common focus was upon ethnic minority groups and socio-economic status (Figure 3.4). It is important to

note, however, that only a small number of these restricted entries into the project according to these socio-demographics variables.

Figure 3.4: Distribution of projects (N=17) according to socio-demographic group targeted



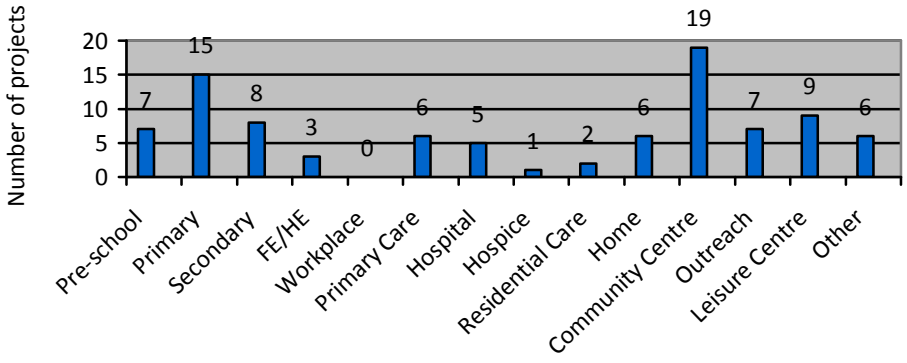
N does not add up to 17 as projects could target more than one group

3.2.3 TARGET AREA AND SETTING

Of the 38 projects, 10 were implemented across both City and Hackney, 3 operated solely in the City and 26 operated solely in Hackney.

Projects were implemented in a variety of settings (figure 3.5). The most frequently occurring settings were in primary schools and community centres. The 'other' category included parks, pupil referral units, special schools and trips out to the seaside. The only setting that was never used was the workplace.

Figure 3.5: Distribution of projects (N=37≠*) according to setting



≠One project did not answer this question so N=37 rather than 38

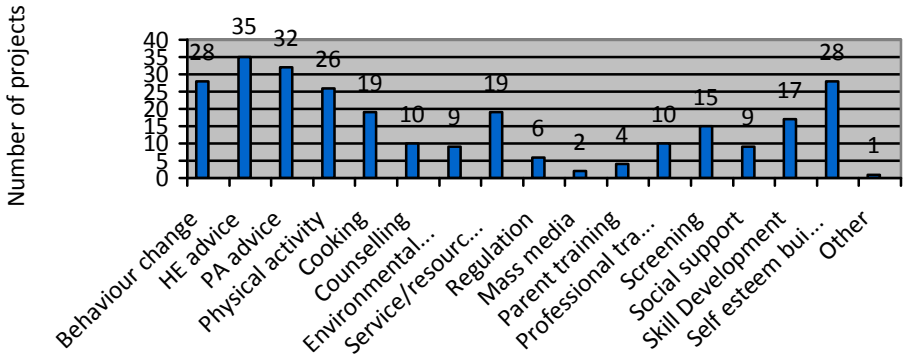
*N does not add up to 37 as projects could cover more than one setting catergory

3.3 PROJECT COMPONENTS, PROVIDERS AND LENGTH

3.3.1 PROJECT COMPONENTS

Nearly all of the projects offered participants' advice on healthy eating and physical activity and a significant majority used behaviour change techniques and self-esteem building activities (figure 3.6). Other components focused on individuals such as skill development, screening and risk assessment, cooking, tasting and food preparation and counselling were also employed in many projects.

Figure 3.6: Distribution of projects (N=38*) according to project components



*N does not add up to 37 as projects could cover more than one age catergory

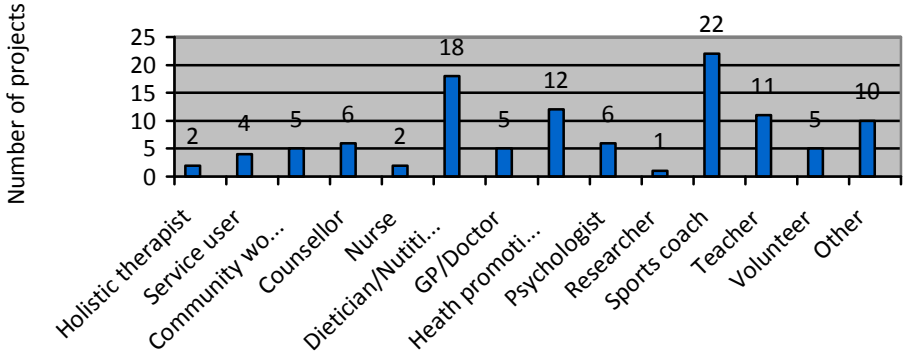
Across all projects there appears to be a trend towards a greater focus on physical activity. Twent-six out of the 38 projects offered opportunities for participation in some form of physical activity compared to 19 projects offering opportunities for healthy cooking, food preparation and tasting.

Another trend is a greater focus across all projects on components targeted towards individuals in terms of advice giving, skill development, counselling and so on. Fewer projects contained components that changed the environment, increased access to services and resources or trained professionals.

3.3.2 PROJECT PROVIDERS

As might be expected, the most common type of personnel involved in delivering the projects were dieticians and sports coaches/exercise workers (figure 3.7). Two other common types of providers were health promotion and public health specialists and teachers. A small number of projects used service users and volunteers as part of their project delivery team.

Figure 3.7: Distribution of projects (N=38*) according to type of project provider

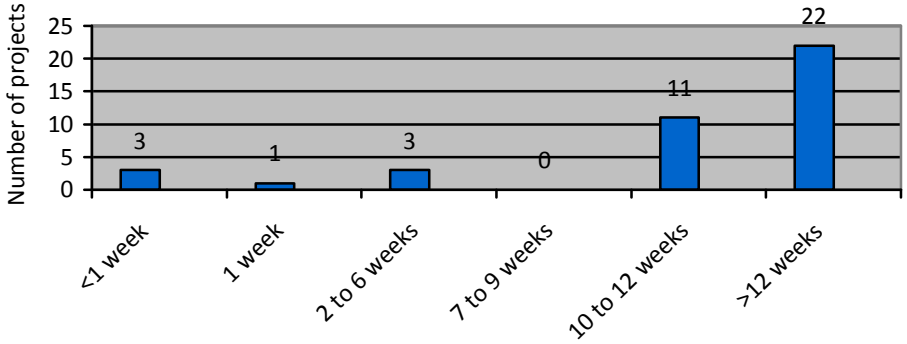


*N does not add up to 38 as projects could use more than one type of provider

3.3.3 Project Length and follow-up

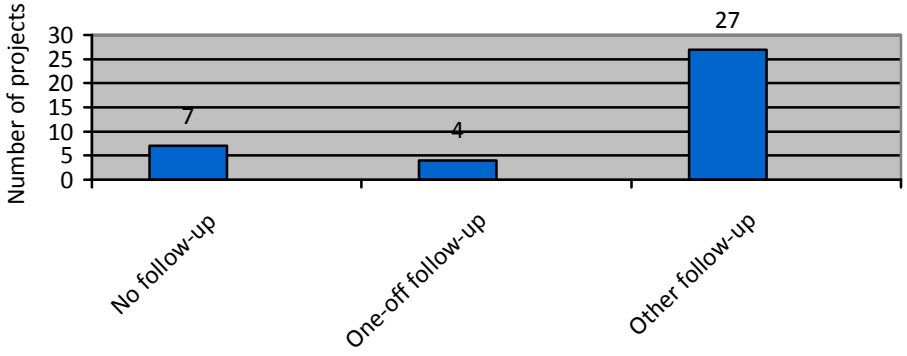
The core period of all but seven projects lasted for 10 weeks or more with a significant majority lasting more than 12 weeks (figure 3.8). Projects included in the latter category includes those who operate all year round such as the dietetic services and 'Hackney Healthy Schools' as well as those that run discrete programmes which last a number of weeks or months.

Figure 3.8: Distribution of projects (N=38) according to project length



The majority of projects offered follow up activities after the core period of the project had ended (Figure 3.9).

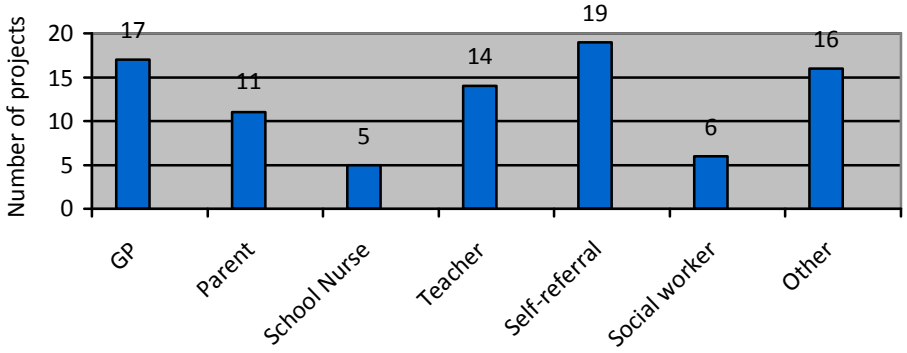
Figure 3.9: Distribution of projects (N=38) according to whether they include follow-up activites



3.4 Referral routes, participation and drop-out

The main referral routes into projects were through GPs or through self-referral (figure 3.10). Other referral routes mentioned were through health professionals such as physiotherapists, counsellors, psychologists, and early years workers. Many projects emphasised the importance of word-of-mouth and advertising within the local media.

Figure 3.9: Distribution of projects (N=38*) according to referral into project



*N adds up to more than 38 as projects could have more than one referral route

Of the 23 projects that recruited individuals into their projects, we had data on the number of participants projects can accommodate per year for 22 projects and data on the actual number of participants for 20 projects. Just 12 projects provided data on drop-out rates.

Project capacity ranged from just 8 to 1800 with an average of 386 participants across projects. In terms of actual recruitment in 2008, figures ranged from 14 to 1770 with an average of 347 participants. Some

projects exceeded their capacity in 2008, whilst others fell significantly below 100% capacity. The range was between 30% to 175% with an average of 82%.

On average 65 participants dropped out from the projects before completion but across projects these figures ranged from 0 to 640. The average drop-out rate across the 13 projects that provided figures was 17% (range 0 to 47%).

3.5 Project set up, funding and costs

3.5.1 Project Set up

29 projects reported that service users were involved in the design or delivery of the project. Of these projects 28 provided details of how service users were involved. Users were most often involved through marketing and promotion of the service (table 3.2).

Table 3.2 Distribution of projects (N=28) according to ways in which service users were involved in the design or delivery of projects

Methods of involvement	**N**
Service user representative included in management board	4
Recruitment of current or previous service users as part of service delivery team	5
Engaging service users in marketing and promotion of service	20
Engaging service users in fund raising for the service	8
Engaging current service users in recruitment of future service users	10
Organising service user programme design and deliver meetings	7
Administration of service user 'programme design and delivery' suggestion forms	6
Other	13

Thirty-five projects indicated which types of information they had used to inform the project design and delivery (table 3.2). The most commonly used were, an analysis of local needs and experience of other interventions. The least source of information used was guidance from NICE.

Table 3.2 Distribution of projects (N=35) according to source of information used in setting up the project

Source of information	**N**
Analysis of local needs	26
Specific named theory/model of behaviour change	6
Referred to in setting up/running the intervention	8
Experience of other interventions	22

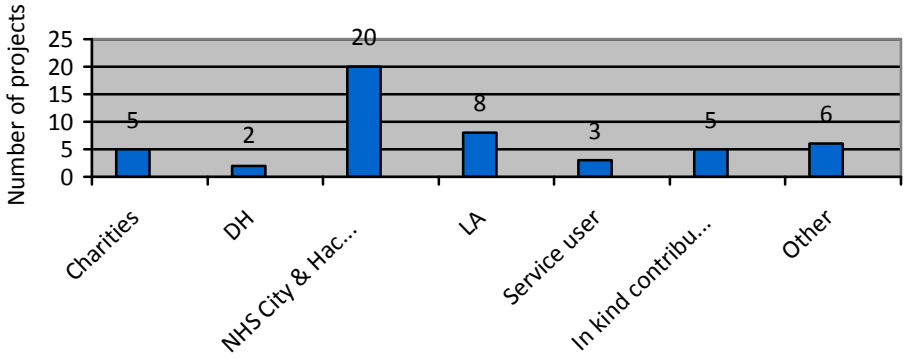
Source of information	N
Expert advice	19
NICE 2006 guidance	3
Other research evidence (please specify below)	8

3.5.2 PROJECT FUNDING AND COSTS

A total of 24 projects provided an estimate of the total cost of their projects. The total costs of these projects in 2008 were £1,236,379. Costs ranged from £2500 to £235,000 with an average cost of £51,516.

Twenty-nine projects provided data on the source(s) of their funding (figure 3.13). NHS City and Hackney were the most common source of funding. For eight projects, funding from this source was the only source of funding.

Figure 3.13: Distribution of projects (N=29*) according to source of funding



*N does not add up to 29 as projects could have more than one funding source

Twenty-five projects provided data on how much funding they received from each source (table 3.4)

Table 3.4 Amount of funding projects receive according to source

	Number of projects	Total amount of funding (£)
Charities	5	93000
DH	2	56000
NHS City & Hackney	18	511901
LA	7	394580
Service users	3	811
In kind contributions	2	34000

	Number of projects	Total amount of funding (£)
Other	5	375000

3.6 Monitoring and evaluation

3.6.1 Baseline and follow-up data

The majority of projects have collected monitoring and evaluation data or are in the process of doing so (figure 3.14) and a significant number collect both baseline and follow-up data (figure 3.15)

Figure 3.14: Distribution of projects (N=38) according to whether monitoring and evaluation data are collected

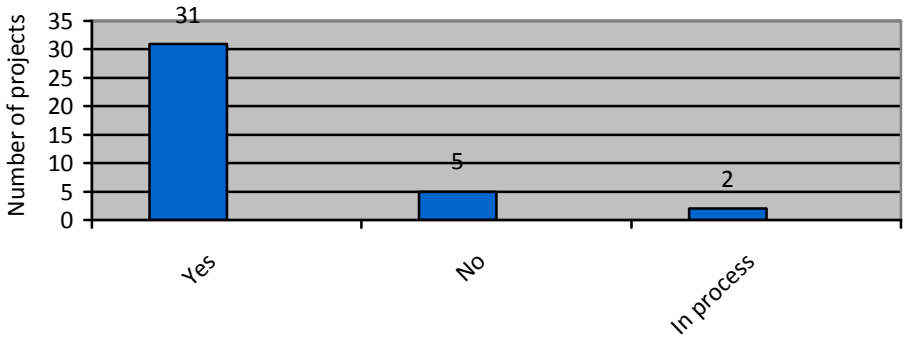
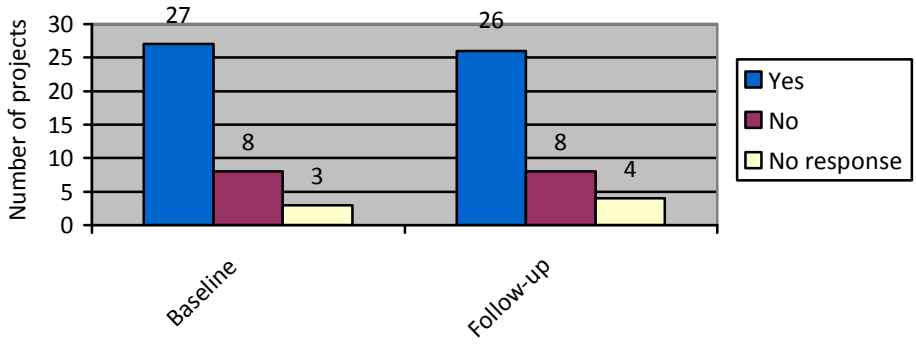


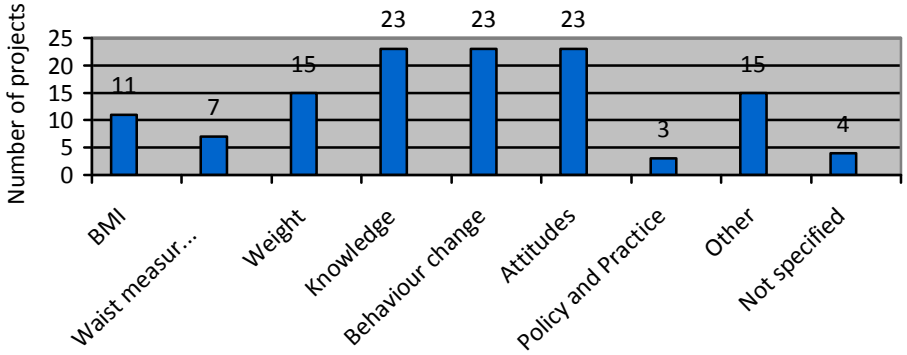
Figure 3.15: Distribution of projects (N=38) according to whether baseline and follow-up data are collected



3.6.2 MEASURING SUCCESS

Success is measured in a variety of ways by projects although changes in knowledge, behaviour and attitudes were the outcomes most often specified by projects (figure 3.16). Other measures included self esteem, changes in body shape and appearance, continued adherence, fitness, blood pressure and, in the case of the refurbishment of community kitchens project, capital works completed on time.

Figure 3.16: Distribution of projects (N=38) according to measure of success*

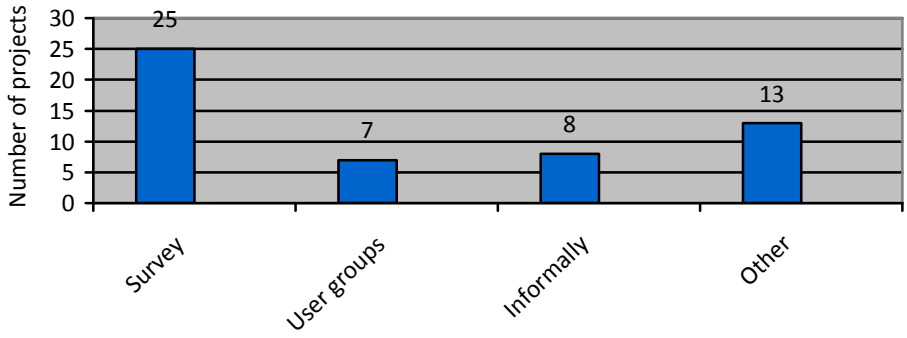


*N does not add up to 38 as projects could cover specify more than one measure

3.6.3 SERVICE USER FEEDBACK

All but two projects ask for feedback from service users, with 31 projects asking for such feedback regularly and four asking for it occasionally. One project does ask for service user feedback but this was reported to be done 'rarely'. Out of the 36 projects that collect feedback, the most common method of obtaining feedback was through a survey on completion of the course (Figure 3.17).

Figure 3.17: Distribution of projects collecting service user feedback (N=36*) according to method employed



*N does not add up to 36 as projects coupld specify more than one means of collecting service user feedback

4 Case Studies

Summary. Five case studies identified with NHS City and Hackney were examined to provide in-depth and contextualised descriptions of sample healthy-weight projects in the area. The five projects were Exercise on Referral, Family Cycle Club, Healthy Lifestyles, Personal Best, and Young at Heart. Key project descriptions are highlighted in a summary box and are discussed in-depth following a structured format detailing its context, processes and outcomes. An assessment of barriers and facilitators to success are then presented. Overall key barriers identified are limited resources for long-term follow-up; personal circumstances of service users; inappropriate or insufficient referrals; lack of support from schools (where applicable); insufficient publicity; availability of venues and facilities; and the weather. Key facilitators include no or minimal cost to service users; inclusivity of projects; safe environments and friendly atmosphere; family bonding; highly-qualified and experienced staff; effective teams; good management and operating systems; and availability of project review and feedback. Comments from service users are also presented here.

4.1 Exercise on Referral

4.1.1 Context

Hackney's Healthwise Exercise Referral Scheme (ERS) is a partnership between the NHS City and Hackney, London Borough of Hackney and Greenwich Leisure Ltd (GLL). Set-up in 2007, the project's main aim is to provide high-quality exercise on referral for people living with chronic health conditions. It also aims to provide 1) diverse opportunities to engage people in physical activity; 2) follow up and support for the client through-out the journey; and 3) an enjoyable social opportunity for residents in Hackney. It targets a wide age range and aims to reach those who do not normally have access to any leisure facilities. The scheme utilises venues such as Britannia, Queens Bridge, Kingshall and Clissold Leisure centres. The leisure centres are open from 8:00 to 20.00.

Aim: to provide high-quality, affordable exercise referral scheme within a safe and structured environment for people with long-term conditions
Location: Hackney
Year set-up: 2007
Provider: Greenwich Leisure Limited (GLL)
Key partners: Physiotherapy department (St Leonard's Hospital), Dietetics and Cardiac Departments (Homerton Hospital), Public Health Department, Hackney Council
Target groups: People with long-term health conditions
Project description: the scheme provides residents affordable access to leisure activities to encourage physical activity

4.1.2 Process

ERS offers behaviour change techniques, including advice and information about healthy eating, physical activity and self-esteem building. Supervised exercise sessions are provided to people with the following conditions: risk of developing or existing CHD, hypertension, diabetes (type 1 or 2), mild to moderate depression, back pain, asthma, osteoporosis, stroke, stress, obesity, have fallen or at risk of falling, and children aged 8 - 13 who are obese. Exclusion criteria include unstable cardiac disease, emphysema, advanced diabetes, severe osteoporosis, severe rheumatoid, arthritis with mobility problems and recent stroke. Referrals are usually made by GPs or practice and hospital specialist nurses, pharmacists, cardiac rehab and community dieticians.

Exercise activities offered in this scheme include gym based sessions, aqua aerobics, circuit/body conditioning classes, cardiac rehabilitation, personal fitness and weight management programmes. Initial assessments include motivational interviewing, weight and height measurements, BMI, BP, waist circumference and SF-12 assessment. The programme is often tailored with exercises that are most appropriate to the client.

Participants for this scheme are entitled to free access to the leisure facilities for an initial period of 13 weeks, after which are either offered GLL membership at a reduced rate or are sign posted to an appropriate community based exit route. GLL membership starts from £11.95 per month, and are increased annually in stages to full price membership (Year 2 – £15.95, Year 3 – £24.95 or concessionary £18.95 and Year 4 onwards).

There is currently a six week waiting list for the project. The programme lasts for 13-26 weeks. Following completion, participants graduate into 'Wellness', which is the point at which they should have the necessary competencies and skills to work on their own.

