Appendix 1

Obesity Task and Finish Review Group

Monday 17th December 2012.

Present: Councillors Regan (in Chair), S. Richmond and Newall.

Officers: Neneh Binning and Abbie Metcalfe, Democratic Services.

Discussion held at the meeting

Members highlighted the importance of carrying out a piece of work on Obesity:

- Obesity leads to long term health problems such as diabetes and cancer. Therefore tackling obesity at an early stage means such conditions can be avoided, thus creating a saving on the pool of resources set out for long term conditions
- Determining whether there are gaps in services, or where services can work together and provide a more efficient service to the individual seeking support

Members discussed the way forward:

- Look at obesity as a patient pathway scenario, (Members mentioned this to be a good method as it had been used and worked well in the Stroke Project) to identify the support available and gaps in the services.
- Clarity is needed when a person is deemed obese and whether the appropriate support is available to them from the offset.
- Identify guidelines/ definition and bands on determining obesity and when obesity becomes an issue on a person's life.
- Identifying what happens when a person goes to the doctors and is determined obese, are they referred to dieticians, nutritionists, hospitals?
- Look at pregnant women who are obese, what support is available to help pregnant women manage their weight and support them to eat healthy and make healthy choices.
- What is being done to tackle the psychological issues involved in obesity, is there enough support to change habits and determining why people gain such weight.
- Collate information on exercise on prescription, whether there are specific gyms for people with obesity.
- Visits to leisure centres and hospitals to see first-hand what is being done to tackle obesity.

Members acknowledged that with obesity there could be an overlap when looking into issues of children obesity and discussed extending an invitation to Members of Children and Young People Committee to attend specific meetings or make recommendations to the committee once this project is complete.

Members discussed sharing findings with the Clinical Commissioning Group (CCG) to influence their priorities for next year. The Democratic Officer advised that obesity is not currently a CCG priority and offered caution, however suggested if the findings in this piece of work are substantial the option is there for the CCG to look into obesity and develop actions.

Members felt that the initial meeting should involve Public Health and Clinical Commissioning Group. In addition the Democratic Officer suggested that inviting the Darlington Borough Council Officer responsible for the Area Wide Strategy, would be helpful in determining where Darlington is at, on obesity.

Members felt that by collating evidence and forming recommendations, the work of this project could be concluded by April.

Actions:

a) To set up an initial meeting with representations from the Clinical Commissioning Group, Public Health and the Area Wide Strategy.
b) To hold a further meeting to formulate the Terms of Reference and clarify the end objective of this project.

Obesity Task and Finish Review Group

Thursday 24th January 2013

Present: Councillors Regan (in Chair), Francis, McNab, Newall, E A Richmond, S Richmond and H Scott.

Officers: Neneh Binning, Abbie Metcalfe, Democratic Services. Ken Ross, Public Health Specialist, NHS County Durham and Darlington Public Health and Jackie Kay, Interim Deputy Chief Operating Officer, Darlington Clinical Commissioning Group.

Apologies: Chris Sivers, Assistant Director of Development and Commissioning, Darlington Borough Council. Councillors Donoghue and J Taylor.

Discussion held at the meeting

Discussion with Darlington Clinical Commissioning Group

The Interim Deputy Chief Operating Officer gave members an overview of Obesity in relation to Darlington Clinical Commissioning Group and mentioned obesity does not appear as a priority in the Clear and Credible Plan alone but is a priority in connection with other long term conditions such as Type 2 diabetes.

Members were informed that there are preventative measures for both children and adults, with a mixture of services that are locally. Members raised concerns that services needed to be clearly signposted.

Discussion ensued on weight management services, treatments, and exercise classes. The Interim Deputy Chief Operating Officer highlighted the importance of psychological support to modify behaviour and used Slimming World as an example of a referral scheme that incorporated a variety of tools designed to help patients break down habits and change their relationship with food.

Conversation led to children and obesity. Points raised were; family eating patterns influencing children, generation of inactive children, a new culture of dining out and snacking as factors contributing to childhood obesity.

Members queried whether medical factors played a role in gaining weight. It was answered that in general metabolic causes of obesity were rare, however if patients were put on 'very low calorie diets' and failed to lose weight, it would lead to healthcare professionals screening for thyroid problems. It was highlighted that if a person eats more than they burn in energy they would simply gain weight.