Participant experience is monitored through telephone calls and periodic reassessments. ERS employs the SF12 to assess satisfaction. The scheme also receives general feedback from users and GPs via telephone calls, questionnaires and letters. Health improvement is monitored through the collection of physical indicators. Whilst no formal evaluation is available at this time, the manager highlighted that a service review is currently being drafted. Front line staff assess the programme from participant records and personal interactions. Where appropriate, ongoing contact with participants is offered for up to 26 weeks.

'I was not discouraged in any way and the project works for me - thanks guys!'

'Improved energy, stamina, strength and flexibility. I will continue and the effects will continue… I hope to get even fitter!'

'The two month wait was too long, the initial assessment went wrong due to poor time management and the trainers clearly had more work than they could deal with.'

'The project has helped considerably, improved concentration and well being.'

'I can swim, I can do gym, weights I can run - a whole load of things.'

'A wonderful scheme - should be offered to everybody for free on the NHS as a cost effective means of preventing long term chronic physical and mental distress.'

4.1.3 Outcomes

In 2007 it was estimated that 200 participants a month would enter and 1400 would fully complete the scheme. Furthermore it was estimated that 1000 participants who completed the scheme would then be referred to an exit route. More recent data highlights an actual average figure of 1500 per year entering the scheme (instead of estimated 2400). Management suggests they receive 100 referrals per week. Completion rate of those referrals however was still unavailable.

According to staff, a successful participant might achieve increased self-esteem, higher self-confidence, health education and increased mental well being and weight loss.

4.1.4 Analysis

Overall the programme was considered successful and appropriate by both staff and service users. Future repetitions of the project would need to include the flexibility, a strong team and supportive colleagues. Front line staff would also like to increase the number of specific classes including techniques like 'stretching' and 'breathing'. The model appears to lend itself well to duplication and according to the manager this is something that is currently being worked on. There are also plans to improve administration systems. ERS management is looking to the future to continually improve the service through monitoring and evaluation. The five factors considered to contribute to the success of the project are 1) the diversity of programmes offered; 2) follow up assessments; 3) motivational interviewing; 4) safe environment; and 5) highly qualified staff. The ERS project is also multi-component in design and is consistently adapted through consultation with key stakeholders and key government policy, guidance and recommendations.

However, ERS faces several barriers to participant engagement. The average drop out rate for the previous two years was 500, whilst the actual dropout rate for 2008 was 640. Reasons for dropping out are related to participants' personal circumstances and onward referrals. ERS staff highlight that while it is often difficult to change participants' habits, the process should allow them to set goals that are in line

with what they are personally prepared to work towards. The initial consultation lasts around an hour during which staff identify the most appropriate exercise plan for participants. Staff are also aware that the initial point of contact will influence the perceived quality of their service and are mindful to offer a sensitive and empathic introduction to all their new starters. Phone calls are also made within 1, 3 and 6 months of joining the course to see what participants have learned so far. Staff also suggest that social support is an important element to keep participants motivated.

From an organisational perspective, there is also insufficient capacity to focus on longer term follow-up which is also partly due to 'inappropriate referrals' from community health workers. Front line staff felt that there was insufficient time dedicated for 'one on one attention' for participants. To address this, it was suggested that initial referrals should be reduced to enable staff to offer a more supportive role to clients.

It has also been suggested that more staff training would be beneficial for the scheme, especially in terms of counseling and cultural sensitivity. ERS staff deal with extremely diverse clients including those with social phobias and mental health issues. They also deal with cultural issues (e.g. women might not want to reveal their skin). Furthermore, as obesity and depression often come hand in hand, staff highlighted the need to have the necessary skills to be able to deal with this effectively.

Sustainability is also an issue to be considered. Introduction of cost for access to leisure centres after 3 months has been identified as a barrier to continued participation. Challenges also remain as the programme needs more space within the leisure centres. According to staff, a recent increase in available centres has enabled the team to be more flexible.

4.1.5 VFM Project Score

PROJECTS		Acceptability	Multi-component	Ongoing/long term	Intergenerational	Equity promoting	Not facility dependent	Monitoring and evaluation	Coverage	Retention rate	Cost	VfM Score
Weight		**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
INDIVIDUALLY-BASED PROJECTS *WITH* WEIGHT/DISEASE ENTRY CRITERIA (range of VfM minimum score = 84 maximum = 252, average VfM score: 172)												
Healthwise	Raw	2	2	2	1	2	1	3	3	1	3	
	Weighted	18	20	18	9	20	6	24	27	8	18	168

4.2 Family Cycle Club

4.2.1 Context

Family Cycle Club (FCC) is a six-week family cycle course for all ages and abilities, designed specifically to encourage families to be active together and to encourage healthy lifestyles within the family culture. Based in Hackney, FCC was launched in October 2007 after Team Hackney won the £30,000 bid to continue and expand existing family cycle clubs as part of its campaign to tackle childhood obesity.

Aim: to encourage healthy lifestyles by training families to cycle and be active together
Location: Hackney
Year set-up: 2007
Provider: STA Bikes
Key partners: London Cycle Campaign, Team Hackney, Streetscene (London Borough of Hackney)
Target groups: 'Hard to reach' groups
Project description: This is a six-week cycle course designed to encourage physical activity and healthy living within the family culture

The scheme has the following aims: 1) to encourage healthy lifestyles; 2) to train families to cycle and be active together; 3) to encourage sustainable means of transport; and 4) to promote the environmental benefits of cycling. The scheme particularly aims to help 'hard to reach' groups including ethnic minority groups, families on benefits, disability groups, families with children with special needs, lone parents, Charedi community members, inactive children/adults and non-riders.

'Families working together and learning together' is the underlying principle for FCC. It places healthy living and physical activity within the family context wherein parents and children learn together which encourages bonding and social support within families. It introduces young people to cycling within a safe environment and provides training for both parents and children to develop the necessary skills to encourage cycling in the long-term.

4.2.2 Process

The six-week course runs every Saturday morning and is being held in primary schools, estates, and parks in Hackney, including Sir Thomas Abney Primary, Tyssen Community Primary, Milton Grove, Wilton Estate and Fellows Court. The project provides opportunities for families to learn 'cycle safety' and 'confidence skills'. It combines cycle training, bike maintenance, second hand bicycle purchase and the provision of a voucher for £30 towards the purchase of a bike at the end of completion of successful training. Bike maintenance is considered an essential component of the scheme to address the often poor quality of bikes owned by participants. Second hand bikes are being purchased to support those who do not have a bike of their own or whose bikes are beyond repair. Second hand bikes are being obtained partly via Waltham Forest Bike Recycling Project.

The cycle training components of the scheme are tailored to suit the individual's needs. Participants are initially assessed to evaluate their cycling skills level based on a set of 'Bikeability Milestones'. The scheme incorporates sustainable healthy lifestyles to include messages on healthy eating and to develop the skills to maintain this lifestyle. Participants' progress are assessed individually and participants' feedback are also collected. As Gail Bristow from STA Bikes explained:

> '… We have training components and we try to increase ability of cycling. We first train them to use the bike and then how to maintain the bike and we give them a little gentle input of healthy eating about what you eat and how it affects how you feel. We encourage them to have good breakfast to get more energy and try to reinforce them. We try to make it fun and we organise events and people make their own networks. We evaluate progress and we have a report from every person who participates. They are in groups and we evaluate them in groups in terms of age and often split parents from children because you get different messages. We have [different] levels of abilities. At the end of the session each individual has to fill out what they covered. They have an initial assessment and at the end we are able to assess their progress and then they get a certificate…'

The cycle training is offered free of charge. The scheme is publicised via schools, posters, newspaper advertisements, and most popularly, through word-of-mouth.

4.2.3 OUTCOMES

In their submission for the London Cycle Campaign Awards in 2008, Team Hackney proudly highlighted the 432 attendances for all the cycling sessions, including 77 people who had never cycled before. According to STA Bikes staff, the positive outcomes of this scheme could include improved self-esteem, increased knowledge on cycling and healthy living, and increased awareness of service provision and facilities in the borough. It also fosters social cohesion and promotes positive attitudes about keeping fit, staying active and encouraging healthy environments.

'I am more confident, no problem getting on the bike.'

'We enjoyed riding the bikes, made a few friends, and we told more people about it.'

'The trainers were extremely patient with us.'

'The trainers worked really well with different age groups.'

'You can really get an understanding on how to do the simplest of things… things that are common sensical, but when you're riding you don't know how to do it.'

'It was perfect – I couldn't fault it if I tried.'

'Keep up the good work. It's valuable for me and my family… advertise it more and let more people know about it…'

'The kids will remember this as a positive experience… it's fun and they learned to ride a bike through this club.'

'My son absolutely loved it.'

4.2.4 ANALYSIS

One of FCC's major strengths is its ability to encourage bonding in families by providing them with the opportunity to do something together. This is particularly highlighted among families with a child with a special need. Cycling is considered as an activity that every member of the family can take part in.

Cycle training is also delivered in an informal and friendly atmosphere by highly-trained and experienced staff. There is a positive and encouraging atmosphere that makes learning fun and enjoyable. The programme is designed to become culturally sensitive and flexible to suit individual participants' ages and skills. There are also mechanics on hand and the venue provides a suitable and secure environment to learn how to cycle.

With Hackney's diverse population, language can sometimes become an issue. But with FCC's focus on the family, there are occasions when older children act as interpreters for their parents whose first language is not English.

FCC also fosters social cohesion by bringing together individuals from various segments of the community. FCC staff prides this scheme for enabling some of its participants to gain skills and capabilities, especially among young people. As part of the training, participants are taught how to maintain bicycles. With this skill, young people can help other members of the community to maintain their bikes and gain a more approachable (if not respectable) position in their community.

However, due to the lack of funding, FCC is not able to offer follow-up sessions for its service users. There are also no informal drop-in facilities to repair bikes or to brush up on their skills. Public attitudes on cycling have also been a barrier for FCC. As Gail Bristow expressed:

> '…in the past a lot of people had associated us as a programme for people who were already cycling and where cycling is a part of their choice and not as necessity. So now we try to encourage people from local communities to take part in this cycling training. Now a lot of people are mothers who have their children in school and looking for career development to become not only cyclist but trainers as well. We work in local parks and school so all could come and join us and have access easily. Another thing we do is we make sure that when we go for training in schools there is always one man and one woman trainers. Teenager groups are always very difficult to engage with. Some of them may be

embarrassed when we go to parks; they don't want others seeing them that they do not know how to cycle. It doesn't happen in schools because they are familiar with the environment and feel safe…'

The public perception of cycling as a poor person's transport also needs to be overcome. As STA Bikes staff explained, there is a need for cycling to be perceived as aspirational and to make it look more attractive to people. The fear of the road is also a barrier to participant engagement. There is a need to encourage people to use cycle training to overcome this fear by delivering techniques on how to be safe when they on the road. Structural and environmental barriers also exist such as issues with safe parking, and of course, the good old British weather.

In October 2008, FCC won the *London Cycling Campaign Award* for the Best Community Cycling Initiative for Young People or Children. Service users and members of staff are truly proud to be part of the scheme and to receive recognition for the good work they have accomplished so far.

4.2.5 VFM Project Score

PROJECTS		Acceptability	Multi-component	Ongoing/long term	Intergenerational	Equity promoting	Not facility dependent	Monitoring and evaluation	Coverage	Retention rate	Cost	VfM Score
Weight		**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
INDIVIDUALLY-BASED PROJECTS *WITHOUT* WEIGHT/DISEASE ENTRY CRITERIA (range of VfM minimum score = 84 maximum = 252, average VfM score: 193)												
STA Bikes Saturday Family Cycle Club	Raw	2	3	2	3	3	2	3	3	3	3	
	Weighted	18	30	18	27	30	12	24	27	24	18	228

4.3 Healthy Lifestyles

4.3.1 Context

The Healthy Lifestyles project is funded by Team Hackney, an initiative which is lead by NHS City and Hackney. The project aims to work with children between the ages of 7 to 13 years and their parents to address childhood obesity. The programme offers support to young people in achieving healthier lifestyles through physical activity, healthier eating and behaviour change, with an emphasis on having fun and building self-esteem.

There are 10 members of staff which includes the project co-ordinator, fitness instructors, community dieticians, drama leaders and psychologists. The sessions are conducted between 17.00 to 19.00 at Space Leisure Centre (Tuesday) and 9.30 to 11.00 (Saturday).

Aim: to help families become healthier by enabling them to make healthier choices, build self-esteem and confidence
Location: Hackney
Year set-up: 2006
Providers: Core Fitness Club
Key partners: NHS City and Hackney, Hackney Council, 2012 Olympic Unit, School Sports Partnership, Immediate Theatre
Target groups: No specific target group
Project description: This is a 10-week course which works with 7-13 year olds who are overweight and their parents to help prevent and treat childhood obesity by promoting physical activity, healthy eating and positive self esteem within the families

4.3.2 PROCESS

A structured 10 week program is offered to help prevent and treat childhood obesity with an aim to reduce weight or stop weight gain. This is achieved by promoting physical activity, healthy eating and positive self esteem within the family setting. Each week comprises of physical activity sessions for an hour and a combination of 10 one-hour sessions of healthy eating/healthier lifestyles with the parents (i.e. sessions around emotional well being, confidence building, self-esteem, body image and assertiveness). Activities are facilitated through drama skills workshop to help participants achieve and maintain a healthier lifestyle. In order to address some of the fundamental reasons behind childhood obesity, parents are also encouraged to take part in a new component to the programme which consists of psychology sessions to increase their own knowledge, provide parents with the skills and support system for their children, and to assist them to make their own healthier lifestyle choices.

Before families are invited onto the programme, they must go through an initial consultation and assessment session which is carried out before the sessions commence. Participants' BMIs, waist circumference and body fat percentages are measured before and after participating in the project. Pre and post project questionnaires are also conducted to enable families and the team to review and assess their attitudes and knowledge on eating and exercise habits and to observe any health behaviour changes at the end of the programme. Registers are taken each week to monitor attendance. Participants are also asked to provide feedback after each session and take part in team meetings to discuss any issues they may have.

After the completion of the project, communication with the participant is maintained for 6 months to 1 year. There is a Healthy Lifestyles Club they can attend to continue with their physical activity and there is also gym membership for children. If funding allows, parents may also be entitled to subsidised membership. Most participants fully engage with the programme and enjoy it. The exercise component is most enjoyed and the drama and psychological aspects are least enjoyed. Participant satisfaction is assessed via video diaries and parent evaluations (initial, mid and end).

'I found it (the sessions) very stimulating and enjoyable.'

'My daughter and I enjoyed it….its improved my daughters health and weight and knowledge about health.'

'A balance in gender would have been good...'

'The facilitators were very good, very friendly and professional.'

'I found the nutritional aspects very educational.'

4.3.3 OUTCOMES

Several health outcomes are expected from this project. According to the service delivery team, participants increase in their self confidence, feel better about themselves and parents show changes in their attitudes and health behaviours. They are also said to be able to make better lifestyle choices (e.g. they are more conscious of food labeling and the nutritional information on food packages). In 2008, significant changes were observed in children's BMI. There was also a 70-80% reduction in BMI and waist circumference among families. In some cases parents showed greater improvements than children.

4.3.4 ANALYSIS

The project is quite flexible in terms of adapting the activity or service style to suit the participants' needs and interests. In terms of implementation and ongoing success, the project team feels as though they have achieved all the goals they have set out to achieve. There are good systems in place and it is well marketed in the local area.

In terms of reaching the target audience, although it is thought that the project achieved this, participant retention is an issue. Participant retention is currently around 70%. Some families may take part for a week or two before deciding whether to join or not. It also appears that certain groups may be more likely to drop out than others (e.g. teenagers aged 11-13). This may be related to feelings of embarrassment in taking part in physical activity. In addition, participation may also often depend whether parents want to take part.

Other factors that have impacted upon the project are related to the locality and timing of the project. Since some sessions are held in the evening, some participants have found it difficult to travel to the location during these hours or have been put off by the area itself due to its negative reputation. To overcome this issue, the project eventually changed location.

Another barrier is language. Several families have dropped out because of this. Although language is not seen as an issue in the physical activity component of the programme, it is most certainly imperative in engaging participants in its nutrition and psychological components. Incentives (e.g. prizes, awards) have been employed to reduce drop-outs and to encourage greater participation. The project team also offers full support to the families and are always happy to change aspects of the programme to encourage them to continue. For families who do stay in the scheme, it was said that they have done so because they enjoy it and gain something positive from it.

4.3.5 VFM PROJECT SCORE

PROJECTS		Acceptability	Multi-component	Ongoing/long term	Intergenerational	Equity promoting	Not facility dependent	Monitoring and evaluation	Coverage	Retention rate	Cost	VfM Score
Weight		**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
INDIVIDUALLY-BASED PROJECTS *WITHOUT* WEIGHT/DISEASE ENTRY CRITERIA (range of VfM minimum score = 84 maximum = 252, average VfM score: 193)												
Healthy Lifestyles Project (Hackney)	Raw	2	2	2	2	1	1	3	1	2	1	
	Weighted	18	20	18	18	10	6	24	9	16	6	145

4.4 PERSONAL BESTS

Aim: to stop the rise of childhood obesity in Hackney and to increase the number of quality physical exercise hours in schools
Location: Hackney
Year set-up: 2007
Providers and key partners: Team Hackney, Schools, Voluntary sector
Target groups: School children
Project description: This project is an Olympic/Paralympic awareness programme that encourages children to continually challenge themselves in sports

4.4.1 CONTEXT

Hackney's Personal Bests (PB) is a fun Olympic and Paralympics awareness programme encouraging children to continually challenge themselves to improve their own personal best scores. The key element of the programme is that kids compete only against themselves and '*be the best they can be*'.

The project was set up using an analysis of local needs with the experience of other interventions and expert advice. The schools are selected using BMI levels and by recommendations from the Healthy Schools and the School Sports Partnerships. Hackney has 60 primary schools, of which 13 were engaged in 2008, and a further 26 were invited in 2009.

Team Hackney provides the full funding for PB. The total cost of the project is £60,000. The main bulk of the funding goes towards materials, equipment and incentives (£30,000) and contracted services of

coaches (£25,000). The remaining £5,000 is spent on rent and staff training. The PB team consists of 15 people: two 2012 staff, an experienced and active lead coach and 12-13 contracted coaching staff from three local companies (Leyton Orient, Let's Get Fit for Sport and Core Health and Fitness).

'The Swimmer told us never to give up..... and I got to hold a gold medal!'

'I liked beating my scores'

'I cheered on everyone to try and get their personal best'

4.4.2 PROCESS

The main thrust of the programme is based upon children completing a series of Olympic-based athletic disciplines, using junior athletics equipment supplied by the 2012 unit. The sports activities in this scheme include discus, shot put, javelin, standing long jump, standing triple jump, sprint relays, Boccia (for wheelchair users) and goal ball (for blind competitors).

On the first session participants are taught how to use all the equipment. Scores are recorded and the children are told that they will be competing not each other, but against their own personal best. After this session, the PB team returns to the school at least three more times. Throughout the programme, children are encouraged to complete a colourful and informative health-related workbook which was designed by the 2012 unit in partnership with Healthy Schools and Schools at the Heart.

Invited speakers like local Paralympics champion, Dervis Konuralp also comes in to talk to the children about how to overcome barriers to participating in sports and to increase their awareness of Paralympics and disability sports.

Schools can also nominate between 10-15 pupils to complete the *Young Leaders Award* qualification free of charge. This course is considered as the first stage of a coaching qualification which provides the opportunity for older children to work with younger children and to develop their leadership skills. In addition, the programme also offers an after school club, access to a local sports and athletics club and through this the opportunity to feed into 'Hackney's mini Games squad'.

Schools also have the option to incorporate the programme into core subjects such as mathematics, English and ITC skills by considering aspects such as scoring, recording and creating performance graphs for the students. PB supplies the document *'Curriculum Links'* as a resource for teachers to enable them to rapidly identify opportunities for cross-curricular planning.

4.4.3 OUTCOMES

In 2008, about 579 children took part in the project, of which 27 had a disability. About 144 children also took part in the PB final, of which 12 had a disability. The project also reached approximately 3000 children through its PB assemblies.

"Majority of the children appeared very engaged and for most it was a first attempt at the sport. There was definitely element of team support. Kids cheered whilst their peers took part"

Research Observation

Evaluation data collected by the PB team from the first year showed that all participants managed to improve on at least one sport from the project. About 36% improved on at least 3, and about 9.3% on all 5. The PB 2008 teacher evaluation which surveyed 10 teachers from the 13 schools demonstrated that 80% of the staff involved considered the programme to be 'excellent' whilst the remaining 20% rated it as 'good'. All participants rated the staff involved in coaching as 'excellent', 80% considered the equipment used as 'excellent' and; 90% considered the enjoyment levels of the children as 'very high'.

In 2009 the evaluation has been extended to all participants which measured baseline and completion scores. The short questionnaire using the Borg Scale includes measures of

'Best sports event the school has ever attended' (Gainsborough)

'Excellent really well run and the children really enjoyed themselves' (Parkwood)

attitude, knowledge and behaviour change. Additional data relating to participation, hours of activity, qualifications and performance will also be recorded for each school.

4.4.4 ANALYSIS

PB is an example of how to engage children in physical activity that is fun, informative and challenging. The inclusiveness of the programme means that no health status, disability or cultural issue can prevent individuals competing together and it enthuses children at an early age. According to staff, the five things that make the programme most successful are: 1) its involvement with the 2012 Olympic and Paralympic Games; 2) its innovative scoring methods; 3) the health workbook; 4) equipment used and; 5) its inclusivity.

PB staff note that the most important and but also most difficult element of the process is building relationships with schools to ensure they allocate time to run the scheme. Barriers to participation from schools are related to the extremely high turn over rate of teaching staff in Hackney and the busy learning schedules that the children have. Initially PB focused on Year 6 students, but after noting in the evaluation that the pressure of SATs was influencing their engagement rate, they shifted the focus to Year 4 and 5 instead. Furthermore to tackle these issues, the manager and/or lead coach will attend every first and last session at the school. Additionally the manager invests substantial time to ensure that the school head teachers and PE staff are knowledgeable and engaged enough to enthusiastically drive forward the project in their school. This also frees the coaches to focus solely on building relationships and the skills of the children. The level of engagement for schools does tend to range depending upon the number of participants, the number of hours that are allocated by the school to the project (e.g. some schools may have sports afternoons of two hours dedicated time, whilst others have less than an hour). Schools also vary in the space they have available. The PB team is flexible in order to make the best of what they can get.

According to PB's staff, Hackney children share a unique outlook towards physical activity, which is heavily influenced by issues around money, general apathy, heavy parental work commitments, high use of technology and a lack of local events and sporting opportunities. Also, Hackney has no athletic tracks and therefore athletes have to leave the borough to train. Plans for an Olympic stadium are not expected to be completed until 2011. Staff involved in the project have themselves grown up in Hackney and thus can relate to the children's experiences. However, they also expressed concern in the drop in physical activity, the focus on computer games and the more sedentary lifestyles kids experience these days.

Interviews highlighted that although simple evaluation was collected from the teachers and children, they prefer to focus on quality and assessing the reactions of the children, for example 'a child's smile, a kid sweating or an obese kid beating a kid that always wins, you can't measure that but that is what counts'. The sports covered in PB are activities that can actually encourage children with weight problems to be competitive and aim to do well to represent their schools. From the 144 children surveyed at the finals, 30% had not had the opportunity to compete or represent their school before.

Future plans are to link more closely with the Hackney based obesity programme, The Healthy Lifestyle Group and further signposting to other initiatives such as Fitchance and the London Youth & Mini Games. They also plan to introduce the programme to more schools in Hackney including previously untargeted private and Jewish schools. The team has high expectations, especially since gaining Beacon Status for Community Engagement and would like to see it replicable across many different age groups and running annually in schools as part of the curriculum, far beyond the Olympic and Paralypmic games in 2012. Good progress is already being made with the introduction of the New Age Games (for the elder generations) and an adapted programme for the Hackney youth centres.

4.4.5 VFM Project Score

PROJECTS		Acceptability	Multi-component	Ongoing/long term	Intergenerational	Equity promoting	Not facility dependent	Monitoring and evaluation	Coverage	Retention rate	Cost	VfM Score
Weight		**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
INDIVIDUALLY-BASED PROJECTS *WITHOUT* WEIGHT/DISEASE ENTRY CRITERIA (range of VfM minimum score = 84 maximum = 252, average VfM score: 193)												
Hackney Personal Bests	Raw	2	2	2	1	3	1	3	1	3	2	
	Weighted	18	20	18	9	30	6	24	9	24	12	170

Aims: to increase the number of older adults participating in physical activity; reduce the number of falls by increasing fitness and flexibility; help build confidence and support network in the community
Location: City of London
Year set-up: 2005
Providers: Sports Development (City of London)
Key partners: City and Hackney PCT, Adult and Social Care (City of London)
Target groups: Disability, low income groups, older adults (50+)
Project description: This is a membership scheme for people aged 50plus which provides programmes of physical activity, health checks and advice

4.5 Young at Heart

4.5.1 Context

Originally launched in October 2005 the scheme aims to increase levels of physical activity among people aged 50 plus and reduce the number of falls through increasing flexibility, fitness and independence. The underlying philosophy of the programme is based on building up the physical health of members by participation in fun, sociable and active classes.

The scheme began as a six month pilot scheme and expanded due to the unexpected level of interest from participants. By the end of the first 2 years, over 400 people had registered which subsequently led to a re-launch in April 2008. YAH also introduced the fee of £10 for City residents and £15 for non city residents.

Funding comes mainly from the voluntary organisations and NHS City and Hackney (£12,500) but also from charities (£2,000) and 'others' (£50). This is then allocated to materials (£2,000) rent facilities (£5,000) salaries (£31,000) training (£100) and payment to contracted services (£16,000). Coaching staff include qualified line dancers, ball dancers and personal trainers.

4.5.2 PROCESS

As members, participants are given the opportunity to become socially active, obtain free health checks and related advice pertaining to height, weight, BMI and blood pressure monitoring. Membership also includes access to a wide range of designated activity sessions, a YAH shopper bag, pedometer and steps record sheet, bi-monthly newsletters, monthly guided walks to various places in and around the City[1] and surrounding areas, subsidised access to specified Adult and Community Learning courses, quarterly health checks, Christmas cards, invitation to summer outings and the anniversary party. Members also get the chance to become involved in marketing, design, fund-raising and promotional aspects of the programme.

YAH staff work with the members' physical ability and personal motivations to offer a highly flexible and tailored activity plan. The 2008 programme consisted of line dancing (Monday); swimming and short mat bowls with salsa in the evening (Tuesday); gentle exercise 1 (stretching, mobilising, toning and cardio) and evening gentle exercise 2 (improving muscle and joint mobility, posture, strength and flexibility including chair-based exercises) followed by pilates, learning about London and gym work out sessions (Wednesday); gentle exercise 1 and swimming (Thursday); gym work out, pilates and ballroom dancing (Friday); and badminton and table tennis (weekends). The Salsa, 'Learning About London' and Pilates classes are 12-week courses run by Adult and Community Learning.

Participant recruitment often comes from GP referrals, YAH website, advertisement at gyms, leisure centres and other local signposting. Upon registration participants are required to complete a comprehensive enrolment form and a two-hour induction with a member of staff. The form collects health and contact information including emergency contact details, medical history relating to heart and chest complaints, previous conditions, current medications, physical abilities and expectations. During the induction the member of staff discusses behaviour change with the participant including how they will benefit, how to make gradual changes and what effects that might have.

Feedback is obtained continually via informal methods and annually via a feedback questionnaire. Any feedback received are always considered and taken into account when making decisions.

4.5.3 OUTCOMES

In 2008 YAH had 200 members from people from over 15 boroughs. YAH project states to bring about outcome changes in weight measurement, knowledge, social cohesion, behaviour changes and attitude. The three monthly health checks are an opportunity for staff to monitor the health changes in participants. During the 2008 health checks members' height and weight measured for Body Mass Index (BMI) and Blood Pressure show that 51.5 % of those measured were in the normal range and between 18.5 – 25 for BMI. Additionally 71.4 % are in the normal range (diastolic less than 90) for Blood Pressure and 79.6 % are in the normal range (less than 86 beats per min) for Pulse Rate. In 2007, of those measured 47 % reduced their BMI, 58 % reduced their Blood Pressure and 60 % lowered their pulse rate. These measurable health outcomes are complimented by regular feedback that highlights a positive response to the programme including an improvement in fitness, feeling healthier and active in day to day lives, gaining knowledge and the confidence that comes with that and also having their awareness about their own body raised.

---

[1] Golden Lane Leisure Centre Golden Lane Estate EC1Y 0SH
Middlesex Street Community Hall Petticoat Square Middlesex Street E1 7EA
Mansell Street Community Hall 33 Guiness Court Mansell Street E1 8AB
City YMCA Barbican 2 Fann Street EC2Y 8BR

'I joined it, been there ever since, they haven't got rid of me yet!'

'we are all sorts, all shapes, sizes, colours, creeds... the lot... and it really brings us all together'

'At the time I had a shoulder injury, I thought I was going to always have an arm that was useless.... I've gone from strength to strength, It's gone way beyond my expectations'

'The safety is uppermost in their minds'

'I go aerobics, swimming, gym short mat bowels, table tennis, badminton, Friday trip with the youths, dragon canoeing.....I join in everything'

'it would be great if it was free, but if you work it out, I've tried out the others, it is still really great value for money... you don't mind paying it'

'I know that I like it, it suited my needs and other people's needs.....It is fantastic it keeps me excited'

4.5.4 ANALYSIS

Overall staff members highlight being involved in the project as a very positive experience, both professionally and personally. Members are considered to see the difference between what they used to do and what they can do now, and seeing those results is motivation for them. The flexibility of the programme in terms of timing, predominantly drop-in classes, varied venues, and variations in activities appear to work well for its members. The general experience of the members is considered to be very welcoming. YAH consider the best things about the programme are the enthusiasm and open mindedness of the staff and its members.

Members support each other to encourage participation. For example one active member arranged to meet others at the tube and lead them across the city so that people would be more willing to come knowing they would not get lost. Free refreshments are also good incentives and whilst sessions are held at four main venues across the city[i] YAH tend to alternate where they hold events according to requirements and demand of local participants.

YAH highlight case studies of members who have recovered from serious health issues as a result of being involved in the programme and they note that the atmosphere in the gym is happy and excitable. Additionally, members might also begin to take more control of their own health concerns by bringing in information and questions for the coaches to follow up. There are also a number of unintended outcomes as YAH staff note that both staff and members have taken real ownership of their classes and also meet on a social level outside of the YAH planned activities. This growth in social aspect is what has led the programme to develop far beyond its pilot aims. In addition to the planned outcomes, members have gone on to become involved in voluntary positions working at the marathon on the water stations and swimming gala members are often involved in both participating and organising the events.

The appropriateness of YAH against its intended aim to reduce the number of falls was considered by staff to be very high. Cultural barriers are rarely faced but the staff seem open to raising their awareness around what is appropriate and what is not when issues arise. YAH note however that they have been unsuccessful in recruiting members from the Asian Community who represent a high proportion of the local demographic. Attempts have been made however it has been noted that the lifestyle of the community is often more family orientated.

The success and flexibility of the programme may in part be due to the geographical focus of the programme within the square mile of the City of London. Future repetitions of the programme may benefit from more funding so that YAH could offer more. They are also looking to build in a healthy food preparation and cooking component in the new financial year. Members currently seem happy to travel some distance to attend classes, but YAH would love to see the scheme expanded across the capital where members could hold a membership card to enable them to access all sessions.

Other good aspects of the programme are the health outcomes. The regular checks encourage members to go to doctors and act as good health security. Staff and members are seen to enjoy their sessions equally. The downside to the project is its heavy reliance upon equipment. Whilst service users would also like to see the programme a little more subsidised, those approached seemed very pleased with the value for money the programme offers.

> " My experience is very nice, this is the first time in my life that I join a gym, at first I was a little embarrassed but now I am quite happy"
>
> "The trainer she looks after us to do things properly and we are satisfied"
>
> "Losing some weight is one of the reasons I joined the project, for as long as it is there I will use it"
>
> "I think it is wonderful....I do the line dancing, I go for walks, aerobics....., we are lucky to be in this area and enjoy it"

For those who stopped attending the classes, the YAH coordinator often calls members to discuss how they might re-engage with the programme. Of the 10 or so members who have left, reasons are often related to members moving away or do not have enough time to take part. Staff also noted that those most vulnerable to dropping out are those who do not engage with the social aspects of the programme as this often leaves them less motivated. Barriers to engagement are often associated with confidence and general awareness of exercise. Staff highlight that there is often a negative connotation attached to physical activity that the team have to tackle. Activities run all year round, but service users are given exit routes to follow if they wish to participate in certain activities on an even more regular basis. Beyond this there is no follow-up engagement once a member leaves the programme.

The 2009 Service Report has not been completed yet; however preliminary results are reported to be encouraging. From a cost effective perspective, the long-term health benefits of the programme around rehabilitation, reducing isolation and depression have huge impact on its members. By engaging in the programme, people are not focusing on what is wrong with them but the next thing they are doing which helps people to keep healthy.

4.5.5 VFM Project Score

PROJECTS		Acceptability	Multi-component	Ongoing/long term	Intergenerational	Equity promoting	Not facility dependent	Monitoring and evaluation	Coverage	Retention rate	Cost	VfM Score
Weight		**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
INDIVIDUALLY-BASED PROJECTS *WITHOUT* WEIGHT/DISEASE ENTRY CRITERIA (range of VfM minimum score = 84 maximum = 252, average VfM score: 193)												
Young at Heart	Raw	2	3	3	1	3	1	3	3	3	2	
	Weighted	18	30	27	9	30	6	24	27	24	12	207

5 Assessment Metric Development

SUMMARY

- Our review of the international research evidence and national and local obesity strategies revealed several cross-cutting characteristics associated with effective interventions to achieve healthy weights. These were: multi-component, ongoing, not facility dependent, tailored and personalised, targeting at risk groups, working across sectors, and involving families.

- The views of local commissioners and project delivery teams were sought regarding: criteria to evaluate the success of projects, encouraging coherence and integration between projects and arguments for continued investment in healthy weight-related projects.

- Suggested criteria for success included: positive user experience, on-going activities and interventions, comprehensive monitoring and evaluation, good retention rates, targeting those most in need and reducing health inequalities. Assessment of projects in the future should consider both the measurement of immediate outcomes such as knowledge, attitudes and self-esteem as well as longer term outcomes such as behaviour change and weight.

- Key factors to facilitating greater coherence and integration amongst projects were: emphasising the common goal to which all projects are contributing; creating opportunities for networking amongst projects; greater integration amongst commissioners as well as projects; and developing stronger connections amongst projects along the referral pathway.

- The strongest argument for continued investment in healthy weight-related projects is their multi-faceted nature and their potential for wide ranging health and economic benefits. Healthy weight projects focus on changing the behaviours associated with the prevention of a wide variety of chronic diseases. They can also promote mental health and well-being.

- Combining the views of commissioners and project delivery teams with information from the research evidence and national and local strategy, we developed a Value for Money (VfM) metric to measure economy, efficiency and effectiveness. This metric helps to assess, in an explicit and transparent way, the extent to which projects display characteristics associated with effective interventions and good practice and the extent to which projects achieve good coverage and retention.

- The VfM metric was made up of the following 10 criteria: acceptability, multi-component, ongoing, intergenerational, equity promoting, not facility dependent, monitoring and evaluation, coverage, retention, and cost.

5.1 Evidence on Effective Healthy-Weight Interventions

We examined the most up to date reviews of the effectiveness of interventions to promote healthy weights to identify a set of characteristics for effective interventions. Information was sought from NICE guidance, Cochrane and other systematic reviews, strategy documents from the Department of Health, the Foresight Report, the National Obesity Observatory and NHS City and Hackney obesity and healthy eating strategies. Box 1 below discusses some of the cross-cutting themes extracted from this literature.

Box 5.1. Characteristics of effective interventions to promote healthy weights

Multi-component: The most successful interventions for adults appear to be those which bring together physical activity, dietary advice and behaviour changes. There is strong evidence that a combination of physical activity, behavioural therapy, and diet is effective for weight loss. A combination of active support for diet and behaviour therapy is effective for weight loss: change of approximately 4kg compared with a passive approach (advice or self-help) at 12 months. There is some evidence to suggest that these kinds of interventions are particularly beneficial for individuals from higher socio-economic groups. [14]

The Cochrane review conducted by Oude and colleagues[15] concluded that "*combined lifestyle interventions compared to standard care or self-help can produce a significant and clinically meaningful reduction in overweight in children and adolescents*" (p.2). The results of this review further show that family based, lifestyle interventions with a behavioural programme aimed at changing diet and physical activity thinking patterns provide significant and clinically meaningful decrease in overweight in both children and adolescents compared to standard care or self-help in the short and the long term.

Multi-component and sustainable community-based interventions by health professionals can support maintenance of a healthy weight. School-based interventions can promote increased levels of physical activity and healthy eating but the evidence to date is not yet conclusive on whether these impact on actual obesity rates. More long term follow-up is needed[14]

Not facility dependent: long term integration of exercise into daily life is more successful when opportunities for physical activity are not facility dependent, for example walking. Interventions in the family appear to be more successful when they promote activity that can be done in or from the family home[10, 16]

Ongoing: behaviour change and maintenance of healthier lifestyles is more likely to occur if people are engaged with a service over a period of time rather than given one off ad hoc advice on lifestyle change.

Tailored: interventions should consider individual preferences and circumstances and as far as possible be adaptable to meet their individual needs. [14]

Targeting at risk groups: there are certain groups who are at greater risk of developing obesity. These include those in deprived communities and also people at certain times in life, for example when giving up smoking or after childbirth.

Engage local providers: work across local providers is essential to ensure consistent messages are provided and to create an environment in which the wider determinants of obesity can be tackled.

Involving families and other groups: The latest NICE guidance cites evidence from four systematic reviews which suggest that there is a large positive association between parental and social support and physical activity in young people. Involving family members (usually spouses) in behavioural treatment programmes can be more effective for weight loss than targeting the overweight individual only. On the other hand, group behavioural programmes do not result in a greater weight loss than behavioural programmes aimed at individuals at 12 months[14].

5.2 THE VIEWS OF COMMISSIONERS AND PROJECT DELIVERY TEAMS

A consultation event was organised on the 3rd April 2009 to bring together commissioners and project delivery teams to discuss initial findings from our research and collect their views on how healthy-weight projects should be assessed. As discussed in chapter 2, we ran three discussion groups and table 5.1 outlines the topics covered in each group.

Table 5.1. Outline of discussion groups held at a consultation event for providers and commissioners of healthy-weight projects in City and Hackney.

DISCUSSION AIMS	PROMPT QUESTIONS
GROUP A	
To discuss how we should be measuring effectiveness • To agree the three most important measures of effectiveness across all projects	What does 'effectiveness' mean to you? What criteria do you currently use to assess whether or not your project is effective? Are there different criteria for physical activity and healthy eating projects? Are there any criteria or measures that apply to all types of projects?
GROUP B	
To discuss points of coherence and integration across projects • To highlight three key ways to promote coherence and integration across projects	What are the benefits of coherence and integration across projects? How do you find out about what is going on throughout the borough to promote healthy-weight and how do you interact with/work with other projects? Do you think there is coherence across projects? If not why? What might help?
GROUP C	
To produce a list of arguments for expanding/continuing investment on healthy-weight projects • To highlight the three best reasons for continued investment on healthy-weight projects	Why should the PCT continue investing on healthy-weight projects? Why should the PCT expand investments on healthy-weight projects? What are the benefits of continued investments on healthy-weight projects?

A key aim of the consultation event was to combine the insights generated with those from national and international evidence to inform the development of the assessment metric. The main points to arise from the three groups are presented below.

5.2.1 GROUP A: ASSESSMENT CRITERIA

The discussion was set in the context of complementing evidence of effectiveness of healthy weight projects available in the literature with local knowledge and expertise to ensure the relevance of any assessment criteria that were developed. Participants were observed to use the terms 'output' and 'outcome' differently, and for a common understanding, the facilitator described 'outputs' as immediate or early term effects and 'outcomes' as taking place over the longer term. There was general agreement that measurement indicators should:

- Take account of both outputs and outcomes;

- Differentiate between individual and population-level measures;
- Specify clear goals for both providers and users; and
- Recognise both overweight and underweight

Specifically, participants identified the following key measures and areas were measures could be developed:

- Positive user experience
  (This covered a number of dimensions: easily accessible; culturally appropriate; tailored and personalized; user involvement in project design and delivery; empowering users with knowledge and skills for behavioural change.)
- Long term/ongoing projects rather than one-off activities
- Combination of both quantitative and qualitative indicators
- Long term change in both knowledge and behaviour
- Continuation (or drop out) rates
- Projects that target the most needy/highest risk groups (while maintaining consistent messages to those at lower risk)

It was pointed out that the focus on overweight and obesity could be to the detriment of underweight which is also a problem within certain population groups. Some participants observed that charging a small fee for activities (alongside free taster sessions) was more likely to sustain users' attendance.

5.2.2 GROUP B: DEVELOPING COHERENCE AND INTEGRATION ACROSS PROJECTS

Coherence and integration were discussed in terms of referral pathways, learning from each other, and the commissioning process. Several barriers and facilitators for greater coherence and integration were identified:

- Developing stronger connection between projects along the referral pathway.
- GPs as a crucial part of the referral pathway as they are often at the root of referrals, especially for those at risk, and need to know what is available.
- Monitor the partnership work that projects are involved in as part of the commissioning process.
- Set up a website for the healthy-weight programme.
- There was some discussion of developing clusters within the programme as whole (e.g. according to age group or localities). However, it was felt that this may lead to fragmentation rather than integration.
- A recognition that although diverse, all projects are working towards a common goal – helping people to achieve healthy weights. Emphasising that all projects are working towards a common goal in diverse ways would encourage greater integration rather than competition between projects.
- The importance of integrated commissioning was highlighted. It was felt that fragmentation and lack of coherence at the provider end is sometimes caused by different commissioners commissioning the same services but in different ways. This can lead to inconsistency and lack of coherence in terms of delivery
- It was felt that wider networking was key to integration and coherence. This needed to be at both provider and commissioner levels.

Many participants noted that they were meeting each other for the first time at the consultation event. They welcomed the event as a chance to network with other healthy-weight projects and get to know what kinds of other projects existed. It was noted that to achieve integration and coherence across projects and commissioners a good model might be the one used for the NHS City and Hackney teenage pregnancy and parenting programme.

5.2.3 GROUP C: FUTURE INVESTMENT IN HEALTHY WEIGHT PROJECTS

The following arguments were raised at the event in relation to expanding and continuing investments on healthy weight projects:

- Healthy-weight projects focus on changing the behaviours associated with the prevention of a wide variety of chronic diseases. They also promote mental health and well-being. Healthy-weight projects can therefore facilitate overall health improvement and well-being in communities.
- Tackling childhood obesity can lead to healthier and happier children and parents. Starting early is beneficial and can have immediate positive outcomes. The benefits can also be carried over to future generations as healthy children today can teach tomorrow's children to live healthily.
- There are long-term beneficial effects of working with pregnant women on obesity, especially in terms of the health benefits on children.
- These projects position national targets on obesity within the local context and outcomes from projects can provide rapid assessments for long term measures on health inequalities.
- Healthy-weight projects offer a holistic approach to improving health and can ripple into other areas of strategy, such as:

    - Improved social interactions and community cohesion
    - Capacity building through increased participation involving wider sectors, within and across communities
    - Encouragement in the use of community facilities and open spaces
    - Investment in projects can support development of projects, volunteering and employment opportunities
    - Fiscal savings in the long-term through prevention of chronic illnesses
    - Positive impacts on the wider economy through reduced sick days and improved productivity
    - Influence on other aspects of government policy (e.g. transport)
    - Contribution to building the evidence base

5.3 VALUE FOR MONEY (VFM)

5.3.1 THE CONCEPT

The concept of value for money is concerned with determining whether or not an organisation has obtained the maximum benefit from the goods and services it acquires and/ or provides, within the resources available to it. VFM measures the perception that goods and services received are worth the price paid for them.