The Interim Deputy Chief Operating Officer commented that national programmes and policies do add value such as the 'Change 4 Life' campaign and access to cookery

programmes. Members were informed that the ‘Eat Well, Cook Well’ course had been held in County Durham and had been a success.

Points were raised that education and cooking skills are weak, more knowledge is needed to encourage basic meal preparation to reduce dependencies on takeaway, ready meals and food outlets. Comments were made that a balance needs to be achieved to have cheap, accessible and healthy foods.

The Interim Deputy Chief Operating Officer mentioned cooking programmes that have been commissioned in Darlington have had huge benefits, but highlighted that if facilities provided crèche, child care needs would be met enabling the programmes to be easily accessed. Members were also informed that cooking was no longer on the school curriculum.

Discussion ensued on to Gastric Bands; the Interim Deputy Chief Operating Officer informed Members that when the service was initially set up, it was expected to have 20 patients referred a year. Members recognised some patients have compulsive obsessive disorders which have led to extreme eating habits and require intensive support and surgical intervention. Members were informed that it was a procedure for life (though it can be reversed) and involved the patient having liquidised foods.

Members queried what could be done to tackle obesity. The Interim Deputy Chief Operating Officer established points that needed to be looked at:

- Establish what services are currently being commissioned
- Do those services cover the needs?
- Are the right individuals being targeted?
- Are the programmes commissioned, evidence based?
- Do the programmes support the national food policy changes?

Members discussed behaviour, certain individuals when told they are overweight or obese could feel trapped, become negative, fall in to depression, secret/comfort eat, as people react differently Members established that there was no universal solution.

The Interim Deputy Chief Operating Officer mentioned that the most successful campaign was the banning of smoking in public places which had a major effect on health improvement and was an example of national policy change having an impact on health. Although there is no parallel to obesity, campaigns such as food labelling and school meals are perceived to have a positive impact. The Jamie Oliver Campaign in schools was mentioned in raising awareness and promoting healthy eating in schools.

Discussion with NHS County Durham and Darlington Public Health

The Public Health Specialist informed Members that Adult Obesity has a three tier approach. Tier 1 involves people that are overweight, verging on the obese but able to do something themselves. Health Care Professionals will provide Tier 1 with the right information and sign post them to services such as physical activity and sports development teams. The support needed in Tier 1 is light.

Tier 2 involves a group of individuals that are diagnosed obese or morbidly obese and have co-morbidities, examples given were heart disease, arthritis and diabetes. Tier 2 would be referred to a 12 week exercise referral programme, commissioned by Public Health, to the Dolphin Centre and Eastbourne Sports Complex. Once the 12 weeks have been completed the individuals were given the opportunity to join into a Membership at a discounted rate providing them with an incentive to carry on. Tier 2 also involved family support through the FISCH programme, which works towards lifestyle and behaviour modification.

Tier 3 consists of individuals that are morbidly obese with a BMI over 35. Tier 3 consists of Bariatric Surgery and Gastric Band. The referral criteria require patients to lose weight before surgery for a number of reasons; clinical risks, anaesthetic risks and to test a person's ability to change their eating habits. The patient will be assessed by an occupational therapist and a psychological therapist before surgery and once referred, which is seen as important as after surgery the patient will be expected to change their eating habits.

The Public Health Specialist informed Members that the GPs do have access to pharmacological treatments such as tablets to lose weight, however prescriptions can have side effects, and are only prescribed in controlled ways. Patients in addition will also have to lose weight before access as recommended by NICE Guidelines.

The Interim Deputy Chief Operating Officer added that Nurses are being trained to give dietary advice, with an aim to give consistent messaging to patients and sign posting to adequate services. Members were informed that dietetic services are important alongside co-morbidities such as diabetes and heart disease as the health care professionals will look at the patient's diet.

In relation to childhood obesity, the measures in place are family interventions, where diets and activities are measured and improved with health care professional's over a 12 week programme. Tier 3 is not accessible for children, there are no surgical treatments for children, instead a referral is made to a specialist paediatric teams who then intervene.

The Public Health Specialist highlighted that certain schools follow the 'child measurement programme' and are duty bound to inform parents the results. Certain

children can be classed over weight but can still be physically fit. Problems tend to surface during adulthood.

Members queried how activities and programmes were promoted to make families aware of services. Members were informed that an IMPACT register was being developed, an online register that outlines various activities. The current form of promotion is advertising registers of activities in libraries and schools.