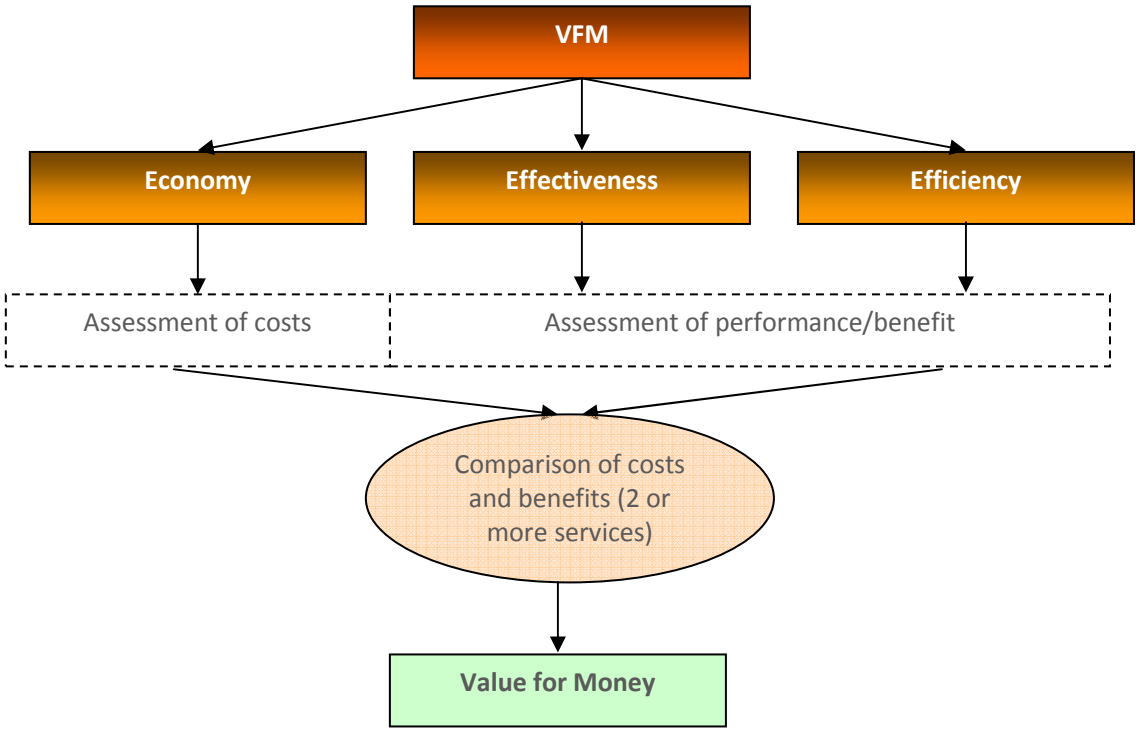
The measurement takes account of not only the cost of goods and services, but also the mix of quality, cost, resource use, fitness for purpose, timeliness and convenience to judge whether or not, when taken together, they give a good return on investment, i.e. constitute good value.

When services deliver good value for money, it essentially means that they have managed their financial, human and physical resources to achieve what is known as the three 'E's:

- Economy (concerned with how much is spent and the cost of the services provided)
- Efficiency (concerned with productivity, i.e. how much is gained in return for the money spent).
- Effectiveness (concerned with the extent to set objectives or targets are achieved).

Typically, the assessment of these factors involves carrying out an economic evaluation; the main forms of which are cost minimisation, cost effectiveness, cost utility, or cost benefit analysis (Figure 5,1).

Figure 5.1: VFM framework



Delivering value for money has become more important in the current environment of constrained resources.

5.3.2 The challenge

In an ideal world, all services commissioned by the PCT and local authority would have been economically evaluated and the evidence of their cost/benefit profiles readily available to service commissioners; but this is not the case. Economic evaluation of interventions in public health is an underdeveloped field and there is limited reliable evidence available. As a typical example, the 2008 NICE Programme Development Group 'Rapid Review of Economic Literature Related to The Promotion of Physical Activity, Play and Sport for Pre-school and School Age Children in Family, Pre-school, School and Community Settings' noted the very limited economic evidence in the literature (of the 101,479 studies identified only 2 were deemed to be full economic evaluations. A further 37 studies were not economic evaluations but could potentially inform economic modelling). Furthermore, resources (e.g. staff, skills, time, and money) to carry out robust economic evaluations are constrained.

5.3.3 The practice

In practice, assumptions about the 'value' of most services often rest on a consideration of either their costs or impacts but not both together. In the instances where both are assessed, it is often in an unsystematic and non-explicit manner. While this might be argued to be a pragmatic alternative to carrying out economic evaluations, there is clearly a need to develop approaches that are more robust and explicit than what currently obtains.

There are limited examples of work being done to fill the economic evidence gap; but generally there appears to be a move towards developing approaches with the following features:

a. Pragmatic (i.e. less costly and time consuming to implement but still offering some fairly robust and systematic methodology)

b. Accommodate local perspectives of what constitutes value for money
c. Define metrics that can measure these perspectives; and
d. Gain consensus on the most important ones.

5.3.4 Description of the Value For Money (VfM) Metric

The criteria used in the assessment metric presented here is a product of extensive discussion and debate based on synthesised information from the literature and feedback from commissioners and project delivery teams. A strongly participatory approach was emphasised at all stages of development in order to frame perceptions of value within the local context of City and Hackney and engender a sense of ownership. Each criterion was weighed on a scale of 1-10 in relation to its relative importance in assessing effectiveness and value for money. Listed below are the 10 criteria included in the assessment metric:

- *Acceptability* - refers to the project's acceptability and appropriateness to service users. This criterion has four dimensions: 1) culturally and socially appropriate; 2) service user involvement; 3) no or minimal costs to users; and 4) tailored and personalised. Interventions that are acceptable to service users are more likely to be effective. This criterion was assigned a weight of 9.

- *Multi-component* – refers to the project's characteristic of being multi-component in terms of its focus and strategies. This criterion has two dimensions: 1) targeting multiple health components (e.g. healthy eating, physical activity, mental wellbeing, etc); and 2) incorporating multiple strategies for user empowerment (e.g. knowledge, confidence, skill development, behaviour change, social support, community empowerment). There is evidence to suggest that multi-component strategies are more likely to be effective for healthy-weight related behaviour change. This criterion was given a weight of 10.

- *On-going/ Long-term follow-up* – refers to the extent to which project's provide an on-going service and long-term follow-up. Projects which provide sustained interventions are more likely to be effective than short-term or one-off interventions. This criterion was given a weight of 9.

- *Intergenerational* – refers to the project's ability to involve people from different generations. This criterion has two dimensions: 1) family level (i.e. brings together and targets the whole family e.g. children and parents); 2) community level (i.e. provides opportunities for people from all age groups to come together). There is evidence to suggest that targeting whole families is crucial for the success on interventions especially when trying to change children's and young people's healthy-weight related behaviour. On the community level, creating opportunities for people of all age groups to come together can build social cohesion to support positive behaviour change. This criterion was given a weight of 9.

- *Equity promoting* - refers to the project's agenda to engage 'hard to reach' groups by reason of ethnicity, religion, social exclusion, disability, etc. Projects should try to avoid excluding particular groups and actively promote the inclusion of diverse groups. This is key for reducing health inequalities. This criterion was given a weight of 10.

- *Not facility dependent* – refers to the project's capacity to be delivered independent of facilities (e.g. venue or equipment). This is important for the creation of sustainable interventions. Engaging people in activities which do not require special facilities and equipment can help to ensure that participants continue to practice healthy behaviours after the intervention period. This criterion was given a weight of 6.

- *Monitoring and evaluation* – refers to the quality of the project's mechanisms for monitoring and evaluation. This criterion has four dimensions: 1) ongoing monitoring and feedback; 2) baseline and follow-up data collected; 3) multiple indicators of success are used; and 4) service user

evaluation. Good monitoring and evaluation practices can help to identify any problems with project implementation, provide feedback on participants' progress and generate evidence about project impacts. This criterion was given a weight of 8.

- *Coverage* – refers to the project's ability to achieve its recruitment targets. Projects are unlikely to be cost-effective if low numbers of people take part. This criterion was given weight of 9.

- *Retention* – refers to the project's drop out rates. There is evidence to suggest that sustained interventions are more likely to be successful so it is important that participants stay with the project until the end. This criterion was given a weight of 8.

- *Cost* – refers to the cost per participant of the project. This is a relatively crude measure for cost-effectiveness but it does give some basic information. This criterion was given a weight of 6.

Each project was scored against the ten criteria on a three point scale based on the information collected within the survey.

Table 5.2 at the end of this chapter presents an overview of the assessment criteria providing a definition of each criteria, its allocated weight, its dimensions, the sources of data used to assess it and the scoring mechanism used.

5.3.5 Application of the Value For Money (VfM) Metric

The assessment metric was applied to each of the healthy-weight related projects identified in our survey. Each project was assessed by two researchers independently. Scores from the two researchers were then compared to assess similarities and differences in assessment. Differences were reconciled through discussion referring back to the survey data as necessary. A third researcher was brought in if agreement could not be reached. Once consensus was achieved, the raw scores for each criterion were multiplied by the relevant weight. Weighted scores were summed across all 10 criteria to generate an overall VfM score. The results are presented in the next chapter.

Table 5.2. Assessment criteria, data source and scoring mechanism

Criteria (weight)	Dimensions of assessment	Definition	Data source	Scoring mechanism
Acceptability (9)	Culturally and socially appropriate	The project attempts to be culturally and socially appropriate	Q10, 17	1=Low/none 2=Medium/somewhat 3=High/firm efforts taken
	Service user involvement	Service users are consulted and have influence over the project design and content	Q8, 9	1=Low/none 2=Medium/some 3= High/extensive involvement
	No or minimal costs to users	No or minimal financial costs to users	Q43	1= High costs 2= Medium costs 3= Low or no cost
	Tailored and personalised	Interventions tailored to suit individual needs	Q10, 24	1=Low/no tailoring 2=Medium/tailored to some extent 3=High/one-to-one service
	OVERALL SCORE FOR ACCEPTABILITY			1=Low 2=Medium 3=High
Multi-component (10)	Multiple health outcomes	Project targets several health outcomes (e.g. healthy eating, physical activity, mental health)	Q17, 18	1=Low/single health outcome 2=Medium/two health outcomes 3=High/three or more health outcomes
	Multiple intervention strategies (e.g. for user	Participants are empowered in terms of knowledge, confidence and skills gained for behaviour change. Structural and	Q10, 17, 18, 53	1=Low/single strategy 2=Medium/two strategies 3=High/three or more strategies

Criteria (weight)	Dimensions of assessment	Definition	Data source	Scoring mechanism
	empowerment)	community empowerment may also be included		
	OVERALL SCORE FOR MULTI-COMPONENT			1=Low 2=Medium 3=High NB: Single component projects with good links to other projects should rate more highly
On-going/ Long-term follow-up (9)	On-going	Participants are engaged with the service over a period of time rather than given one off ad hoc advice	Q17, 27	1=Low/one-off 2= Medium/less than 4 3=High/ more than 4
	Long-term follow-up	After participants complete the core requirements of the project, they are engaged in follow-up activity. This could be for example referring participants to other healthy-weight related projects in City and Hackney	Q28	1=Low/none 2=Medium/one-off follow-up 3=High/more than one-off follow-up
	OVERALL SCORE FOR ON-GOING/LONG-TERM FOLLOW-UP			1=Low 2=Medium 3=High

Criteria (weight)	Dimensions of assessment	Definition	Data source	Scoring mechanism
Intergenerational (9)	Family level	Project involves multiple family members e.g. children and parents	Q17, 20, 21	1=Low/no family involvement 2=Medium/some family involvement 3=High/extensive family involvement
	Community level	Project provides opportunities for people across all age groups to participate in projects together (building social cohesion)	Q11, 17	1=Low/single age groups 2=Medium/some mixing of age groups 3=High/ good mix of age groups
	OVERALL SCORE FOR INTERGENERATIONAL			1=Low 2=Medium 3=High
Equity promoting (9)	Engages 'disadvantaged' groups	Project engages with groups that are 'hard to reach' by reason of ethnicity, religion, social exclusion, disability, etc.	Q15, 16, 17	1=Low/no engagement 2=Medium/ somewhat 3=High/firm efforts taken
Not facility dependent (6)	Not facility dependent	Intervention can be delivered independent of facilities	Q23	1= totally facility dependent 2= partially dependent 3= not facility dependent
Monitoring and evaluation (8)	Ongoing monitoring and feedback	Monitoring and evaluation data are collected	Q44	0=no 1=yes

Criteria (weight)	Dimensions of assessment	Definition	Data source	Scoring mechanism
	Baseline and follow-up	Baseline and follow-up data are collected	Q46, 47	1=yes to both
	Measurement	Multiple indicators of success are used	Q48	0=none 1=one indicator 2=two or more indicators
	Service user evaluation	Feedback from service users are collected	Q49, 50	0=none 1=informal feedback 2=formal feedback
	OVERALL SCORE FOR MONITORING AND EVALUATION			1=Low 2=Medium 3=High
Coverage (9)	Actual coverage	Project achieves recruitment targets. This is calculated as actual number of participants divided by target number of participants	Q34, 35	1=Low (less than 50%) 2=Medium (between 50-80%) 3=High (between 80-100%)
Retention (8)	Retention	Drop out rate fairly low	Q37	1=Low (more than 50%) 2=Medium (between 10-15%) 3=High (less than 10%)

Criteria (weight)	Dimensions of assessment	Definition	Data source	Scoring mechanism
Cost (6)	Cost per participant	Cost per participant Total cost of project divided by number of participants in 2008	Q35, 39	Score will depend on the type of project - For individually-based projects *with* weight/disease related criteria: 1=High cost (> £650) 2=Medium cost (between £159-£650) 3=Low cost (< £159) For individually-based projects *without* weight/disease related criteria: 1=High cost (> £292) 2=Medium cost (between £154-£292) 3=Low cost (< £154)

6 ASSESSMENT METRIC RESULTS AND OVERALL PROGRAMME ASSESSMENT

SUMMARY

- In the first part of this chapter the results of the VfM assessment are presented within five project clusters: 1) individually-based projects with weight or disease related entry criteria; 2) individually-based projects without weight or disease-related entry criteria; 3) settings focused projects; 4) dietetic services; and 5) universal national programmes.
- A general description of each cluster is provided followed by an outline of how well projects measure up against the criteria. Barriers and facilitators to success are also identified for each cluster. The data used to assess projects is ordered alphabetically by project name in the Appendix.
- For settings-focused projects and individually-based projects the minimum VfM score was 84 and the maximum was 252. Settings-focused projects such as the Hackney Healthy Schools Programme had the highest average VfM score of 228 (range 215 to 240). Individually-based projects with entry restricted to those who are already overweight or at risk had the lowest average VfM of 172 (range 133 to 215). Individually-based projects with no weight or disease related entry criteria had an average VfM of 193 (range 145 to 228).
- The differences between VfM scores across the three types of projects listed above reflect a number of factors. In comparison to the majority of individually-based projects, settings-focused projects performed better on coverage and retention and had lower costs per head. Individually-based projects, especially those which involved intensive personalised one to one intervention, were more likely to experience a lack of referrals, high drop-out rates and high costs per head.
- The development of the VfM metric followed a structured process of consultation designed to result in a set of indicators reflecting local perceptions of value for money and framed within the available evidence base.
- The indicators that make up the metric are useful in that they can serve as a common set of outcome indicators which projects should routinely report on in addition to project-specific outcome measures. They can also help inform the direction of future investment.
- Experience with approaches to assess value for money that seek a compromise between the methodological rigour of full scale economic evaluations and the pragmatic use of limited resources is still in its infancy and it is necessary to treat the results with some caution. Given the 3 point scoring system used, and the need to make qualitative judgments in certain areas, the metric should be seen as a crude rather than precise indicator of VfM. For this reason, much of the discussion on the value for money delivered by projects is at the cluster rather than individual project level, except in the case of striking outliers.
- A further implication of the modest sensitivity of the metric is that feedback on its applicability should be continually captured and used to subsequently refine it. The refinement for instance may take the form of substituting indicators with new ones or expanding the measurement scale from 3 points to 5.
- Some projects, such as the universal programmes and dietetic services, do not readily fit the metric and for projects like these, a partial set of indicators (or even separate metric) may require to be used for assessment.

6.1 Assessment of individually-based projects *with* weight or disease related entry criteria

Projects in this cluster are characterised by a secondary prevention focus with entry restricted to those individuals who are already overweight or living with a chronic disease such as diabetes. There were nine projects in this cluster. Four provide weight loss programmes (Counterweight, Healthy Living, the Weight Management Group and Youth in Progress) and three are exercise on referral schemes (the GP Referral Scheme – Orthodox Jewish Community, Healthwise and Practice-based Health Trainers). Of the remaining two projects one is a healthy eating programme for people living with diabetes (Tackling Diabetes), the other is a walking group for Asian women (the Walking Project). All except Youth in Progress are targeted towards adults. The mean VfM score for the group was 172 with a range of 133 – 215 (table 6.1).

Table 6.1 Value for Money (VfM) metric for individually-based projects with weight or disease-related entry criteria.

Projects		VfM outcomes and cost metrics										VfM score
		Acceptability	Multi-component	Ongoing/ long term	Inter-generational	Equity promoting	Not facility dependent	Monitoring & evaluation	Coverage	Retention	Cost	
	Weight	**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
Counterweight	Raw	1	2	2	1	2	1	1	1	2	3	
	Weighted	9	20	18	9	20	6	8	9	16	18	**133**
GP Referral Scheme - Orthodox Jewish Community	Raw	2	3	2	1	3	1	2	2	2	3	
	Weighted	18	30	18	9	30	6	16	18	16	18	**179**
Healthwise	Raw	2	2	2	1	2	1	3	3	1	3	
	Weighted	18	20	18	9	20	6	24	27	8	18	**168**
Healthy Living	Raw	3	3	3	2	1	1	3	1	1	1	
	Weighted	27	30	27	18	10	6	24	9	8	6	**165**
Practice Based Health Trainers	Raw	3	2	1	1	1	2	3	3	1	3	
	Weighted	27	20	9	9	10	12	24	27	8	18	**164**
Tackling Diabetes	Raw	3	3	3	1	2	2	3	1	2	2	
	Weighted	27	30	27	9	20	12	24	9	16	12	**186**
Walking project	Raw	3	2	2	2	3	3	3	2	3	3	
	Weighted	27	20	18	18	30	18	24	18	24	18	**215**
Weight Management Group	Raw	3	2	2	1	2	1	3	2	2	3	
	Weighted	27	20	18	9	20	6	24	18	16	18	**176**
Youth in Progress	Raw	3	3	3	2	1	1	3	1	1	1	
	Weighted	27	30	27	18	10	6	24	9	8	6	**165**

6.1.1 Performance on individual VfM outcome measures

All projects in this group were ranked highly on acceptability as many are free or low cost one to one services which are able to tailor their services to meet individual needs. Counterweight is an exception to this pattern as it is a standardised programme with little room for personalised tailoring. All of the projects did fairly well in terms of their ranking with respect to having multiple components to their interventions both in terms of breadth of health outcomes and the use of a mix of intervention

strategies. Although projects tended to have either physical activity or healthy eating as their main focus, some attention was given to both. Some projects offered social support and access to resources as well as advice and the development of skills for behaviour change. As might be expected this group of projects did not rate particularly highly on the intergenerational criteria as most aimed to target individuals within a specified age range rather than whole families or communities. With the exception of the Walking Group, all the projects were dependent on facilities. Although the majority of projects achieved their intended coverage in 2008, some of the projects tended to see fairly small numbers of people especially the weight loss programmes.

Barriers to recruiting more participants were identified by projects as long distances for participants to travel to projects, relying on GPs or other health professionals to refer eligible clients, receiving inappropriate referrals and a lack of time for adequate marketing and promotion. The small number of participants recruited resulted in a very high cost per head for Healthy Living, Tackling Diabetes and Youth in Progress. Retention was also a problem for some of the weight loss programmes (Healthy Living and Healthwise) and for one of the exercise on referral schemes (Healthwise) who all reported large dropout rates. Participants' personal circumstances, lack of motivation and a reluctance to see health as a priority were cited as reasons why people drop out of the programmes.

Barriers and facilitators to the success of projects are summarised below.

Facilitators	Barriers
▪ Flexible and tailored with goal setting and reviews of progress ▪ Ongoing individual attention (e.g. assignment of key workers) ▪ Signposting and referral to other projects and services ▪ Provision of opportunities for professional development (e.g. training to become a peer supporter) ▪ Experienced multi-disciplinary teams with a wide range of specialised skills, expertise and knowledge ▪ Safe, friendly and non-stigmatising environments ▪ Mix of intervention strategies	▪ Lack of and/or inappropriate referrals ▪ Not enough time and other resources to adequately promote the service to encourage more referrals ▪ Difficulties in gaining support from health services and professionals for referrals ▪ Lack of support from families ▪ Complexities of local communities and their needs (e.g. intersection of gender and ethnicity and its impact on health behaviours) ▪ Lack of funding and resources for long-term follow up

6.1.2 Overall VfM assessment

The mean VfM score for the group was 172 with a range of 133 to 215. The figures are lower than the mean and range for the individually based projects that had no weight or disease entry criteria and the settings-focused projects. Comparatively, these projects tended to be less intergenerational and, equity promoting and had more problems with retention. The overall costs of projects in this cluster ranged from £2,500 to £255,000 with an average of £72,945. Costs per participant varied considerably between projects with a range of £124 per participant (the Walking Group) to £1,500 (Healthy Living and Youth in Progress). Higher costs per participant were not always associated with higher total costs. For example, one of the projects with the highest total costs at £255,000 (Healthwise) had one of the lowest costs per participant (£159) due to high coverage. Three projects stand out in this cluster for their above average VfM scores: the Walking Project, the Exercise on Referral Scheme for the Orthodox Jewish Community and Tackling Diabetes.

6.2 Assessment of individually-based projects *without* weight or disease entry criteria

This cluster of 14 projects target individuals regardless of weight or health status. There is a wide variety of interventions delivered in this cluster including information dissemination, skills development, behaviour modification, and community advocacy. The majority of projects were community-based. The target age range for these projects spanned all age groups. The mean VfM score for this cluster was 193 with a range of 145 to 228 (table 6.2).

Table 6.2 Value for Money (VfM) metric for individually-based projects *without* weight or disease-related entry criteria.