Members were informed of the drafting and development of a Physical Activity Strategy in Darlington which has input from leisure services within Darlington and works towards decreasing sedentary behaviour. The Strategy will go out to consultation in March to be implemented in autumn.

General Discussion

Members discussed the following points, health awareness in the work place, how the town is planned out to be activity friendly, and whether a person's environment allows them to make healthier choices. In relation to patients with co-morbidities the Members questioned whether these patients are being appropriately diagnosed and referred.

Members discussed reasons why individuals become obese and concluded that the reasons were multifactorial, such as industry promotion of food and drink and lifestyle choices of parents which then influence children.

Members felt information should be gathered from the Assistant Director of Development and Commissioning to understand how the Single Needs Assessment and Health and Wellbeing Strategy incorporate obesity.

Members made the following points for further clarification:

- What are the services available
- How are these services identified
- Which providers are commissioning the current services in place

Actions

Members agreed with the Democratic Officer on a way forward for the project:

- To hold a meeting on childhood obesity, inviting the Children and Young people Committee, and have representations from experts on childhood obesity.
- To arrange a meeting with Head of Cultural Services, and affirm Health Referral Programmes within the community and gather information on the Physical Activity Strategy.
- To hold a meeting with representatives from psychological therapies and determine the psychological aspect to obesity.

- To hold a meeting with a representative from County Durham and Darlington NHS Foundation Trust and determine the surgical element of obesity and referrals being made.
- To establish and make contact with the GP lead on obesity and determine whether there is a method of common screening and whether there are patterns in practices through Darlington.
- To establish what the FISCH programme involves and what the IMPACT register contains.
- To seek information from the Assistant Director of Development and Commissioning, on how the Single Needs Assessment and Health and Well Being Strategy incorporate obesity.
- To seek information from the Dolphin Centre Catering Manager and establish whether the Councils catering menus incorporate and cater for healthy options.

Childhood Obesity Task and Finish Review Group

28th February 2013, 9.30am, CRM2

Councillors: Councillor S Richmond (Acting Chair), Councillors Donoghue, J Kelly, McNab, Newall, E A Richmond, C Taylor and J Taylor.

Officers: Neneh Binning, Democratic Officer – Health, Karen Graves, Democratic Officer, Democratic Services, Ken Ross, Public Health Specialist, Public Health Team, Mike Crawshaw, Head of Culture, Emma Reah, Sport and Physical Activity Development Manager, Yvonne Coates, Head of Family Support, Services for Children and Jenni Cook, Services for People, with responsibility for Children and Families.

Apologies: Councillors; Hutchinson and Regan (Chair). Alison Raw, School Games Organiser.

Public Health overview on Childhood Obesity

The Public Health Specialist explained that the Single Needs Assessment of Darlington will continue to cover childhood obesity heavily as it is recognised as a key public health issue. Childhood obesity disproportionately affects the community in Darlington, with prevalence in deprived areas than affluent areas of the community.

The physical and social issues of childhood obesity were explained as:

- High blood pressure
- Glucose intolerance
- Diabetes
- Muscular skeletal
- Genetic components
- Self esteem
- Bullying
- Separation from peers
- Eating patterns
- Environment (e.g. access to facilities, playing areas)

It was highlighted that childhood obesity could also be linked to having obese parent/s.

Conversation ensued on the family factor, it was recognised that resource for modification and improvement should be focussed here. Food within families can be used as a mechanism of control and that parents do not necessarily see their children as overweight. Members were informed that obesity, in one sense, is a form of malnutrition as it is too much of one thing and less of another.

Other reasons for childhood obesity can be lack of physical activity, with increased levels of sedentary behaviour in families, for instance depending on the car more.

Members were informed that excess weight in childhood leads to health problems in childhood, in adolescence, increase problems into adulthood and throughout the remainder of a person's life.

There are none physical factors in adults, such as poor self-esteem, abnormal body image, weight begins to dictate social interaction, self-exclusion from jobs, and negative perception.

Talk ensued on diabetes, members were informed the pancreatic function slows down with age but diabetes was relatively unusual with children.

The Public Health Specialist informed members of the National Child Measurement Programme and how that will continue under the Local Authority as of the 1st April 2013.

Obesity rates over the reception age and year 6 are varied. Obesity tends to be lower during reception years and increased by year 6. Darlington was not significantly different to England or the North East. Nevertheless it was highlighted that there tends to be a strong correlation between obesity and deprived areas and less association with affluent areas.