Projects		VfM outcome metrics										VfM score
		Acceptability	Multi-component	Ongoing/ long term	Inter-generational	Equity promoting	Not facility dependent	Monitoring & evaluation	Coverage	Retention	Cost	
	Weight	**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
Be Active Keep Healthy Project- Orthodox Jewish Young People	Raw	2	2	3	2	3	1	3	2	3	3	
	Weighted	18	20	27	18	30	6	24	18	24	18	203
BEAP - Best Eco Active Project	Raw	2	3	2	2	3	1	1	1	3	2	
	Weighted	18	30	18	18	30	6	8	9	24	12	173
Chinese Cardio Project	Raw	3	3	2	1	3	1	3	3	3	3	
	Weighted	27	30	18	9	30	6	24	27	24	18	213
Community Development & Health Advisory Project	Raw	3	3	2	3	3	1	2	1	2	1	
	Weighted	27	30	18	27	30	6	16	9	16	6	185
Fitness Fun Project	Raw	3	2	3	3	3	1	2	3	3	3	
	Weighted	27	20	27	27	30	6	16	27	24	18	222
Hackney Food Skills Project	Raw	3	2	2	3	2	1	3	1	3	1	
	Weighted	27	20	18	27	20	6	24	9	24	6	181
Hackney Personal Bests	Raw	2	2	2	1	3	1	3	1	3	2	
	Weighted	18	20	18	9	30	6	24	9	24	12	170
Healthy Lifestyles (City)	Raw	2	3	3	2	3	1	2	1	3	3	
	Weighted	18	30	27	18	30	6	16	9	24	18	196
Healthy Lifestyles Project (Hackney)	Raw	2	2	2	2	1	1	3	1	2	1	
	Weighted	18	20	18	18	10	6	24	9	16	6	145
Hoops 4 Health	Raw	2	2	2	2	3	1	2	3	3	3	
	Weighted	18	20	18	18	30	6	16	27	24	18	195
Keep fit and Tai Chi	Raw	2	1	2	2	3	1	3	2	2	3	
	Weighted	18	10	18	18	30	6	24	18	16	18	176
S.H.E.L Multi Sport Camp	Raw	2	3	2	2	3	1	2	3	3	3	
	Weighted	18	30	18	18	30	6	16	27	24	18	205
STA Bikes Saturday Family Cycle Club	Raw	2	3	2	3	3	2	3	3	3	3	
	Weighted	18	30	18	27	30	12	24	27	24	18	228
Young at Heart	Raw	2	3	3	1	3	1	3	3	3	2	
	Weighted	18	30	27	9	30	6	24	27	24	12	207

6.2.1 Performance on individual VfM outcome measures

These projects generally made considerable efforts to reach 'hard to reach' groups and thus ranked highly in equity promoting. All projects in this cluster are community-based projects which facilitates sensitivity to community needs and ensures they are socially and culturally acceptable to its target population. These projects also generally did fairly well in terms of having multiple components and strategies. Interventions are also on-going and opportunities for sustainable behaviour change are generally offered through exit routes or referral to other local organisations. However, as most of these projects are reliant on the availability of venues, this cluster scored poorly on facility dependence.

The following barriers and facilitators to successful project delivery common to the cluster were identified:

Facilitators	Barriers
▪ Community knowledge ▪ Informal and friendly atmosphere ▪ Enjoyable sessions	▪ Lack of available facilities ▪ Poor cooperation from local organisations ▪ Lack of publicity ▪ Weather conditions ▪ Unsustainable funding

6.2.2 Overall VfM assessment

The mean VfM score for this cluster was 193 with a range of 145 to 228. Projects in this cluster are small- to medium- scale projects with overall costs ranging from £7,000 to £70,000 and an average of £32K. Costs per participant however varied considerably between these projects with a range between £8 per person to over £1,000 per person. This variation is greatly dependent on each project's participant reach and coverage. Keep Fit and Tai Chi for example has an overall cost of £8,200 but recruited 1,000 participants which lowered its cost per head. Healthy Lifestyles (Hackney) on the other hand reflected an estimated £1,222 per person because of its low recruitment rate. Thus, such projects would benefit by expanding recruitment coverage, improving cooperation with local organisations and widening publicity.

6.3 Assessment of settings-focused projects

Settings-focused projects are characterised by interventions that attempt to influence the environmental setting so that people are better supported to make lifestyle changes and take the actions needed to maintain a healthy weight. The key features of these projects are their delivery in natural social settings (e.g. schools, nurseries, community centres) and groups rather than an individual-oriented approach. There were several projects within the cluster (table 6.3 on the next page). The mean VfM score for the group was 228 with a range of 215 to 240.

6.3.1 Performance on individual VfM outcome measures

The projects generally provided good user experience. They delivered interventions in a format that was acceptable to the cultural and social norms of participants. Activities were also able to be tailored to suit individual needs and users were well engaged in one form or the other in the design and delivery of the interventions. The activities delivered ranged across several themes including providing information, behavioural support, healthy eating and physical activity sessions as well are empowering people in terms of their knowledge, confidence and skills gained for behaviour change. Activities were not one-off but ongoing, strongly inclusive and encouraged the involvement of different age groups such as children and parents.

As a result the projects tended to score well on measures of acceptability, longevity, activities across several intervention themes, intergenerational scope, and equity promotion. All projects scored highly scores on their capacity to deliver long term rather than on-off interventions. Except for the Community Kitchens and Neighbourhood Maps projects, they all collected adequate monitoring (baseline, follow up and user survey) data. The two exceptions are understandable given the manner in which they are delivered. Community Kitchens in particular is a relatively new project.

Unlike the other projects which were not restricted in location, Community Kitchens, Hackney Healthy Schools and HAPPY in Hackney depended on specific physical facilities to be delivered.

Table 6.3 Value for Money (VfM) metric for settings-focused projects

Projects		VfM outcomes and cost metrics										VfM score
		Acceptability	Multi-component	Ongoing/ long term	Inter-generational	Equity promoting	Not facility dependent	Monitoring & evaluation	Coverage	Retention	Cost	
	Weight	**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
Community Kitchens	Raw	2	3	3	3	3	1	1	3	3	3	
	Weighted	18	30	27	27	30	6	8	27	24	18	**215**
East London Food Access	Raw	2	3	3	2	3	2	3	3	3	3	
	Weighted	18	30	27	18	30	12	24	27	24	18	**228**
Hackney Healthy Schools Programme	Raw	2	3	3	2	3	1	3	3	3	3	
	Weighted	18	30	27	18	30	6	24	27	24	18	**222**
HAPPY in Hackney*	Raw	3	3	3	3	3	1	3	3	3	3	
	Weighted	27	30	27	27	30	6	24	27	24	18	**240**
HAPPY@Home	Raw	3	3	3	3	2	2	3	3	3	3	
	Weighted	27	30	27	27	20	12	24	27	24	18	**236**
Neighbourhood Maps	Raw	3	2	3	3	3	3	1	3	3	3	
	Weighted	27	20	27	27	30	18	8	27	24	18	**226**
Nursery Fruit Scheme	Raw	3	3	3	2	3	3	2	3	3	3	
	Weighted	27	30	27	18	30	18	16	27	24	18	**235**

*Healthy Activities and Practices with Pre-school Years

The information provided on coverage, retention rates and costs for most of the projects was insufficient to enable consistent and credible scoring on these indicators. However, the settings-based nature of these projects is such that they are on-going/long term and reach a wider audience; and are therefore likely to have higher coverage and retention rates and lower cost per head (partly from economies of scale) relative to projects in other clusters. They were therefore notionally assigned high scores on coverage, retention and cost indicators.

Nevertheless, it is important to note that settings-focused projects may have problems with retaining schools, nurseries etc. Whether or not a setting participates depends on management support and whether or not the goals of the projects conflict with other priorities with the setting (e.g. health promotion versus academic achievement).

Managers of the projects further identified the following factors as contributory or inhibitory to their success:

Facilitators	Barriers
▪ Service provider experience ▪ Widespread stakeholder support and involvement ▪ Projects that were flexible, accessible and offered a menu of activities ▪ Project objectives linking clearly with wider agenda locally and nationally.	▪ Capacity of host facility site – physical space, staff expertise, leadership and management ▪ Funding uncertainty

6.3.2 Overall VfM assessment

The mean VfM score for the group was 228 with a range of 215 to 240. This is the highest mean score of all the clusters that were assessed on all 10 indicators. High facility dependence and inadequate provision for monitoring and evaluation explain the projects within the cluster with the lowest VfM scores.

6.4 Assessment of dietetic services

Five projects make up the Dietetic Services. They offer a range of services such as weight management programmes for adults and children, services for pregnant and breastfeeding women and professional training. They also contribute towards many of the settings-focused projects such as the Healthy Schools Programme and Happy in Hackney. We had very little data on these projects to judge coverage and retention and no data to assess cost. This is because it is difficult to break down the dietetic service into individual projects with their own cost, participation and retention figures. These projects were therefore only judged on the first seven assessment criteria. It was not appropriate to assess the Counterweight professional training against any of the criteria. The mean VfM score for the group was 122 with a range of 94-153 (table 6.4).

Table 6.4 Value for Money (VfM) metric for dietetic services

Projects		VfM outcomes and cost metrics										VfM score
		Acceptability	Multi-component	Ongoing/ long term	Inter-generational	Equity promoting	Not facility dependent	Monitoring & evaluation	Coverage	Retention	Cost	
	Weight	**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
Dietetic services – counterweight training	Raw	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	Weighted	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dietetic services - above 5 years old	Raw	2	2	2	1	1	2	3	-	-	-	
	Weighted	18	20	18	9	10	12	24	-	-	-	111
Dietetic services - under 5 years old	Raw	3	3	2	2	3	1	3	-	-	-	
	Weighted	27	30	18	18	30	6	24	-	-	-	153
Dietetic Service - Adults	Raw	3	2	2	1	2	2	3	-	-	-	
	Weighted	27	20	18	9	20	12	24	-	-	-	130
Health promotion events and training	Raw	2	2	1	1	1	2	2	-	-	-	
	Weighted	18	20	9	9	10	12	16	-	-	-	94

6.4.1 Performance on individual VfM outcome measures

These projects show consistent strengths in terms of acceptability, the multi-component nature of interventions and the collection of extensive monitoring and evaluation data. Most show some merit in terms of being ongoing rather than one-off interventions and all but one rank fairly well in terms of not being wholly facility dependent. This is because they are able to deliver their services in a range of sites. Rankings are more mixed in terms of equity promoting efforts and the extent to which projects are intergenerational. As might be expected the Health promotion events and training scored lower than other projects due to the unique nature and purpose of the project to raise awareness, provide information and train other health professionals rather than change the behaviour of clients and the public.

Barriers and facilitators to the success of projects are summarised below.

Facilitators	Barriers
▪ Skilled and knowledgeable dieticians who can deliver the most up to date and scientific information about healthy eating in an easy to understand way ▪ Good partnership working with other relevant projects and teams (e.g. health visitors and Children's Centres) ▪ The use of evidence-based interventions	▪ A small service which can be easily overlooked ▪ Lack of dietetic time to dedicate to projects ▪ For professional training, health professionals report a lack of time and local practice support to attend and then set up a service ▪ Lack of marketing of service provision ▪ Healthy lifestyle messages are sometimes viewed as something 'we all know about already' ▪ Healthy lifestyle services are relatively new – they take time to market

6.4.2 Overall VfM assessment

It was difficult to be confident in our assessment of the Dietetic services due to incomplete data and the difficulties in breaking down the service into distinct projects. The mean VfM score of 122 for the group was higher than for universal national programme (see below) which reflects their greater ability to tailor services to individual needs and their greater attention to comprehensive monitoring and evaluation.

6.5 Assessment of universal national programmes

The universal programmes are nationally driven interventions that PCTs are statutorily obligated to deliver locally. Conventionally, guidance on the delivery of such programmes is issued by the Department of Health following wide consultation with regional and local stakeholders.

6.5.1 Performance on individual VfM outcome measures

The top-down strategy driving these programmes meant that user involvement in the programme design and delivery was low. A need to ensure a nationally consistent approach limited the extent to which activities could be tailored to individual needs. Hence the programmes rated low on acceptability. Their targeted nature also resulted in a low rating on their intergenerational dimension. Likewise, they are delivered from fixed physical facilities and so rated low on the facility dependency Criterion. The projects did not report any barriers or facilitators to success.

Overall, this is a difficult cluster to assess: first, because a lack of information on coverage, retention and cost meant that they could not be scored on these criteria. Secondly, they are statutory

programmes that *must* be implemented independent, arguably, of what their cost/benefit or value for money profile might be. Given the case, the focus of attention then for local commissioners should be to use process evaluations to understand how the programmes might be better reconfigured (within the boundaries of the guidance) to enhance their value.

Table 6.5 Value for Money (VfM) metric for universal national programmes

Projects		VfM outcomes and cost metrics										VfM score
		Acceptability	Multi-component	Ongoing/ long term	Inter-generational	Equity promoting	Not facility dependent	Monitoring & evaluation	Coverage	Retention	Cost	
	Weight	**9**	**10**	**9**	**9**	**10**	**6**	**8**	**9**	**8**	**6**	
Child Health Promotion Programme	Raw	1	2	3	1	1	1	3	-	-	-	
	Weighted	9	20	27	9	10	6	24	-	-	-	**105**
School Health Service & NCMP*	Raw	1	2	2	1	1	1	1	-	-	-	
	Weighted	9	20	18	9	10	6	8	-	-	-	**80**

* National Child Measurement Programme

6.5.2 Overall VfM assessment

The Child Health Promotion Programme VfM score was 105 and the NCMP was 80. The higher score of the former owed to its ongoing/long term nature and provision made to collect monitoring and evaluation data.

The mean VfM score was 93 which is the lowest for all the clusters; but is obviously biased by the exclusion of the scores on 3 criteria. But it is instructive to note that even if the missing scores were assigned at the maximum level, this would result in a mean VfM score of 162 that was still well below the mean for other clusters.

6.6 Overall programme assessment

Chapter 3 revealed several gaps in the overall suite of healthy weight-related projects currently commissioned by NHS City and Hackney including the greater emphasis on changing individuals rather than the obesogenic environment and the use of the workplace as a setting for projects or as a target for change itself. This section examines these gaps in more detail using a life course approach and the thematic cluster framework developed in the Foresight report on obesity.

6.6.1 Mapping projects according to the life course

Across the programme as a whole there are projects at each stage of the life course (table 6.6). This is encouraging as a key recommendation from the Foresight report on obesity is that different interventions targeting behaviour change need to be implemented across the life course. There are projects which encourage breast-feeding and good maternal nutrition in the early years, primary prevention projects for children and young people and secondary prevention projects for adults and older people.

There are two potentially significant gaps. Firstly, there are no projects specifically targeted towards young people as they leave school and either enter the workforce or go on to higher education and secondly, there are very few primary prevention projects targeted towards adults and older people. It is difficult to target young people in the transition period between statutory education and work or higher

education. A focus on healthy workplaces may meet the needs on young people in transition and adults.

Table 6.6 : Healthy weight-related projects (N=38) mapped according to stage in life course*

Age Group	N (%) Projects	Names of Projects		
Antenatal and pre-school (including parents)	5 (13%)	→Child health promotion programme →Dietetic children's services (under 5 years old) →Nursery Fruit Scheme →Happy@Home →Happy in Hackney		
Primary school aged	12 (32%)	→National child measurement programme →Hoops for Health →Healthy Lifestyles (City) →Motor Skills Programme	→Be Active Keep Healthy Project - Orthodox Jewish Young People →SHEL Multi-Sport Camp → Hackney Food Skills Project →BEAP - Best Eco Active Project →Dietetic children's services (above 5 years old) →Hackney Healthy Schools Programme →Healthy Lifestyles (Hackney) →Hackney Personal Best	
Secondary school aged	9 (24%)	→Youth in Progress		
Young people	7 (18%)	→Youth in Progress		→Dietetic services (counterweight) →Healthy Living →Keep Fit and Tai Chi →Healthwise →Practice-based health trainers →Tackling Diabetes
Adults (up to 50 years)	11 (29%)		→GP Referral Scheme - Orthodox Jewish Community →Walking project →Dietetic services (adults)	
Older adults	12 (32%)	→Chinese Cardio Project →Counterweight →Young at Heart		
Across all ages	7 (18%)	→Fitness Fun Project →STA Bikes →Dietetic services - health promotion events and healthy eating/obesity teaching →Community Development and Health Advisory Project →East London Food Access →Community Kitchens →Neighbourhood Maps		

*N does not add up to 38 or 100% as projects could target more than one stage in the life course

6.7 Mapping projects according to Foresight clusters

As mentioned in the background section of this report, the UK Government's Foresight team recently published a comprehensive report on the topic of obesity. The report presents a detailed framework for conceptualising physiological, behavioural, social and environmental influences on eating, physical activity and energy-balance. This framework or 'systems map' was devised following an evidence review and multiple consultations and consensus sessions with a wide range of multi-disciplinary experts. The determinants of energy balance (consumption versus expenditure) are grouped into seven thematic clusters: social psychology, food production, food consumption; physical activity environment; individual psychology; individual physical activity; and physiology. Brief definitions of each cluster are given in Box 6.1.

Box 6.1 Definitions of thematic clusters from the Foresight Report on obesity

- ***Physiology*** = biological variables (e.g. genetic predisposition to obesity);
- ***Individual psychology*** = individual and family attitudes, knowledge, stress and self-esteem;
- ***Individual physical activity*** = level of individual and family physical activity (recreational, domestic, occupational and transport);
- ***Food production*** = drivers of the food industry such as pressure for growth and variables reflecting the wider social and economic situation in the UK such as purchasing power and societal pressure to consume;
- ***Food consumption*** = characteristics of the food market such as level of food abundance and variety, the nutritional quality of food and drink, the energy density of food and portion size;
- ***Physical activity environment*** = variable that may facilitate or obstruct physical activity such as access to and costs of physical exercise, perceived dangers in the environment, walkability, opportunities for unmotorised transport ;
- ***Social psychology*** = societal attitudes such as social acceptability of fatness, media availability and consumption, TV watching, education, peer pressure

Each of these clusters suggests possible strategies for intervention. These are listed in table 6.7 and the healthy weight projects are plotted against the intervention strategies.

There are projects in all but two cells in table 6.7. There are currently no projects that target the food production cluster to impact on some of the drivers of the food industry that lead to the production of convenience and high energy foods. There are also no projects that fall directly within the social psychology cluster. These represent major gaps in the overall programme and these gaps may limit the impact of the programme overall as the purpose of a whole system approach to promoting healthy weights is to provide interventions that target all the determinants of obesity.

Table 6.7 A map of healthy weight-related projects in City and Hackney according to the key determinants of obesity identified by the Foresight Obesity Report

Individual psychology	Individual physical activity	Physical activity environment		Food production	Food consumption	Social psychology	Physiology
Projects that aim to change individual/parental attitudes, knowledge, self-esteem etc	***Projects that aim to increase individual/parental physical activity level***	***Projects that provide increase access to, and affordability of, physical activity***	***Projects that aim to change the environment to encourage walking and 'active transport'***	***Projects that aim to change the drivers of the food industry***	***Projects that aim to change the characteristics of the food market***	***Projects that aims to change societal attitudes***	***Projects that aim to minimise generational effects***
*Weight loss programmes (N=4) *Dietetic services (N=5) *Tackling Diabetes *National Child Measurement Programme	*School and community-based physical activity projects for children & families (N=9) *Exercise on referral schemes (N=3) *Community based physical activity projects for adults (N=4)	*Exercise on referral schemes (N=3) *Hackney Healthy Schools Programme *Happy in Hackney *Happy@Home	*Neighbourhood maps	None identified	*Best Eco Active Project *Community Kitchens *East London Food Access *Hackney Food Skills Project *Hackney Healthy Schools Programme *Happy in Hackney *Happy@Home *Nursery Fruit Scheme	None identified[2]	*Child Health Promotion Programme *Dietetic services (under 5years old)

[2] Some of the projects do try to tackle societal attitudes indirectly at a more individual level or through advocacy work. For example STA bikes challenge the notion that cycling is not aspirational as it is often viewed as an inferior mode of transport in comparison to the car.

7 CONCLUSIONS AND RECOMMENDATIONS

The research project described in this report:

- identified and mapped healthy weight-related projects at a local level in the London boroughs of City and Hackney;
- reviewed project aims, objectives and coverage as well as their strengths and weaknesses;
- developed a Value for Money (VfM) metric in consultation with project comissioners and project delivery leads;
- applied this metric to assess the potential impact of individual projects; and
- evaluated the potential impact of the programme overall according to the whole systems framework and life course approach recommended by the Foresight obesity report.

There are a diverse range of healthy weight-related projects operating in City and Hackney which together target many of the key determinants of obesity identified in both research evidence and national strategy. Although there are exceptions, there is evidence that projects are doing well in terms of incorporating local community knowledge in the design and implementation of healthy-weight related projects, trying to engage hard to reach groups and those most in need and offering multi-component and ongoing interventions. Settings-focused projects were those that represented the greatest potential impact due to their capacity to reach large numbers of people, their focus on changing the environment as well as the individual, and the extent to which they proactively attempt to be inclusive and engage whole families rather than individuals in isolation.

The uncertainty of funding emerged as a threat across all types of projects. Dependence on facilities such as venues and equipment also emerged as a common issue for all but a handful of projects. Difficulties with coverage and retention were experienced by many projects, especially individually-based projects targeting those who are already overweight. Problems with coverage also affected some of the individually-based projects that had no weight-related entry criteria. Common reasons for these difficulties included a lack of time and resources for marketing the projects and difficulties in establishing referral routes from other services and health professionals.

Although the overall programme together targets many of the key determinants of obesity across the life course there are some notable gaps. There are few projects specifically targeting young people and similarly few primary prevention projects for adults and older people. Whilst there is a concentration of projects targeting individuals, and a significant number which increase opportunities for physical activity and healthy eating, there are far fewer projects which attempt to change the environment itself through for example, transport policy and working with the food production industry.

The VfM metric that we developed followed a structured process of consultation designed to result in a set of indicators reflecting local perceptions of value for money and framed within the available evidence base. However, given the 3 point scoring system used, and the need to make qualitative judgments in certain areas, the metric should be seen as a crude rather than precise indicator of VfM. Our results should therefore be treated with some caution. The VfM approach we developed is an innovative one that requires further development and testing.