Cultural factors were briefly mentioned, ethnic minorities tend to have a much healthier different diet, and when they become accustomed to the western diet it has a detrimental effect to their diet and body weight.

The Public Health Specialist stated it was key to look at maternal obesity. Where women are obese during pregnancies, it could lead to complications during birth, and more importantly affect the health of the child growing up as proven by literature.

It was suggested that work be undertaken with schools as they are heavily involved in a child's life and have the power to influence the child's behaviour, such work can be promoting the healthy schools status, and influencing the breakfast club, cooking courses and adequately training staff. Members acknowledged the school Nurses role in the child measurement programme and comments were made that intervention can be undertaken through PHSE.

Work needs to be undertaken to encourage physical activity to reduce sedentary behaviour looking at the holistic obesity generic environment. When children become obese the intervention and services in place are:

- Referral to the community pathway
- Referral to secondary care

Members inquired whether there are any best methods to motivate parents to act upon making their child healthy. The Public Health Specialist stated that the family unit is looked at as a whole in order to have positive engagement. Mass media highlights that parents do not often see their child as obese and the reasons why are complex. The Head of Culture added that the national measurement programme would highlight to families health issues of their child but that parents need to recognise the results and engage with the School Nurses.

The Public Health specialist defined obesity as a symptom or an outcome of a set of circumstances and behaviour.

Member's queried whether medical factors play a role in obesity. The Public Health Specialist stated that medical and genetic factors are screened for however everyone is different; a person can have a high BMI yet still be physically fit. Regardless, before intervention, children will be screened for medical issues.

Members questioned whether influence can be made in childrens packed lunches. The Head of Culture explained that the Council are currently responsible for providing school meals for 17 schools in Darlington and that pattern has changed dramatically and commented that the best move had been moving to a single choice menu. However the schools are fighting a billion pound industry. What influences parents purchase power is their income.

Projects and Programmes tackling childhood obesity

The Head of Culture and the Sports and Physical Activity Development Manger guided Members through a presentation.

The Head of Culture outlined that there was varied range of projects in communities and were needs led. Some projects were part of wider sub regional or national projects.

The Sports and Physical Activity Development Manager outlined that the team supported local clubs with grant funding and applications as many of these clubs were voluntary. As a Council, local authority sports facilities, sports development led session, local clubs and swimming lesson were offered, and where there was a gap there is normally a voluntary organisation offering a particular type of activity. The role of the team is to work in partnership with voluntary organisations in providing health improvements.

The Head of Culture outlined that there was a high demand for children swimming, with 2000 children accessing swimming lessons at the Dolphin Centre each week and highlighted that 700 were being taught key stage 2 swimming and 90% of that figure were swimming 25m by the age of 11.

It was highlighted that one school had a class of 28 pupils, 24 of which could not swim, which showed that not all children can access swimming.

Members were informed of the Sixty Active Minutes (SAM) programme. SAM works with schools to encourage children and families to gain the Governments recommended Sixty Active Minutes. SAM works with the Dolphin Centre, Eastbourne Sports Complex and in the community to encourage families to adopt the initiative.

In terms of holiday programmes, last year 630 children engaged with 20 activities across a variety of venues through the six week holiday. Costs were kept extremely low with activities from £1 or a membership of £15 for 4 weeks' worth of activities. The programme involved working with a variety of clubs through the community.

The Head of Culture highlighted the School Games Organisers role, in supporting and influencing school festivals, interventions, the breakfast club and providing 20 sports engaging children that would not necessarily be into sports. Recently the Darlington Dance festival was held at Darlington Civic Theatre in conjunction with pupils from 24 schools, where children were involved that didn't participate much in other activities.

The Sports and Physical Development Officer outlined the FISCH programme where school years 4 and 5 (aged 8-10) across County Durham and Darlington, deliver a programme aimed at obesity intervention. The programme is a ten week course and includes psychical activity and theory-based sessions in relation to healthy lifestyles. An additional physical activity session is available either before or after school, every week. There is an option for 1 to 1 support with the family through the programme.

Families could be referred into 'Mind, Exercise, Nutrition, Do It', a family and community based programme for overweight and obese children aged between 7-13 years old. The programme includes family involvement, practical education in nutrition, physical activity and behavioural change. The programme is a national programme based on imperial evidence and involves families setting a target to work towards together.

The Head of Culture outlined 'Sportivate' a £32 million lottery programme that gives 14-25 year olds access to a six week course in a range of sports. The programme has resulted in 162 young people remaining in sports (evident in data attained over 2012/13.)