In light of these conclusions we make the following recommendations in terms of strengthening existing provision and individual projects, developing the healthy weight programme as a whole, and future mechanisms for monitoring and evaluation:

- There is a need to continue to invest in projects from all five clusters identified in this report. Although settings-focused projects represent the greatest potential impact, such projects need to be supplemented by more intensive projects that target those who are already overweight and those at risk. Interventions that target the whole population plus targeted interventions to those most in need represent the best strategy for promoting health and reducing inequalities.

- To support projects that experience difficulties with coverage and retention there is a need for greater coherence and integration between individual projects and between projects and other local services and organisations. Ways of increasing publicity for projects and strengthening referral routes should be explored as part of the new healthy weight strategy.

- Some projects are always going to be dependent on facilities. However, given that this is a factor in sustaining behaviour change over the longer term there is a need to explore the potential for increasing the number of projects which rely less on fixed facilities and venues such as the Walking Group, Fitness for Fun and STA Bikes. The Walking Group, for example, which currently serves Asian women who are already overweight, could be considered as a model to support a much wider variety of groups.

- Funding instability was a factor that impacted on the ability of projects to invest in follow-up activities and planning for the long-term. Consideration should be given to investing in projects over a longer term.

- There is a need to expand the healthy weight programme in a number of areas which are currently not well served, especially in terms of projects that directly target the obesogenic environment. The potential of the following should be considered in future planning:

    - the workplace as a setting for healthy weight projects

    - changes to the environment to encourage walking and active transport

    - the development of projects with local food outlets to improve the nutritional value of food available in the community

- The indicators that make up the VfM metric that we developed in partnership with project commissioners and project leads should serve as a common set of outcome indicators which projects should routinely report on in addition to project-specific outcome measures. These can also help inform the direction of future investment.

- REFERENCES

[1] World Health Organisation (2003). *Fact Sheet on Obesity and Overweight: A Global Strategy on Diet, Physical Activity and Health.* Available online at: http://www.who.int/hpr/NPH/docs/gs_obesity.pdf

[2] Department of Health (2009). *Health Profile of England 2008.* Available online at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_093465

[3] Health Survey for England (2009). Available online at: http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity/statistics-on-obesity-physical-activity-and-diet:-england-february-2009

[4] Department of Health (2009). Available online at: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Obesity/DH_6585

[5] Department of Health (2008). Healthy weight, healthy lives: A cross-government strategy for England.

[6] Simon, G.E., Von Korff, M., Saunders, K., Miglioretti, D.L., Crane, P.K., van Belle, G., Kessler, R.C. (2006). Association Between Obesity and Psychiatric Disorders in the US Adult Population. Archives of General Psychiatry, 63, 824-830.

[7] Department of Health (2009). Available online at: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Obesity/DH_6585

[8] BBC (2009). *NHS obesity surgery on the rise.* Available online at: http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/7909865.htm

[9] Department of Health (2009). Available online at: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Obesity/DH_6585

[10] Butland, B., Jebb, S., Kopelman, P., McPherson, K., Thomas, S., Mardell, J., Parry, V. (2007). *Foresight: Tackling Obesities: Future Choices.*

[11] ibid

[12] Saunders, R.P., Evans, M. & Joshi, P. (2005). Developing a process-evaluation plan for assessing health promotion program implementation: A how-to guide. *Health Promotion Practice, 6,* 134-147.

[13] Nutbeam, D. (1999). Health promotion effectiveness – the questions to be answered. In European Commission *The Evidence of Health Promotion Effectiveness: Shaping Public Health in a New Europe* (pp. 1-11). Brussels - Luxembourg: ECSC-EC-EAEC.

[14] NICE (2009) '*Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings'*, National Institute for Health and Clinical Excellence, Publication Health Guidance 17

[15] Oude Luttikhuis H, Baur L, Jansen H, Shrewsbury VA, O'Malley C, Stolk RP, Summerbell CD (2009) "Interventions for treating obesity in children (review)", *The Cochrane Library*, *1*, Wiley Publishers

[16] NICE (2008) "*Intervention Review: family and community*", Promoting physical activity for children: Review 7 – Family and community interventions, NICE Public Health Collaborating Centre

8 APPENDIX

8.1 HEALTHY-WEIGHT RELATED PROJECT LIST

	PROJECTS	LOCATION
*	10-14's Cycling Programme (ASC's & Holidays - ongoing)	City/Tower Hamlets/Hackney
*	10-14's Football Training (Attlee)	Tower Hamlets
	121 programme – GP referral / CHyps + and ELIC funding	
	Ad hoc healthy lifestyle events / health promotion events	as above
	Asian Women's Walking Project	
	Be active, keep healthy (Jewish Exercise Project)	Hackney
	Child health promotion programme (the Healthy Child)	St Leonard's Hospital
*	Childhood obesity project	St Leonard's Hospital
*	Children and young people - complex care (targeted / specialist)	Dietetic department
	Children's Centre Services	Dietetic department
	Chinese in Need	
	Community & Health Advisory Project -Bengali women's and girls aerobics	City of London
	Cook and eat with kids	
	Counterweight	Counterweight
	Counterweight	
	Dietetic Services for adults	Dietetic department
	Dietetic services for children above 5 years - this includes special needs, chyps plus, schools dieticians etc	Dietetic department
	East London Food Access	
	Exercise on Referral	

	PROJECTS	LOCATION
*	Family Cycle Clubs	
	Fitness fun	
	GP Referral Programme- Orthodox Jewish community	
*	Hackney Healthy Children's Project	
	Hackney Healthy Schools Programme	Hackney Technology & Learning Centre, 1 Reading Lane, London E8 1GQ
	Hackney Personal Best	
	HAPPY @ Home Programme for parents on healthy lifestyles	hackney Technology & Learning Centre, 1 Reading Lane, London E8 1GQ
	HAPPY in Hackney Programme (under fives healthy settings programme)	
	Health Promotion Project - VLC Centre	
	Healthy Lifestyles	City of London
	Healthy lifestyles	Space, Hackney Community College
	Hoops for Health	
	Individual patient consultations advocate	Homerton Hospital
	Motor skills programme - training schools to run motor skills programmes to get children with co-ordination difficulties active	
	Neighbourhood Maps project	Homerton, Hackney Wick, the canal (Hackney stretch
*	New Age Games	
	Nursery Fruit Scheme	
*	Physical Activities for Schools and Parents	
	Physical Activity for Older People	
	Practice based health trainers	Service commissioned from the Greenwich Leisure Centre
	Refurbishing of kitchens & activity spaces in community	

	PROJECTS	LOCATION
	centres Hackney wide	
*	School Travel Advisers	
	School Travel Plans	
	SHEL multi-sports camp	
	SONshine Club	
	Tackling diabetes	
	The School Health Service and the National Child Measurement Programme	St. Leonard's, Nuttall Street
	Volunteer accreditation 'Estate Activators' prog	
*	Weight management group - 14 week course	Homerton Hospital
	Young at Heart	City of London

*** non respondents**

8.2 Project Set Up

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
Be Active Keep Healthy Project- Orthodox Jewish Young People	• Primary prevention • Open to all regardless of weight or disease related criteria • Hackney but take up is as follows: N16 – 94percentage, N15 – 4percentage, E5 – 2percentage • 3 to 11 years, 12 to 16 years	**Aim:** Provide opportunities for 11-15 year old Orthodox Jewish residents to exercise and gain a better understanding of their health in an environment that is culturally relevant. Structured programmes of exercise with instructors are offered in swimming and cardiovascular exercise to participants recruited through the local Jewish press and community organisations. High demand for the initial pilot project has been turned into an ongoing programme **Process:** It consists of three, ten week projects (including overweight girls' project) run in split gender groups, accessing initially sixty to currently one hundred and twenty five Orthodox Jewish young people. The programmes are delivered as follows: • Programme 1 - run in Trampoline Orthodox Jewish gym (circuit gym classes, aerobics) and a programme for 13 – 15 year old males ran as a seven day intensive swimming programme; at Britannia Leisure Centre. • Programme 2 - run in Leaside (gym, kayaking, mountain biking) • Programme 3 and 4 run in Bremmer Community Centre (aerobics, circuits, ball games) This is a one off programme unless the person is over weight then they automatically proceed to the next programme.
BEAP - Best Eco Active Project	• Primary prevention • Open to all regardless of weight or disease related criteria • Hackney Haringey • 3 to 11 years, 12 to 16 years	**Aim:** To promote awareness of the environment and the benefits of physical activity, to encourage the growing and eating of fruits grown by participants, to raise self-esteem, help participants to forge new friendships and to promote team working.
Child Health promotion programme	• Primary and secondary prevention • Universal national programme • Across City and Hackney	**Aim:** It is an early intervention and prevention public health programme that lies at the heart of the universal service for children and families, with a strong evidence base taken from Health for All children. The programme aims to: • Assess family strengths, needs and risks. • Give mothers, fathers (carers) the opportunity to discuss their concerns and aspirations

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
	• Pre-birth (antenatal),0 to 2 years	• Assess growth and development in order to detect abnormalities **Process:** • It offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices including advice on healthy eating, weaning and breastfeeding. • It supports the early detection of risk factors for obesity and provides early advice.
Chinese Cardio Project	• Primary prevention • Open to all regardless of weight or disease related criteria • Hackney • 45 to 54 years, 55 to 64 years, 65 years and over	**Aim:** The aim of the project is to promote cardiovascular health among the Chinese community in Hackney by organising walking/cardio group sessions for members of this community twice weekly.
Community Development and Health Advisory Project	• Primary prevention • Open to all regardless of weight or disease related criteria • Portsoken Ward of City of London • 12 to 16 years, 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over,	**Aim:** It offers Portsoken residents the chance to better understand health-related and family issues and get information about local services through a weekly programme of activities.
Community kitchens	• Primary prevention • Settings focused • Hackney-wide	**Aim:** To develop the physical capacity of community halls in some of the most disadvantaged communities in order to provide cohesive packages, including healthy eating skills, which can help improve health.

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
	• All ages	
Counterweight	• Secondary prevention • Weight related admission criteria • Hackney and the City • 45 to 54 years, 55 to 64 years, 65 years and over	**Aim:** To provide fortnightly counselling and support sessions using the counterweight model along with thirty minutes of physical activity.
Dietetic children's services – above 5 years old (counterweight professional training)	• Secondary prevention • Dietetic services • Across the borough of City and Hackney • 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over	**Aim:** To offer training programmes for health care professionals e.g. practice nurses that deliver key messages on healthy eating to support weight loss for adult clients. **Process:** Participants are given support packs on counterweight and leaflets for their clients. Support sessions, face to face or via the telephone /email are conducted for the trained health professionals to ensure the correct counterweight message(s) are delivered.
Dietetic children's services - above 5 years old	• Primary and secondary prevention • Dietetic services • Across the borough of City and Hackney • 3 to 11 years, 12 to 16 years, 17 to 24 years	**Aim:** To provide a range of dietetic services which include having a schools dietician work as part of the healthy schools programme one day per week to support schools achieving healthy schools status.
Dietetic children's services - under 5 years old	• Primary and secondary prevention • Dietetic services • Across the borough of City and Hackney • Pre-birth (antenatal),0 to 2 years, 3 to 11 years, 12 to 16 years, 17 to 24	**Aim:** To provide a flexible, inclusive dietetic service especially to vulnerable families in Hackney. **Process:** The service provides nutrition promotion within a range of settings including clinics, homes, nurseries or community centres, to children, parents and women before, during and after pregnancy.

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
	years, 25 to 34 years, 35 to 44 years, 45 to 54 years	There are four areas to the service • Nutrition promotion - healthy eat session • Clinical work - one to one dietetic advice service for parents and pregnant women etc. This also includes home visits to those who find it difficult to attend • one to one Public Health - for e.g. Kiddies Gym, Maternal nutrition project; toddler parties • Training for health and communication workers
Dietetic Service - Adults	• Secondary prevention • Dietetic services • Across the borough of City and Hackney • 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over,	**Aim:** Use clinical skills / knowledge to empower and support behaviour change among adults so they can achieve their weight loss objectives. **Process:** overweight or obese patients registered with a GP within City and Hackney are free to use the one to one consultation services offered by the dietetic services.
East London Food Access	• Primary prevention • Setting focused • Disadvantaged ward and localities in Hackney, especially where access to affordable fresh produce is a barrier to consumption of fresh produce • 0 to 2 years, 3 to 11 years, 65 years and over, All ages	**Aim:** To support community health and well-being through facilitating access to good quality fresh food among the deprived communities living on isolated urban estates, where there are no local shops providing these types of foods or no access to supermarket shuttle bus services. **Process:** • Set up organisations (social enterprises) that operate weekly food stalls on multiple local estates, supplying fresh produce at equivalent local retail prices but with much higher quality • Supply fruit to nurseries and schools • Deliver fruit to local businesses and workplaces.

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
Fitness Fun Project	• Primary prevention • Open to all • All parts of the borough within Hackney • 3 to 11 years, 12 to 16 years, 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years,,,	**Aim:** To introduce fitness activities to a diverse ethnic mix of participants from hard to access communities in areas of high deprivation. **Process:** • There are three groups of participants; children - sessions are run before and after school or during lunch times, parents - session times vary, parents and children - sessions are held after school. • Qualified Instructors with appropriate qualifications and CRB certification lead the activities. • Range of activities include – Family Yoga, Pilates, Kids Sports dance, Street Dance, Capoeira, Family Fun Dance, Aero - Circuit, Salsa Fun, Hip Hop, Bollywood Dance, Aerobics, Fit Kids class, Boxercise.
GP Referral Scheme - Orthodox Jewish Community	• Secondary prevention • Weight –related admission criteria • The Orthodox Jewish Community in Stamford hill, Hackney. • 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over	**Aim:** It is a pilot project aimed at increasing the level of access to physical activity in the Orthodox Jewish community. It is target ed to those that are obese or have diabetes or hypertension but it is also suitable for some cardiac patients requiring “Phase Four” rehabilitation. Priority is given to those patients who are on benefits and who do not currently have gym membership. **Process:** • Ten week community centre based exercise programme with the option of a further three month subsidised gym membership.
Hackney Food Skills Project	• Primary prevention • Open to all • The London Borough of Hackney	**Aim:** Enhance understanding and empower young people from Upper Primary School to Lower Secondary or even families to make healthy food choices.

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
	• 3 to 11 years, 12 to 16 years	**Process:** Deliver school and youth project centred sessions that focus on • educational activities around cooking and foods skills, through practical cooking courses, school assemblies etc. • food promotional events and day trips As part of the programme a fun quiz/game for young people to play has been developed which can be incorporated into the school curriculum, as it indirectly increases food knowledge. Accompanying this quiz is a monitoring activity which should identify those at risk or in need of further referral.
Hackney Healthy Schools Programme	• Primary prevention • Settings focused • London borough of hackney (work with all school children 5-18 yrs) • 3 to 11 years, 12 to 16 years, 17 to 24 years	**Aim:** This is a universal programme with national LAA (STRETCH) targets that schools volunteer to participate in. The outcome of participation is the achievement of the National Healthy School Status. **Process:** The school develops a working action plan based on an on-line self evaluation audit available from www.healthyschools.gov.uk which it then submits for validation. Status can take one to two years to achieve depending on the baseline.
Hackney Personal Bests	• Primary prevention • Open to all • all areas within the borough • 3 to 11 years	**Aim:** The Hackney Personal Best funded by Team Hackney and delivered by LBH 2012 Olympic and Paralympics Games Unit, is a fully inclusive programme that aims to raise the awareness of the 2012 Olympic and Paralympics games and increase the participation in physical activity among young people within year five, and in some cases year four. **Process:** The project is delivered during curriculum time instead of the schools scheduled P.E lessons and comprises of the following components • Taster programme • An inspirational message around the title 'Be the best you can be' • Sports and Physical Activity element where students participate in an Olympic styled event where they attempt to outperform their personal best score in a specific Olympic-based athletic discipline including but not limited to:- • Shot Put • Discus • Javelin • Standing Long Jump • Standing Triple Jump • Speed Bounce • Relays • Boccia (specialist units/schools only). As part of the event children receive a team t-shirt, certificate and 2012 merchandise as well as special achievement prizes.

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
		There are additional optional components to this project • Educational Programme and Classroom component where participants are asked to complete workbooks that focus on issues of health and wellbeing including physical activity and exercise and healthy eating. • Participating schools are offered the opportunity to have a Young Leaders Award Qualification course delivered to the participants free of charge. • Personal Bests Athletics After School Club, a free after school athletics club which can be run during the summer term. • Free continuous athletics training on a weekly basis at the Hackney's Sports Hall Athletics Club from January to September 2009. • Participation in the Hackney Personal Best fun Olympic and Paralympics awareness programme run during the summer, which familiarises children with the personal best process, encouraging them to be the best they can be. • Schools are given the athletics equipment to continue PB profiling.
HAPPY in Hackney (Healthy Activities and Practices with Pre-school Years)	• Primary prevention • Settings focused • London Borough of Hackney - it is related to under fives • 0 to 2 years, 3 to 11 years	**Aim:** HAPPY in HACKNEY is an accreditation awarded to early year's settings which demonstrate that they have successfully promoted healthy eating and physical activity to children and their carers. **Process:** The programme facilitators help settings plan and develop activities which will help achieve this status. They also provide • Training opportunities/workshops • Individual or group support • Information and advice • Access to Resources (supported by a bursary and Resource list) • Support with Monitoring and Self Evaluation

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
		Settings are assessed in accordance with predetermined criteria and successful settings are awarded a poster, certificate and logo in recognition of meeting the 'HAPPY in HACKNEY' criteria for promoting Healthy Eating, Physical Activity and Emotional Health and Wellbeing
HAPPY@Home	• Primary prevention • Settings focused • London Borough of Hackney. This is for parents of under fives. • 0 to 2 years, 3 to 11 years	**Aim:** To promote healthy lifestyle among children and their parents and/ or carers through a series of activities and the provision of resources. **Process:** • Provide opportunities for the young baby/child to move spontaneously, to learn about them self and the environment • Raise parent's awareness of the importance of healthy eating, and an active childhood and guide them on how to support their children emotionally thereby promoting self-esteem, confidence and wellbeing. • Provide activities promoting healthy eating options • Train early year's staff to run parent/carer workshops on healthy lifestyles and provide resources to support future training.
Health promotion events and health eating/ obesity teaching	• Primary prevention • Dietetic services • Across the borough of City and Hackney • All ages	**Aim:** To organise and deliver health promotion events or other useful techniques in a manner that can be understood by the client group.
Healthwise	• Secondary prevention • Weight/disease related admission criteria • Hackney borough • 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over,	**Aim:** A physical activity referral scheme whereby health professionals can refer patients to low cost physical activity programmes available from a selection of leisure centres in Greenwich. It helps people with medical conditions and those at risk of developing health conditions find a suitable way to get fit and stay healthy. **Process:** Delivery of the programme usually follows the following steps • After referral from a doctor or other health professional a dedicated team of Fitness Professionals will assess the patient to determine current fitness levels and special needs • A suitable, safe and personalised exercise programme will then be designed, incorporating these options or more, •

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
		BACR Phase IV classes • Gym Based Supervised Sessions • Aqua Sessions • Group Exercise Options • Circuit Training. or Group activities. • Progress is monitored and the exercise programme adjusted where necessary. As an additional incentive clients receive an inclusive membership card to the leisure centres with specialist benefits.
Healthy Lifestyles (City)	• Primary prevention • Open to all • The city of London • 3 to 11 years	**Aim:** To educate children and their families about the benefits of healthy lifestyles changes. This is achieved through exercise sessions, family cooking activities and personal development sessions and dietary advice
Healthy Lifestyles Project (hackney)	• Primary prevention • Open to all • Hackney • 3 to 11 years, 12 to 16 years	**Aim:** It helps obese 7 – 13yrs living within the borough to reduce or stop weight gain by promoting physical activity, healthy eating and positive self esteem within the family, using a range of fun and enjoyable activities like drama. **Process:** A key element of the programme is to measure the participant's BMIs, Waist Circumference and body fat percentage before and after the ten week intervention in order to assess the effectiveness of the programme.
Healthy Living	• Secondary prevention • Weight/disease-related admission criteria • South East of Hackney - GP practices that are part of ELIC • 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over	**Aim:** To support weight loss by adopting a holistic approach to healthy lifestyle change through encouraging physical activity, healthy eating, along with providing support and counselling. **Process:** With the advice of a coach individuals develop a bespoke plan for weight loss including physical activity. Healthy eating workshops complementary therapies with group support and counselling are also made available to participants; The plan is followed over an eighteen week period, after which participants are encouraged to pass on the knowledge gained by becoming peer supporters.
Hoops 4 Health	• Primary prevention • Open to all • The London Borough of Hackney	**Aim:** Promote sporting and healthy lifestyles among primary school kids by getting them to participate in basketball. As basketball is one of the biggest Olympic and Paralympics Sports, introducing the sport and the legacy that the 2012 Games will bring to the East London area is one of the underlying goals of the project.. It is carried out by the Basketball Foundation Charity, in partnership with Hoops 4 Health Legacy, and Hackney PCT and covers government strategies in Health - PSA 1 and PSA 2, as

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
	• 3 to 11 years	well as the government strategy for Personal Social Health and Education (PSHE). **Process:** The project is divided into three main areas. 1) Healthy Lifestyle Road shows – professional players from London Leopold help explain health issues using interactive techniques. The sessions focus on: • Healthy Eating • No Smoking • Fitness • Basketball Coaching. Each session lasts approximately twenty five minutes and the afternoon ends with a competition in the main hall for all participants 2) Schools Coaching 3) Tournaments
Keep fit and Tai Chi	• Primary prevention • Open to all • Hackney wide • 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over	**Aim:** To improve health amongst members of the Vietnamese community and those living locally o the project by providing Physical Exercise activity. **Process:** The classes are delivered by a professional trainer at the main hall of the community centre twice weekly; Wednesdays and Saturdays. They are all inclusive and therefore cater to all age groups.
Motor skills programme	• Secondary prevention • Settings focused • London Borough of Hackney • 3 to 11 years	**Aim:** The programme trains educators who work with special needs children, in techniques that will help develop motor skills that better equip children to deal with everyday situations, from dressing themselves and eating to writing. Guidance for teachers on identifying and assessing motor skills needs is also incorporated in the training. **Process:** The programme is recommended by Hackney Healthy Schools Programme and is supported by a multi-professional working party including representatives from the School Sports Partnership, the Inclusion Team and the Primary Care Trust Team (Occupational Therapists and Physiotherapists). The main components of the training include; warm up ideas, key

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
		activities, skill development, some Brain Gym and cool down activities. Teachers/LSA can use these techniques with small groups at playtime or as part of the National Curriculum physical education programme.
Neighbourhood Maps	• Primary prevention • Settings focused • 3 maps are planned: Homerton, Hackney Wick, Regents Canal • All ages	**Aim:** To produce a series of maps for residents of local neighbourhoods in City and Hackney which show local opportunities for increasing physical activity, improving cooking skills and accessing nutritious food.
Nursery Fruit Scheme	• Primary prevention • Settings focused • Children under 5 attending community nurseries, children's centres, early years settings and Orthodox Jewish independent nurseries Currently private nurseries are excluded • 0 to 2 years, 3 to 11 years	**Aim:** to promote healthy eating and good oral health to children at nursery age, by providing free fruit directly to nursery settings across Hackney and using fun sessions like story telling and stickers to reinforce messages.
Practice Based Health Trainers	• Secondary prevention • Weight/disease-related admission criteria • City and Hackney • 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over	**Aim:** to get individuals to engage in physical activity by offering a bespoke solution that is closely aligned with their health needs. **Process:** This project will be piloted with ten surgeries and will involve GP led assessments of clients which includes the measurement of key indicators e.g. blood pressure, height, weight etc in order to determine whether there is a need to increase levels of physical activity. As part of the assessment SF12 questionnaires will be administered and motivational interviews conducted. The results will then inform the development of an in-house exercise / education programme delivered over six weeks after which key indicators are re measured. As the programme is delivered in house it will offer a familiar surrounding for

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
		patients and a 'doorstep' service for the practices, while also providing a bridge to locally provided leisure services.
S.H.E.L Multi Sport Camp	• Primary prevention • Open to all • The London Borough of Hackney • 3 to 11 years, 12 to 16 years	**Aim:** Our S.H.E.L multi-sport camp is designed to deliver the highest levels of professional sports coaching to children between the ages of eight and twelve years and positive messages that are relevant to the children's development stages. **Process:** Sport GWS provide structured and professional sports and coaching sessions which cover the basic skills of each sport, competitive drills, individual games and team competitions. These sessions also incorporate and focus on • Discipline, motivation, teamwork and effort, all of which are gained through participating in sport while also demonstrating the importance of education in relation to pursuing a professional sporting career • Health messages which cover three main topics of Health, Diet, Non-Smoking and Exercise • General topics related to the challenges children encounter e.g. peer pressure, bullying etc. The sessions are highly interactive and incorporate creative techniques like display boards and quizzes to enforce learning with additional resource material provided.
STA Bikes Saturday Family Cycle Club	• Primary prevention • Open to all • Hackney, East London • 3 to 11 years, 12 to 16 years, 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over	**Aim:** To instil physical activity and healthy lifestyle values as part of the culture within families. **Process:** A six week family cycle course.
Tackling Diabetes	• Secondary prevention • Weight/disease-related admission criteria	**Aim:** The programme takes a practical approach to teaching people how to apply healthy eating principles to their daily life, so as to better manage diabetes. Some core skills include healthy cooking practices and shopping for healthy foods.

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
	• The London Borough of Hackney • 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over,	**Process:** The core delivery is a cooking taster course, run over a ten week period with three cycles per year. These taster courses are promoted through a series of outreach sessions. As a follow up to the taster courses, participants also have the option of participating in one of six cooking clubs offered per year.
The School health service and the National Child Measurement Programme	• Primary and secondary prevention • Universal national programme • All local authority schools in City and Hackney • 3 to 11 years, 12 to 16 years	**Aim:** The National Child Measurement Programme is a statutory programme that contributes toward the overall monitoring of obesity among the population. It helps the PCT obtain prevalence rates of overweight and obese children on a school cluster basis. **Process:** Children are offered a health interview and assessment at school entry (reception) which includes weighing and measuring. Weight and healthy eating are discussed with parents and where necessary referrals are made to other professionals including the school paediatrician
Walking project	• Secondary prevention • Weight/disease-related admission criteria • The London Borough of Hackney • 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 years and over,	**Aim:** Create a platform whereby Asian women can participate in physical activity within an inclusive environment **Process:** The Asian Women's walking group has been running over the past seven years with the help of funding received from the PCT. The participants are a combination of referrals from Homerton Hospital, St Leonard's PCT, and Local Mental Health Centres as well as walk ins in response to word of mouth publicity and advertising via posters or the website. The group meets twice weekly (Tuesday and Thursday) for approximately two hours during which time the participants engage in low impact activities that help with weight loss, develop muscular strength, cardiovascular fitness and physical flexibility.
Weight Management Group	• Secondary prevention • Weight/disease-related admission criteria • Hackney • 17 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64	**Aim:** To provide comprehensive lifelong healthy eating advice within group settings, with the aim of achieving and maintaining a five to ten percentage weight loss goal. **Process:** The Weight Management Group consists of seven sessions on a twice weekly basis with an option of morning or evening sessions. Where group sessions are deemed unsuitable, individual appointments can be booked.

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
	years, 65 years and over,	The sessions covers • Health benefits associated with weight loss • Healthy eating advice based on the Eat Well Plate • Input from physiotherapy and counselling services As part of the programme patients are encouraged to keep a food diary and monitor eating patterns and behaviour and participate in physical activity. Advice on further support is also provided once the programme in completed.
Young at Heart Coordinator	• Primary prevention • Open to all • Mainly City of London residents, workers and City of London Outer Estate residents in the fringe boroughs, although anyone can be a member if they are the right age - 50 plus • 45 to 54 years, 55 to 64 years, 65 years and over, All ages	**Aim:** A City of London scheme, launched in 2005 which encourages people aged fifty and over to participate in physical activity by offering a specially devised programme of physical activities, health checks and advice
Youth in Progress	• Secondary prevention • Weight/disease-related admission criteria • Hackney • 12 to 16 years, 17 to 24 years,,,,,,	**Aim:** Help people make a healthy lifestyle change by equipping them with the tools, support and knowledge that encourage this change. **Process:** The programme encourages young people to take part in physical activity, promotes healthy eating through workshops and offers support and counselling. Support is also provided by participants who become peer supporters after completion of

Project Name	Overall Approach, Target Areas and Group	Brief Summary of Project
		the programme.

8.3 Project Length

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year		Drop out		Reasons for drop out
				Average per year	Actual for the last year	Average – previous 2 to 3 years	Actual for the last year	Actual for the last year
Be Active Keep Healthy Project- Orthodox Jewish Young People	Ten to twelve weeks	Other follow-up (please specify below) They are put on the waiting list for the next available projects	Parent Other (please specify below) Local Jewish press is where the advert is placed for the referrals to come through	300	200		6	Personal circumstances
BEAP - Best Eco Active Project	Ten to twelve weeks	Additional one-off follow up	Other (please specify below) Marketing	100		0		
Child Health promotion programme	More than twelve weeks	Other follow-up (please specify below) Follow up according to need	Other (please specify below) not applicable	not applicable				
Chinese Cardio Project	More than twelve weeks	Other follow-up (please specify below) once the course is competed, they are called up by the worker or volunteers to see if they are still carrying on their exercises and how they are health wise.	GP Self-referral Other (please specify below) Other centre workers, health workers and Chinese organisations.	60	58	4	2	Other (please specify below) We felt that they had improved so much and other people were on the waiting list, so we asked if they were happy to leave the project and that they will carry on the exercise when away from class.
Community Development &	Ten to	No additional follow-up	GP Self-referral	50	30			Personal circumstances

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year	Drop out		Reasons for drop out
Health Advisory Project	twelve weeks						Motivation Changing family circumstances / health / employment / training opportunities People tend to stop coming for a while but then re-enter the groups/programmes again
Community kitchens	More than twelve weeks	Other follow-up (please specify below) Plan to interlink with PCT's health trainers and wider healthy eating programme.	GP Self-referral Other (please specify below) Primary care staff, outreach workers, health trainers	0	0	0	0	
Counterweight	More than twelve weeks	Additional one-off follow up	Self-referral	8	14	2	2	Motivation
Dietetic children's services - above 5 years old	Less than one week	Other follow-up (please specify below) Follow up refresher courses for trained staff; one to one support locally whilst trained staff are undertaking a counterweight delivery session to their clients	Other (please specify below) This is a training programme for health professional who in turn set up the programme locally and get referrals / book clients in from their own service users area.	not applicable	24		1	Personal circumstances
Dietetic children's services - above 5	Ten to twelve weeks	Other follow-up (please specify below) One to one consultations may	GP Parent School nurse Teacher Self-referral Health	not applicable	250		52	Personal circumstances

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year	Drop out		Reasons for drop out
years old		last longer than 12 weeks – in terms of supporting weight maintenance. This is client dependent based on clinical and client judgment.	professional e.g. psychologist.				Motivation Onward referral Inappropriate referral to service – this could be client not ready for change.
Dietetic children's services - under 5 years old	More than twelve weeks	Other follow-up (please specify below) One to one consultations may last longer than 12 weeks – in terms of supporting weight maintenance. This is client dependent based on clinical and client judgment. Health promotion & Training sessions are ongoing throughout the year Kiddies Gym runs during term –time – for all children. Overweight children given specific dietetic advice in the clinic are encouraged to take part in the Kiddies Gym session.	GP Parent Teacher Social Worker Health professional e.g. Psychologist, Practice Nurse, Paediatrician, Health Visitors Nursery Nurse, Family Support Worker, Children's Centre Team Members e.g. Speech Therapist, Public Health Co-ordinator, Public Health Midwife,	not applicable			Personal circumstances
Dietetic Service - Adults	More than twelve weeks	No additional follow-up	GP Other (please specify below) Health professional e.g. psychologist / physiotherapist	1320	1000	210	Personal circumstances Motivation

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year		Drop out		Reasons for drop out
								Onward referral Inappropriate referral to service – this could be client not ready for change.
East London Food Access	More than twelve weeks	No additional follow-up	Self-referral	500	250	50	50	Personal circumstances
Fitness Fun Project	Ten to twelve weeks	Other follow-up (please specify below) On going activity	Parent School nurse Teacher Self-referral	650	600	68	60	Personal circumstances Motivation
Hackney Food Skills Project	Ten to twelve weeks More than twelve weeks	Other follow-up (please specify below) This is dependant in which aspect of the project young people have attended. If the young person has attended out of school, then it is common for them to wish to have additional follow up through participating in other Shoreditch Spa activities or ask for referral to other agencies or activities. However, if they have attended our session through school, then they are less likely to have a follow up by Shoreditch Spa.	Parent School nurse Teacher Self-referral Other (please specify below) Extended Schools Co-ordinator, Year Heads at Secondary Schools and Health Hut workers.	84	84			Personal circumstances Project availability Other (please specify below) Sometimes young people cannot attended our extended hours schools programme as they have to collect siblings from other schools; have to be home for their parents; they care for others or they have detentions.

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year		Drop out		Reasons for drop out
Hackney Healthy Schools Programme	More than twelve weeks	Other follow-up (please specify below) Schools have to sustain healthy schools status; from Sept 2009 after achieving status, they will have to complete an annual checker and move onto enhanced healthy school status which will be based on universal and targeted (local and school based) outcomes set by each school over a self-stated timescale.	Teacher Self-referral Schools or key stakeholders may encourage schools to join programme or schools may self refer.	not applicable		4	4	Personal circumstances School has other priorities, leadership and management issues; change of leadership; OFSTED reports; OFSTED giving 'outstanding' to school when it does not have NHSS
Hackney Personal Bests	More than twelve weeks	Other follow-up (please specify below) Assemblies, after school Club	Other (please specify below) The schools are selected using BMI and by recommendations from Healthy Schools and the School Sports Partnerships.	1000	300	0	0	0
HAPPY in Hackney (Healthy Activities and Practices with	More than twelve weeks	Other follow-up (please specify below) This is a programme which encourages and enables	Teacher Self-referral The learning trust promotes the project; settings volunteer to	15	82			n/above; settings may disengage because of leadership and management issues or challenging circumstances which

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year	Drop out		Reasons for drop out
Pre-school Years)		settings to provide sustainable health promotion and education practice whenever the setting is open. It is not a one- off intervention. Settings have to demonstrate evidence which meet criteria which show that they are an effective health promoting /obesity prevention setting.	engage-maybe promoted by colleagues from other settings and early years advisors or health practitioners				may have arisen
HAPPY@Home	More than twelve weeks	Other follow-up (please specify below) One facilitator will work for 6 weeks in one setting; then another facilitator focusing on another health module will follow; parents are encouraged to loan rucksacks of physical development equipment to take home and play with their child. During intervention disposable cameras are given to record evidence of healthy eating and physical activity at home. Top up workshops are offered for staff and parent/carers. Reviewing	Parent Teacher Self-referral Early years consultant	10	1	1	Personal circumstances Other (please specify below) Setting capacity, leadership and management issues/ setting in challenging circumstances

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year	Drop out		Reasons for drop out
		sustainability with settings once specialists have been in. Have tried to up skill setting staff to deliver. Looking at BHF/ Learning & Skills Council vocational qualification to up skill parents to become health champions for early years. Considering pilot.					
Health promotion events and health eating/ obesity teaching	Less than one week	No additional follow-up	Other (please specify below)	not applicable	4902		Motivation Onward referral
Healthwise	More than twelve weeks	Other follow-up (please specify below) They will have continued review sessions with the instructors	GP	1500	1600	500	640	Personal circumstances Onward referral
Healthy Lifestyles	More than twelve weeks	Other follow-up (please specify below) We have exit routes into established community projects	Parent Teacher Self-referral	300	84		0	Personal circumstances
Healthy Lifestyles	Ten to	Other follow-up (please specify below) We are	GP School nurse Self-	90	45	50	50	Personal circumstances

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year		Drop out	Reasons for drop out
Project	twelve weeks	developing a HL2 programme, to revisit all the families who have been on the programme to see how they have been getting on since they left the programme.	referral				Motivation
Healthy Living	More than twelve weeks	Other follow-up (please specify below) Participants are encouraged to stay on as peer supporters who buddy other young people on the programme. We also sign post individuals to various services across hackney. All participants will periodically be surveyed in order to establish sustained impact.	GP	30	30	14	Personal circumstances Project appropriateness Project availability Motivation The number of people completing the 18 weeks was 30. Drop outs occurred either at initial assessment stage or during the first 6 weeks. In the main this was a mutually agreed decision
Hoops 4 Health	Ten to twelve weeks	No additional follow-up	Teacher	1800	1770		
Keep fit and Tai Chi	More than twelve weeks	Other follow-up (please specify below) No response given	Parent Teacher Self-referral	1440	1000		Personal circumstances
Motor skills programme	Less than one week	Other follow-up (please specify below) Training is for half a day; a school then runs a motor skills	GP Parent School nurse Teacher May be any of the above	10	30		Other (please specify below) School capacity-time/staff capacity to deliver programme in school; is it a priority in school

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year		Drop out		Reasons for drop out
		programme in school and gets support to establish, monitor and evaluate it.						improvement plan
Neighbourhood Maps	Ten to twelve weeks	Other follow-up (please specify below) The purpose of the map is ongoing and self-direction	Other (please specify below) not applicable	1	1	1	1	Other (please specify below) n/a
Nursery Fruit Scheme	More than twelve weeks	Other follow-up (please specify below) Health Education Sessions	Other (please specify below) All children attending the participating nurseries are automatically part of the scheme	2200	2200			
PRACTICE BASED HEALTH TRAINERS	Two to six weeks	No additional follow-up		not applicable		0		
GP Referral Scheme - Orthodox Jewish Community	Ten to twelve weeks	Additional one-off follow up	GP	96				Personal circumstances Motivation
S.H.E.L Multi Sport Camp	One week Two to six weeks	Other follow-up (please specify below) Participants are encouraged to attend any GWS future events within the school holidays as well as encouraged into other sports. Activity clubs	Parent Teacher Social Worker	250	200	3	4	Personal circumstances

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year		Drop out		Reasons for drop out
		held locally. Information from healthy lifestyles project for overweight children is also given.						
STA Bikes Saturday Family Cycle Club	Two to six weeks	Additional one-off follow up STA Bikes hope to increase this to provide a regular follow-up drop-in facility	Other (please specify below) Trainees are recruited through schools, listings in local newspapers, and word-of-mouth	200	200	12	5	Personal circumstances
Tackling Diabetes	Ten to twelve weeks	Other follow-up (please specify below) We have regular cooking club sessions which people can come along to as a one off session or on a more regular basis if they so wish.	GP Self-referral Social Worker	30				Personal circumstances Project availability In general, once people join a course they stay involved. The biggest drop out is between interest expressed at outreach and actually starting a course. In the main people change their minds due to the proximity and timing of a course. This would suggest demand for alternate sessions and timings at different locations.
The School health service and the National Child Measurement	More than twelve weeks	Other follow-up (please specify below) Follow up according to need	Parent Teacher Self-referral Social Worker	not applicable				

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year		Drop out		Reasons for drop out
Programme								
Walking project	More than twelve weeks	Other follow-up (please specify below) There is the pre programme questionnaire and a post programme questionnaire once the programme is completed	GP Self-referral Social Worker Other (please specify below) Mental Health Project, Social Services, Hospitals, Counselling Service	68	70	5	3	Personal circumstances
Weight Management Group	More than twelve weeks	No additional follow-up We trialled a follow up drop in session but this was not taken up. Users are given information and advice on where to go next.	GP Other (please specify below) Physiotherapists	160	80	20	27	Personal circumstances Project availability Motivation Commitment to programme may be too much as it covers a long period of time
Young at Heart Coordinator	More than twelve weeks	Other follow-up (please specify below) Activities run all year round, but service users are given exit routes to follow if they wish to participate in certain activities on an even more regular basis.	GP Self-referral Social Worker Other (please specify below) The majority of members come through word of mouth, or self-recommendation	250	200	10	0	Personal circumstances Motivation Due to the scheme being re-launched in 2008 it is currently not known how many have dropped out in the past year. This will be determined in May 2009

Project Name	Core period of the project	Follow up - summary	Main referral route	Participants per year		Drop out		Reasons for drop out
Youth in Progress	More than twelve weeks	Other follow-up (please specify below) Participants are encouraged to stay on as peer supporters who buddy other young people on the programme.	GP Teacher Self-referral	30	30	8	14	Personal circumstances Project availability Motivation Other (please specify below) The reason the drop out rate for 2008 was higher than previous years was that our intake of referrals for 2008 was three times higher than previous years which is reflected in the drop out rate figure. Also see notes for adult 121 weight loss programme

8.4 Funding and Costs

Project Name	Total Cost Estimate	Source of funding	Do users pay for the service?
Be Active Keep Healthy Project- Orthodox Jewish Young People	£12,472	Funding from DH, PCT funding, Payment from family,	Yes
BEAP - Best Eco Active Project	£7,000	LA funding, Payment from family,	Yes
Child Health promotion programme			
Chinese Cardio Project	£8,300	PCT funding	No
Community Development & Health Advisory Project		PCT funding, LA funding	No
Community kitchens		PCT funding, Other contributions in kind,,	No
Counterweight	£2,500	PCT funding	No
Dietetic children's services - above 5 years old			No
Dietetic children's services - above 5 years old			No
Dietetic children's services - under 5 years old			No
Dietetic Service - Adults			No
East London Food Access		Funding from charities/voluntary organisations, PCT funding, Other contributions in kind, Other	Yes
Fitness Fun Project	£40,000	PCT funding, School contributions in kind, e.g. provision of venue, Payment from family	Yes
GP Referral Scheme - Orthodox Jewish Community	£14,800	PCT funding	No
Hackney Food Skills Project	£71,000	Funding from charities/voluntary organisations, PCT funding	No

Project Name	Total Cost Estimate	Source of funding	Do users pay for the service?
Hackney Healthy Schools Programme	£225,000	Funding from DH, PCT funding, PCT contributions in kind, LA funding	No
Hackney Personal Bests	£60,000		No
HAPPY in Hackney (Healthy Activities and Practices with Pre-school Years)	£112,000	LA funding	No
HAPPY@Home	£70,000	LA funding	No
Health promotion events and health eating/ obesity teaching			Yes
Healthwise		PCT funding	No
Healthy Lifestyles	£13,300	LA funding	Yes
Healthy Lifestyles Project	£55,000	PCT funding	No
Healthy Living	£45,000	Funding from charities/voluntary organisations, Other	No
Hoops 4 Health	£35,000	PCT funding	No
Keep fit and Tai Chi	£8,200		No
Motor skills programme	£14,000	LA funding	No
Neighbourhood Maps	£36,000	PCT funding	No
Nursery Fruit Scheme		PCT funding, LA funding, A contributions in kind, School contributions in kind, e.g. provision of venue	No
PRACTICE BASED HEALTH TRAINERS	£235,000	Other	No
S.H.E.L Multi Sport Camp	£11,500	PCT funding	Yes
SAT Bikes Saturday Family Cycle Club	£30,000	Other	No
Tackling Diabetes	£20,807	PCT funding	No
The School health service and the National Child			

Project Name	Total Cost Estimate	Source of funding	Do users pay for the service?
Measurement Programme			
Walking project		PCT funding	No
Weight Management Group		Other	No
Young at Heart Coordinator	£64,500	Funding from charities/voluntary organisations, PCT funding, Other	Yes
Youth in Progress	£45,000	Funding from charities/voluntary organisations, PCT funding	No

8.5 Monitoring and Evaluation

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
	Has it been collected?	How is it available?	Baseline data	Follow up data		Is service user feedback collected?	How is feedback collected?
Be Active Keep Healthy Project- Orthodox Jewish Young People	Yes - provided	Have attached evaluation from Programme 1 Results, outcomes and evaluations: Qualitative and quantitative feedback collated i.e. evaluation forms and focus groups for young people, parents and carers with 70% respondents overall. 75% responded they exercised less than once a week.	Yes	Yes	Changes in weight, Knowledge, Behaviour changes, Attitudes, Other (please specify below), Changes in body shape reported i.e. clothes fit differently, 100% uptake of project, increase in self esteem, confidence reported.	Regularly	Survey upon completion of course From both participants and their parents
Dietetic Service - Adults	Yes	Dietetic department	Yes	Yes	Changes in BMI Changes in weight Knowledge Behaviour changes Attitudes % weight loss over time. Patient satisfaction surveys are	Regularly	Survey upon completion of course User groups Informally Other (please specify below) Compliments to the service collected – this could be emails