Obesity Review in 2010

The Head of Family Support briefed Members of a review held in 2010 in the Northgate Corridor, the review engaged schools, families and children centres in co-operating with the measurement programme and promoting breast feeding.

- Work was underway to involve ethnic communities and staff was recruited from those communities to encourage partnership working.

- In 2012/13 the review integrated with school nurses to tackle obesity in children.
- The healthy star rating was promoted in children settings giving groups incentives to work towards. Work was to encourage community cooking programmes, food educations and physical activities.
- Young people, who could not afford gym membership, were asked to join the initiative and on completion, their gym membership was funded.
- Benefits were evident; there were integrated workings between health visitors and schools, which enabled families and children to be targeted.
- The review also looked at gaming and involved taking children outside and understanding the gaming culture.
- The Ofsted inspection on Haughton School illustrated that healthier snacks were available and praised upon.
- In relation to Children Centres such as Dodmire and McNay Street, practitioners were encouraged to teach families and children how to exercise in smaller spaces as most families did not have gardens.
- The role of Health Visitors will be changing so there should be more work on intervention with families in the future.
- The Local Authority will have responsibility over School Nursing as of the 1st April 2013, with the anticipation that responsibility of children aged 0-5 will become the new responsibility as currently managing responsibility for 5-19 year olds.

Actions

a) That the notes from the meeting be typed up and circulated to Members and Officers.
b) That the Officers be thanked for their attendance.

Obesity Task and Finish Review Group

28th February 2013, 1pm, CRM3

Councillors: S Richmond (in Chair), Francis, Regan, E A Richmond and J Taylor

Apologies: Councillors McNab and H Scott

Officers: Neneh Binning, Democratic Services, Mike Crawshaw, Head of Culture, Emma Reah, Sports and Physical Development Manager and Ken Ross, Public Health Specialist

Sport and Physical Activity Development

The Head of Culture and Sports and Physical Activity Development Manager led Members through a presentation on sports and physical activity development.

Statistically ¼ of the adult population in Darlington were registered physical active. Members were informed that participation in sports (3 x 30 minutes a week) for sport and recreation for Darlington was at 24% which was above the England average in 2012. Darlington was also higher than the North East average.

The Head of Culture explained that such registered activity could consist of non-formal activity such as walking to undertaking classes.

Comments were made that affluent wards tend to exercise more than less affluent wards. Members questioned why rural wards were able to do so. The Head of Culture outlined that there was no rational to the study undertaken, merely participation monitoring, but through social economic factors it was evident that there are health inequalities. The Sports and Physical Activity Development Manager highlighted that those living in rural areas would tend to have own transport enabling them access to physical amenities through travelling.

Comments were made that social deprivation was more inherent in deprived areas and data illustrated Easington and Hartlepool having lower physical activity levels.

Members were informed that 48% of Adults are inactive. The missing percentage may be doing activities however it was less than the standards of 30 minutes, three times a week. Health costs of inactivity are approximately 1.5 billion per annum. Conversation also covered factors such as the ageing population and the 13 year mortality gap illustrating health inequalities within the Darlington community.

The Public Health specialist added professionals have become better in recognising and measuring obesity. With appreciation that male and females have differing

genetics, the risk for women in suffering from coronary heart disease are more predominant during meno pause.

The implications of sedentary lifestyle are contributing to health implications such as coronary heart disease, stroke and Bariatric Surgery.

The Sport and Physical Activity Development Team cover varied range off projects and work areas. The ethos is to work closely with partners from all sectors. Promoting the sustainability of facilities and services and community based projects and venues. Other projects are part of a wider sub-regional or national projects.

Talk moved to the Dolphin Centre which attained 900,000 visitors in 2012 of which 96,000 visits to the Dolphin Centre Gym, 250,000 recreational swims and 6,000 Exercise Referral Visits. The Dolphin Centre is home to 47 clubs and societies.

Members were further informed of Eastbourne Sports Complex which attains 180,000 visitors in a year and is a hub for community sports clubs such as:

- Hundens Greens Association
- Quakers running club
- Darlington Hockey Club
- Middleton Rangers FC
- Gateway Wheelers

Members were informed that the complex was also a disability sports hub and very accessible. The complex was host to services such as exercise for stroke referrals and other disabilities, because the venue had more controls in place.

Conversation moved to exercise on referral, which is being delivered from the Dolphin Centre. 250 referrals are being made monthly, by GPS's Nurses and other Health Professionals. The programme involves 12 week supported exercise, with programmes tailored to the individual. Trained staff are supporting individuals to being able to exercise by their self. The Head of Culture noted that such referrals should not be too gym based and take into account other forms of exercise such as swimming and walking.

Exercise on referral adheres to best practice set by the NICE Guidelines and further guidelines set by the British Heart Foundation. The exercise on referral is a medical model, patients will not just be inactive but also have a condition such as diabetes and the pathway will be more defined in the future to concentrate resources on those with strong need for the service.

Members were informed that it was difficult to engage with female's post 16, as once they are out of the high school environment; there was a noticeable drop in their

physical activity participation. Work is underway with Sports England to find a way of tackling the post 16 drop off.

The IMPACT register was briefly mentioned as a tool for health professionals to refer patients to services and also for individuals to locate activities in their area. The Public Health Specialist mentioned that as of the 1st April 2013, the register will come back to Local Authority control and will maintain record of food and health, voluntary recreation, mental health wellbeing. The register will be the main point of access for someone who wants to become more active.

The Sports and Physical Activity Development Team were also helping groups within the community to obtain funding from Sports England, to develop the groups facilities. External successes were:

- Darlington Indoor Bowls Club (£50,000)
- Rockliffe Cricket Club (£50,000)
- Archery (£4,000)
- Cycling (£10,000)
- Age UK Swimming (£10,000)

Pending applications were:

- Bowls (£10,000)
- Carmel School (£50,000)
- Darlington Gymnastic Club

Other community based sessions being held were:

- Nordic Walking
- Walking Groups
- Adult Trampolining
- Running Groups
- Recreational Badminton

Members were informed of the Physical Activity Strategy which is being developed corporately and will be culminated over the next few months, outlining Darlington's priorities for sport over the next 5 years. The Strategy will outline what the commissioning priorities for sport should be. The Head of Culture commented that this would be an issue for senior management and Members.

Members questioned how else activity is being promoted. The Head of Culture emphasises that activities were promoted within the town crier, northern echo, on the Councils websites and through social media.

Employee Health and Well Being Update

The Health and Well Being Development Advisor informed Members on work place health promotion. Work involved encouraging staff to live healthily and involved partnership working with the NHS, Public Health and other organisations.

Members were informed that Darlington Borough Council was awarded both the Silver and Gold level of the Darlington Investors in Health award in 2012 and has provided a number of initiatives to try and encourage staff to adopt healthier lifestyles some of which are outlined below;

- NHS Health Trainers provided free mini heath checks at the Dolphin Centre, Eastbourne Sports Complex and Vicarage Road where staff could drop in and have their height, weight and blood pressure taken. Information was also provided on eating a healthy diet and the importance of regular exercise. From these sessions some staff were also offered more in depth follow up appointments at Doctor Piper House. The NHS does not charge the Council for providing this service.
- Campaigns such as Stoptober encouraged smokers to give up smoking for 28 days and provided information on smoking cessation support services. A smoking cessation adviser talked to groups of staff about giving up smoking and help available.
- The Council has also implemented a revised Work Place Stress Policy and Procedure which emphasises the need to be open and honest about stress (and other mental health issues). A leaflet for staff accompanied the policy which outlined the Council's approach to dealing with work related stress and also included information on how to seek help and advice. A training programme for Managers supported the policy which over 170 managers have attended.
- The Council worked with the NHS and the Darlington Partnership on an alcohol survey where staff were asked to answer questions on their own drinking patterns and their perceptions of what other adults their age drank. 587 members of staff completed the survey (individual responses where confidential and anonymous) and feedback on the overall results will be provided shortly. Again there was no cost to the Council in participating in the survey.
- A health and well-being site on the intranet is available for staff and provides links and information on a wide range of health and wellbeing issues.
- With the start of 2013 the Alcohol Concern campaign Dry January was launched which encouraged staff to stop drinking for the month of January and provides links to information on safe levels of drinking, the affects that alcohol can have on health and how to access help and support regarding any concerns about your own or somebody else's' level of drinking.

- Staff will have opportunities to work with the NHS to promote awareness of mental health issues later in the year

Members queried how effective health promotion was on absence and sickness. The Health and Well Being Adviser stated by working with Managers, encourages staff to become more active and adopt healthier lifestyles. Members were informed that Darlington Borough Council employees compare well with other authorities; however more work can be done to manage sickness.