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
					conducted which included this client group.		etc; IPSOS mori currently undertaking a patient satisfaction survey for us. This is 2 fold – first is a telephone survey to all clients who attend in a 2 week period in January 2009 to our service and secondly a hand held patient satisfaction survey using 5 key questions about our service e.g. appointment times; knowledge and skill of die titian etc.
Community kitchens	No		No	No	Other (please specify below) Capital works completed in budget, on time and with having managed to maintain the goodwill of the TRAs/hall management	Regularly	Informally
BEAP - Best Eco Active Project	No		Yes		Knowledge Attitudes Questionnaires	Regularly	Survey upon completion of course Informally
Child Health promotion programme	No				Other (please specify below) not applicable	Never	
Chinese Cardio Project	Yes	by contacting us or pct	Yes	Yes	Changes in weight	Regularly	Survey upon completion of

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
					Knowledge Behaviour changes Attitudes Other (please specify below) How far they can walk from the beginning of the project and how far they progress, their blood pressure.		course Informally Other (please specify below) Their personal records of weight, blood pressure and general health.
Community Development & Health Advisory Project	Yes	I can email it to you	No	Yes	Knowledge Behaviour changes Attitudes	Regularly	Survey upon completion of course User groups
Counterweight	No		Yes	Yes	Other (please specify below) not sure	Rarely	Survey upon completion of course
Dietetic children's services - above 5 years old	Yes	Dietetic department	No	Yes	Changes in BMI Changes in weight percentage weight loss	Regularly	Survey upon completion of course
Dietetic children's services - above 5 years old	Yes	Dietetic department	Yes	Yes	Changes in BMI Changes in weight	Regularly	Survey upon completion of course

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
					Knowledge Behaviour changes Attitudes Changes in height		User groups Informally Other (please specify below) Compliments to the service collected – this could be emails etc; IPSOS mori currently undertaking a patient satisfaction survey for us. This is 2 fold – first is a telephone survey to all clients who attend in a 2 week period in January 2009 to our service and secondly a hand held patient satisfaction survey using 5 key questions about our service e.g. appointment times; knowledge and skill of die titian etc.
Dietetic children's services - under 5 years old	Yes	Community and Nutrition Dietetic Department	Yes	Yes	Changes in BMI, Changes in weight, Knowledge, Behaviour changes, Attitudes, Other (please specify below) Clinical Service Changes in height / weight, activity, diet e.g. snack consumption, fat and sugar intake cooking methods Nursery Projects Changes to the provision of snacks / menus/ drinks in nurseries Training Changes in the knowledge of Health, Community and Nursery	Regularly	Survey upon completion of course, User groups, Informally, Other (please specify below) Compliments to the service collected – this could be emails etc; IPSOS mori currently undertaking a patient satisfaction survey for us. This is 2 fold – first is a telephone survey to all clients who attend in a 2 week period in January 2009 to our service and

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
					Workers Kiddies Gym Changes to stamina, activity levels, weight		secondly a hand held patient satisfaction survey using 5 key questions about our service e.g. appointment times; knowledge and skill of die titian etc. We also receive feedback on the health promotion sessions we deliver and on projects delivered e.g. Kiddies Gym, Cook-and-Eat sessions, HAPPY in Hackney and HAPPY at Home Healthy eating sessions
East London Food Access	Yes	We conduct quarterly surveys of users and results are available on demand	Yes	Yes	Other (please specify below) we measure increase in consumption of fresh fruit and vegetables	Regularly	Other (please specify below) By Survey
Fitness Fun Project	Yes - provided	Have attached evaluation from one of the Fitness Fun sessions. Results, outcomes and evaluations: Qualitative and quantities feedback collated i.e. evaluation forms	No	No	Changes in weight, Knowledge, Behaviour changes, Attitudes, Other (please specify below) Changes in body shape reported i.e. clothes fit differently, increase in self esteem, confidence reported, increased uptake of physical activity.	Occasionally	Survey upon completion of course
GP Referral Scheme - Orthodox Jewish Community	In process		Yes	Yes	Changes in waist measurement ,Changes in weight, Knowledge, Behaviour changes, Attitudes	Occasionally	Informally

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
Hackney Food Skills Project	Yes		Yes	Yes	Knowledge Behaviour changes Attitudes Other (please specify below)	Regularly	Survey upon completion of course Informally
Hackney Healthy Schools Programme	Yes - provided	www.healthyschools.gov.uk - school online audits, http://healthyschools.learningtrust.co.uk/ Hackney healthy schools database - records of visits and reports, moderation reports from liz.prosser@learningtrust.co.uk, School OFSTED reports	Yes	No	Other (please specify below) Follow up reporting to start Sept 09; although on-line audits can track this	Regularly	Informally Other (please specify below) my division collects school feedback annually; head teachers e mail feedback after achieving status; we are implementing a 3 question feedback during school visits be team; DCFS/DH are now evaluating the National Healthy Schools Programme with Thomas Coran Research Institute - initial feedback due summer 09
Hackney Personal Bests	Yes	by contacting me.	Yes	Yes	Knowledge Behaviour changes Attitudes	Regularly	Survey upon completion of course Informally
HAPPY in Hackney (Healthy Activities and Practices with Pre-	Yes	http://healthyschools.learningtrust.co.uk, on hackney healthy schools database (records of	Yes	Yes	Knowledge	Regularly	Informally

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
school Years)		visit); audits accessed from zenacarrick@aol.com (project co-ordinator)			Behaviour changes By how well settings are meeting our HAPPY in HACKNEY standard/ criteria via an audit i.e. changes in policy, practice and provision for healthy eating, physical activity and emotional health and wellbeing		Other (please specify below) Regularly by project co-ordinator via verbal questions after final setting assessment; recorded on assessment feedback
HAPPY@Home	Yes - provided	From kim.lambden@ntlworld.com – H@Home project co-ordinator via myself	Yes	Yes	Behaviour changes Attitudes Other (please specify below) By setting engagement and parent involvement and specific outcome measurements from workshops plus team/session evaluations. What have parents learnt, changed as a result of these sessions. This is an LAA target based on number of settings with HAPPY@Home.	Regularly	User groups Other (please specify below) Session evaluation/ team feedback
Health promotion events and health eating/ obesity teaching	Yes	Dietetic department	No	No	Knowledge Attitudes	Regularly	Survey upon completion of course Evaluation forms would be

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
					Other (please specify below) Timing / presentation etc		completed following all teaching / event carried out.
Healthwise	Yes	Through a database	Yes	Yes	Changes in BMI Changes in weight Knowledge Behaviour changes Attitudes Other (please specify below) Adherence	Regularly	Informally
Healthy Lifestyles	Yes	We have it stored	Yes	Yes	Changes in BMI Changes in waist measurement Changes in weight	Regularly	Informally
Healthy Lifestyles Project	Yes - provided		Yes	Yes	Changes in BMI Changes in waist measurement Changes in weight Knowledge Behaviour changes Attitudes	Occasionally	Survey upon completion of course Informally
Healthy Living	Yes - but not provided	Elic report	Yes	Yes	Changes in BMI Changes in waist measurement Changes in weight Knowledge	Regularly	Survey upon completion of course Other (please specify below) Six weekly one to consultation

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
					Behaviour changes Attitudes Other (please specify below) Self esteem confidence personal appearance fitness testing		held in case notes
Hoops 4 Health	Yes - but not provided	The data is collected at the end of the project (May/June)	Yes	No	Knowledge, Attitudes	Regularly	Survey upon completion of course
Keep fit and Tai Chi	Yes	City and Hackney NHS (Care Trust)	Yes	Yes	Knowledge Behaviour changes Attitudes	Regularly	Informally
Motor skills programme	Yes - provided	On training evaluations, school programme evaluations via kim.lambden@ntlworld.com (project co-ordinator) via myself	Yes	Yes	Other (please specify below) Number of schools participating in training and who then go onto run programmes; pupil impact data from schools motor skills programmes	Regularly	Survey upon completion of course Informally Programme Evaluations
Neighbourhood Maps	Yes	Record kept of workshops - photos, notes, attendance	No	No	Other (please specify below) Feedback	Occasionally	Informally
Nursery Fruit Scheme	Yes	Please e mail me on sarah.jean-marie@chpct.nhs.uk			Other (please specify below) no answer given	Regularly	Survey upon completion of course, User groups

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
							We obtain feedback from nursery staff following health promotion sessions. Feedback from nursery staff and parents on the scheme through questionnaires and occasionally focus groups
PRACTICE BASED HEALTH TRAINERS	In process		No	No	Other (please specify below)	Regularly	Other (please specify below)
S.H.E.L Multi Sport Camp	Yes	Attached	No	No	Knowledge, Behaviour changes, Attitudes, Other (please specify below) Parent / Carer feedback. Continued attendance on camps Attitude and enthusiasm shown by participants	Regularly	Survey upon completion of course Other (please specify below) Parent and participant evaluation forms
STA Bikes Saturday Family Cycle Club	Yes	From STA Bikes	Yes	Yes	Knowledge Attitudes Other (please specify below) Increased activity and awareness of the physical, mental and emotional benefits of cycling	Regularly	Survey upon completion of course

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
Tackling Diabetes	Yes		Yes	Yes	Knowledge Behaviour changes Attitudes When the project was set up the aim was to change eating behaviours as well as increase knowledge – people with Diabetes are weighed and measured in other contexts so a decision was taken not to repeat this. It would be possible to review this decision, or seek a partnership with referrers to monitor progress against weight management.	Regularly	Survey upon completion of course User groups Informally
The School health service and the National Child Measurement Programme	No				Other (please specify below) not applicable	Never	
Walking project	Yes - provided	The Health Promotions Department at City and Hackney PCT	Yes	Yes	Changes in waist measurement Changes in weight Knowledge Behaviour changes	Regularly	Survey upon completion of course

Project Name	Evaluation Data		Is baseline or follow up data collected?		Measurements of success	Service Feedback	
					Attitudes		
Weight Management Group	Yes	Dieticians have hard copies	Yes	Yes	Changes in BMI Changes in waist measurement Changes in weight Behaviour changes	Regularly	Survey upon completion of course
Young at Heart Coordinator	Yes	By applying to me for results	Yes	Yes	Changes in BMI Other (please specify below) Changes in blood pressure, number of service users	Regularly	Survey upon completion of course Other (please specify below) Questionnaires, newsletters, emails etc
Youth in Progress	Yes - but not provided	contact Shoreditch Spa	Yes	Yes	Changes in BMI, Changes in waist measurement, Changes in weight, Knowledge, Behaviour changes, Attitudes, Other (please specify below) Self esteem, confidence and personal appearance	Regularly	Survey upon completion of course Other (please specify below) Six weekly one to consultation

8.6 SURVEY TOOL

CHECKLIST

- **CONSENT TO PARTICIPATE**
- **GUIDELINES**
- **SURVEY**
- **PRE-PAID ENVELOPE (FOR SURVEYS SENT VIA POST ONLY)**

CONSENT TO PARTICIPATE

I have read the information leaflet relating to the above review in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the review have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this review, and in particular data from this review, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen to the data once the review has been completed.

1. I hereby freely consent to participate in the study which has been fully explained to me. * (Please tick the appropriate choice)

☐ Yes ☐ No

If 'Yes', please return the consent form along with the completed survey to the University of East London, using the pre paid envelope provided. If you ticked 'No', please return this page only.

Thank You

Name:	
Organisation:	
Job Title:	
Project Title:	

IMPORTANT! AN ASTERICKS (*) AFTER THE QUESTION MEANS AN ANSWER IS REQUIRED

BACKGROUND

Covers: Basic details about the project, its setting up, links with other initiatives and possible roll out.

2. Project Details *

Project Name	
Project Address 1	
Project Address 2	
City/ Town	
Postal Code	
Respondent's Name	
Respondent's Contact number	
Respondent's e mail Address	
Website	

3. What is your role within the organisation? (brief description) *

4. When was the project set up? *

☐	Pre-2002	☐	2004	☐	2007
☐	2002	☐	2005	☐	2008 +

☐ 2003 ☐ 2006

5. Is the project still running? *

☐ Yes ☐ No

6. & 7. Please list the key partners, including those involved in the project's set up and put an X in the column that best describes the organisation type. *

Partner Name	Primary Care Trust (PCT)	Local Authority (LA)	School(s)	Voluntary Organisation	Other

8. Are service users involved in the design and delivery of the project?

☐ Yes ☐ No

9. If 'Yes' to the previous question, how are service users involved, please tick all that apply.

- ☐ Service user representative included in management board
- ☐ Recruitment of current or previous service users as part of service delivery team
- ☐ Engaging service users in marketing and promotion of service
- ☐ Engaging service users in fund raising for the service
- ☐ Engaging current service users in recruitment of future service users
- ☐ Organising service user programme design and delivery' meetings
- ☐ Administration of service user 'programme design and delivery' suggestion forms
- ☐ Other (please specify)

OVERALL APPROACH

Covers: the objectives and main components of the project, target age group, who delivers the project, the involvement of parents and others, and the project's evidence base.

10. What are the programme's (stated) objectives? *

a.	
b.	
c.	

11. What age group does the project target? (tick all that apply) *

☐ Pre-birth (antenatal)	☐ 17 to 24 years	☐ 55 to 64 years
☐ 0 to 2 years	☐ 25 to 34 years	☐ 65 years and over
☐ 3 to 11 years	☐ 35 to 44 years	☐ All ages
☐ 12 to 16 years	☐ 45 to 54 years	

12. To what geographical area is the project targeted?

13. When does the project operate?

Days & Times	
Frequency	

14. Does the project have a specific aim to help particular groups (e.g. lone parents, unemployed, etc)?

☐ Yes ☐ No

If 'Yes', please specify

15. & 16. Other than obesity levels, are there other specific categories which the programme aims to target? (tick all that apply and specify for each category selected) *

CATEGORIES		PLEASE SPECIFY
Cultural groups	☐	
Ethnic groups	☐	
Disability groups	☐	
Religious groups	☐	
Gender	☐	
Socio-economic status	☐	
Sexual orientation	☐	
Behavioural	☐	
No other specific groups are targeted	☐	
Other	☐	

17. Briefly describe your project. (You can cut and paste from the description provided on your project website or project report) *

18. Which of the following does the project cover? (tick all that apply) *

- ☐ Behaviour change techniques
- ☐ Advice/information about healthy eating
- ☐ Advice/information about physical activity
- ☐ Some form of physical activity
- ☐ Healthy food preparation/cooking, and/or tasting
- ☐ Provision
- ☐ Counselling/psychological support
- ☐ Environmental modification (e.g. cycle paths, changes to food offered in workplace canteen)
- ☐ Other (please specify)
- ☐ Legislation/regulation
- ☐ Mass media campaign
- ☐ Parent training intervention
- ☐ Professional training
- ☐ Practical skill development
- ☐ Risk assessment/screening
- ☐ Social support
- ☐ Building Self Esteem
- ☐ Increased access to services/resources

Who delivers the project? (tick all that apply) *

- ☐ Holistic Therapist
- ☐ Researcher
- ☐ Service User
- ☐ Residential worker
- ☐ Community worker
- ☐ Social worker
- ☐ Counsellor
- ☐ Sports/exercise worker
- ☐ Nurse
- ☐ Teacher/lecturer
- ☐ Dietician
- ☐ Volunteer
- ☐ GP/ Doctor
- ☐ Health promotion/education practition
- ☐ Parent
- ☐ Psychologist
- ☐ Other (please specify)

19. If the project targets children, are parents/carers/other family members involved?

- ☐ Yes
- ☐ No

20. If ''Yes'' to the previous question, how are they involved? (tick all that apply)

- ☐ Attend project with child
- ☐ Support child at home with eating and/or exercise
- ☐ Cook with the child
- ☐ Go food shopping with child
- ☐ Other (please specify)

21. Were any of the following used when setting up the project? (tick all that apply)

- ☐ Analysis of local needs
- ☐ Specific named theory/model of behaviour change
- ☐ Referred to in setting up/running the intervention
- ☐ Experience of other interventions
- ☐ Other research evidence (please specify)
- ☐ Expert advice
- ☐ NICE 2006 guidance
- ☐ None of the above

22. Is your project dependent upon any of the following resources? (tick all that apply)

- ☐ Sports Equipment
- ☐ Cooking Equipment
- ☐ Continued Professional Expertise
- ☐ Other (please specify)
- ☐ Local Facility
- ☐ None

23. Are there any mechanisms in place to allow the service to cater to individual needs?

☐ Yes ☐ No

If 'Yes', please specify

24. Does your project engage/ interact with any other local providers of healthy weight-related services?

☐ Yes ☐ No

25. If 'Yes' to the previous question, please specify.

Which other providers do you engage with?

How often?

By what means e.g. e mail, professional networking etc.?

RUNNING THE PROJECT

Covers: the duration of the project and the settings where it is delivered

26. On average, and based on the most recent data, how long does the core period of the project last? *

☐ Less than one week ☐ One week ☐ Two to six weeks

☐ Seven to nine weeks ☐ Ten to twelve weeks ☐ More than twelve weeks

27. After participants have completed the core requirements of the project, do they engage in any follow up activity? *

☐ No additional follow-up ☐ Additional one-off follow up

☐ Other follow-up (please specify)

28. What kind of venue is the intervention delivered in? (tick all that apply)

- ☐ Community Centre
- ☐ Pre-school
- ☐ Primary school
- ☐ Secondary school
- ☐ Further /higher educational institution
- ☐ Primary care (e.g. GPs, antenatal)
- ☐ Hospital
- ☐ Other (please specify)
- ☐ Specialist clinic
- ☐ Home setting
- ☐ Outreach
- ☐ Hospice
- ☐ Residential care (e.g. care homes)
- ☐ Within the workplace
- ☐ Leisure Centre

RECRUITMENT, REFERRAL TO PROJECT AND PARTICIPATION RATES

Covers: the process by which those using the project come to use it, local/ national knowledge of the project, completion rates, the number of people who are able to use the service.

29. What is the main referral route? (tick all that apply) *

- ☐ GP
- ☐ Parent
- ☐ School nurse
- ☐ Other (please specify)
- ☐ Teacher
- ☐ Self-referral
- ☐ Social Worker

30. What are the weight-related admission criteria (if applicable)? (tick all that apply) *

☐	NICE guidelines	☐	BMI percentile for age and sex above 97
☐	Waist/hip ratio	☐	BMI percentile for age and sex above 95
☐	Waist circumference	☐	BMI percentile for age and sex above 91
☐	BMI percentile for age and sex above 99	☐	'obese'
☐	BMI percentile for age and sex above 98	☐	'overweight or obese'
☐	Not applicable	☐	Other (please specify)

31. If you have selected any of the following admission criteria in the previous question, is your specific criteria above or below the NICE guidelines? (Please tick the one that applies)

'overweight' as a BMI of 25 to 29.9kg/m2	☐ above	☐ below	☐ same as
'obesity' as a BMI of 30kg/m2 or above	☐ above	☐ below	☐ same as

32. How many project cycles do you run each year?

33. How many participants can the project cover per year? *

34. How many people, on average, participate per year? (Based on most recent

figures)

Average for the previous 2-3 years	
Actual number of participants for 2008	

35. What is the average distance travelled by service users to your programme?

☐ More than 2 miles

☐ Between 1-2 miles

☐ Other (please specify)

☐ A short bus, car or train ride (less than 15 mins)

☐ A short walk (less than 15 mins)

36. Can you indicate how many participants have dropped out from the project?

Average drop out for the previous 2 to 3 years	
Actual drop out rate for 2008	

37. What do you think are the reasons why participants drop out?

☐	Personal circumstances	☐	Motivation
☐	Project appropriateness	☐	Onward referral
☐	Project availability	☐	Other (please specify)

COSTS AND FUNDING

38. Please provide an estimate of the total cost for the project in the last year?

Total project cost (this includes salaries, rent, training, materials and supplies)	£

39. & 41. Could you tell us who funds this project ? (tick all that apply and indicate the amount of funding you receive alongside each source selected. *

FUNDING SOURCES		AMOUNT OF FUNDING
Funding from charities/voluntary organisations	☐	£
Funding from DH	☐	£
PCT funding	☐	£
PCT contributions in kind	☐	£
LA funding	☐	£

LA contributions in Kind	☐	£
School contributions in kind, e.g. provision of venue	☐	£
Other contributions in Kind	☐	£
Payment from family	☐	£
Other	☐	£

42. Please provide the estimated cost of the project, for each component identified below, for the last year (2008)?

COST COMPONENT	AMOUNT
Rent or mortgage for building and facilities	£
Materials and supplies e.g. cookbooks, pedometers	£
Bills e.g. water, electricity, gas	£
Training e.g. staff training	£
Salaries	£
Contracted services (payment to contracted service)	£

43. Do users pay for the service?

☐ Yes ☐ No

If 'Yes', how much do they pay for each session (concessions and non-concessions)?

MONITORING AND EVALUATION

Covers data collection, follow-up, effectiveness, changes to the project and challenges to the running of the project.

44. Has monitoring/evaluation data been collected about the project? *

☐ Yes ☐ Yes, provided

☐ No ☐ Yes, but not provided

☐ In process

45. If, 'Yes' to the previous question, how and where can this data be accessed?

46. Do you collect baseline data?

☐ Yes ☐ No

47. Do you collect follow-up data?

☐ Yes ☐ No

48. How do you measure the success of the project? (tick all that apply) *

☐	Changes in BMI	☐	Knowledge	☐	Attitudes
☐	Changes in waist measurement	☐	Behaviour changes		
☐	Changes in weight	☐	Other (please specify)		

49. Do you obtain service user feedback? *

☐ Occasionally	☐ Regularly	☐ Never	☐ Rarely

50. If you selected regularly or occasionally in the previous question please select the method of feedback. (tick all that apply)

☐	Survey upon completion of course	☐	User groups
☐	Other (please specify)	☐	Informally

51. List 5 factors that contribute to the success of the project.

52. List 5 barriers to success.

53. What do you think are the key positive impacts of the project on the participant? (tick all that apply)

- ☐ High Self Esteem
- ☐ Knowledge
- ☐ Weight Loss
- ☐ Social Cohesion
- ☐ BMI
- ☐ Behaviour changes
- ☐ Changes in waist measurement
- ☐ Attitudes
- ☐ Other (please specify)
- ☐ Changes in weight

EXPRESSION OF THANKS

You are reminded that this review, and in particular data from this review, will remain strictly confidential.

Thank you for participating.