Actions

a) That the notes from the meeting be compiled and sent to Members.
b) For Barbara Dent (Breathe Easy Group) details to be forwarded to the Sports and Physical Activity Development Manager

Obesity Task and Finish Review Group
Wednesday 6th March 2013

Present: Councillors S Richmond (in Chair), Donoghue, Francis, McNab, Newall, E A Richmond and J Taylor.

Officers: Neneh Binning, Democratic Services, Mr Akeil Samier, Consultant Bariatric and upper GI Surgeon, Darlington Memorial Hospital, NHS Foundation Trust.

Meeting with Bariatric Surgeon

Mr Samier guided members through a presentation on obesity and bariatric surgery and outlined that obesity can be the following:

- Life long
- Progressive
- Life threatening
- Costly
- Genetically – related
- Multi factorial disease of excess fat storage
- Can be associated with multiple co-morbidities

Morbid obesity is clinically severe obesity with a Body Mass Index (BMI) of 40 and above. Medical conditions become the direct result of obesity and those with obesity can die due to their weight.

In terms of distribution of obesity Members were informed that the UK has a population of more than 51% obese. The government's targets for tackling obesity are in danger of not being met. In 2008 25% of the population in the UK was obese. UK is now one of the 5th largest rate of obesity amongst developed nations. It is predicted that by 2050, 60% male and 50% female will be obese.

Mr Samier explained the reasons for why people are obese:

1. Portion sizes have increased, an example given was, 20 years ago the average cheese burger contained 333 calories, now the average cheeseburger contains 590 calories
2. The change in lifestyle is that more people are living sedentary lifestyles, Mr Samier stated there was enough evidence to example car driving as a lead to weight increase
3. Neuromarketing, double shelf spacing has led to 40% increase in sales in shops and supermarkets

Mr Samier outlined factors contributing to obesity, lifestyle changes such as poor diet, skipping meals, alcohol and snacking. Psychological contributions to obesity were

depression, anxiety, stress, low income and social events. The Biomedical contributions highlighted were genetics, metabolism, injury and mobility issues.

The following classification was outlined:

- Normal BMI 20-24.9
- Overweight 25-29.9
- Obese 30-34.9
- Morbidly Obese 35-40
- Super Morbid 40-50

Members were informed of the obesity consequences on the cardiovascular system, such ailments such as hypertension, stroke, deep vein thrombosis, and congestive heart failure were some of the examples. Furthermore obesity consequences on the endocrine system were pancreatitis and diabetes. Death due to diabetes was much higher than the risk of death due to breast cancer.

Obesity consequences on the respiratory system were outlined, asthma, Obesity Hyperventilation Syndrome and sleep apnoea.

Obesity consequences on the immune system were identified as cancers in the areas of breast, pancreas, prostate, liver, colon and kidney. Mr Samier outlined that there was enough evidence to determine obesity can cause the cancers above.

Further consequences outlined were, musculoskeletal, osteoarthritis, problems with the digestive system, problems with the reproductive system and urinary system.

Maternity Obesity was greatly highlighted causing risks of still birth, neonatal death, low breast feeding rates, Fetal distress, and development of childhood obesity.

Talk ensued on childhood obesity, and it was outlined that an obese six year old has a 25% chance of becoming an obese adult and an obese 12 year old had a 75% chance of becoming an obese adult. Mr Samier emphasised the importance of preventative work being carried out with the mentioned age groups.

Obesity in adults is rapidly increasing, comments have been made that public health successes in recent years may be endangered if lifestyle of the elderly are neglected. Obesity in nursing homes is seen as an escalating problem.

The financial implications were outlined:

- In 2005 the treatment of obesity was costing £7.5 billion, with 18 million lost working days.
- Furthermore the cost of benefits was £80 million, as obese people were determined unfit to work.

The psychological issues related to obesity were determined by factors such as social isolation, unemployment, decreased sexual life, low self-esteem, depression and anxiety.

Evidence suggests influence of obesity on mortality of drivers in severe motor vehicle accidents.

Risk of death for a BMI over 30 is 50% higher than the risk of death for a BMI of 20-25 with a BMI of 35 the risk is more doubled. In 2004 over 34,000 deaths were due to obesity, 9,000 of which were premature to retirement age.

Mr Samier did state that it was not easy to lose weight and depends on wide range of factors such as psychological issues, the environment and food availability. Furthermore it was highlighted that the body's capacity to burn weight reduces by 10% per year, therefore, weight gain is expected even if a person diets and exercises.

Members were informed that the NICE obesity guidance 2006 state that obesity should be treated like any other medical condition and patients should have access to appropriate treatment and care.

The medical treatment of obesity was outlined as having:

- poor compliance
- limited licences
- weight yoyo-ing can be associated with increased cardiovascular risk
- expensive
- limited weightless of 5kg-10kg
- side effects
- weight regain

Mr Samier outlined that surgery has proven effective over the long term for most patients with clinically severe obesity. This has been endorsed by the National Institute of Health, The American Medical Association and the National Institute of Diabetes and Digestive and Kidney Disease.

Diet and exercise are not effective long term in the morbidly obese category; surgery is an accepted efficient approach. Medical co-morbidities are improved and some resolved. Where someone is clinically obese and has for instance diabetes, there is a cost saving initiative that losing weight trough surgery would eliminate diabetes, therefore saving money on treatment for diabetes.

Members were shown illustrations of surgical procedures. Gastric Bypass and is more frequently used and allows up to 70-95% excess body weight loss, the procedure means that the patient stays in hospital for two days and then is fit to go back to work.

Another procedure mentioned was the Sleeve Gastrectomy, which involves cutting off ¾ of the stomach. The procedure allows for a 50-65% excess body weight loss and would mean the patient remains in hospital for two days. This procedure is not beneficial for the sweet eater but more appropriate for patients who volume eat.

Members were alerted to the Intra Gastric Balloon procedure (an endoscopic procedure) where a balloon filled with fluid is placed in the stomach. The procedure is used as a means for the patient to lose weight before bariatric surgery. The procedure allows for up to a 40% weight loss. If the balloon burst then the patient's urine would change colour and the balloon would then be removed. Mr Samier highlighted that the NHS would only pay for this procedure for patients with a BMI of over 60. The cost of a balloon was £700 per 6 months. The Intra Gastric Balloon was not a solution as when removed patients can put weight back on.

The final procedure outlined was the gastric band, which was proving bot so popular with the introduction of other bariatric surgical procedures now available. The gastric band is reversible procedure and the patient is able to go home the same day. The loss with the gastric band is between 40-55% excess body weight.

Mr Samier outlined a procedure that he is working to introduce in Darlington known as Endobarriear, which would have the same effect as a gastric bypass (which costs £6,000), and would cost £3,500. The procedure involves the use of a plastic sleeve and is for people who are deemed not fit for surgery. The procedure would also save on diabetic medication.

Factors that are taken into consideration when determining which operation is best for the patient:

- Eating patterns
- Relief of co-morbidities
- BMI
- Complications
- Media Influence
- Long Term Outcome
- Quality of Life

The Bariatric department have set strict criteria for surgery and failure to adhere will mean that a patient would be discharged from the service. Patients must:

- Lose 5-10kg
- Not miss an appointment
- Change lifestyle
- Exercise

- Eat regularly
- Avoid sweets
- Not smoke

Providing the patient complies with the above criteria, the bariatric department would permit surgery.

Conversation ensued on the mortality risk with bariatric surgery and Mr Samier explained that the mortality risk was very low, as the BMI is brought down the risk is reduced dramatically. Bariatric Surgery is proved safer than many other operations such as Gastrectomy, Mitral Valve Replacement and Pancreatectomy.

Mr Samier concluded the presentation by stating that obesity is a significant growing issue and that Bariatric Surgery improves the Quality of Life by curing co-morbidities.

Members questioned whether there was a clear plan to tackle childhood obesity. Mr Samier outlined there was no clear surgical advice on how to tackle childhood obesity but as a consultant felt that surgery should not be used on young children as it would be too aggressive. Instead preventative measures should be focused upon such as changing the child's environment, educating the family, working with schools to influence changes to their vending machine and campaigning for takeaways to be away from schools.

Members queried how genetic symptoms could be tackled. Mr Samier highlighted that there was enough evidence to suggest that where there is an obese parent there is a likelihood of child becoming obese, and stated that children need to be approached earlier and made a comparison to breast cancer, that where there is a history of breast cancer in the family, the women are targeted much earlier and this approach should be adopted with obesity.

Mr Samier emphasised that with adults there should be medical and preventative treatments to tackle obesity and with children work should be focussed on prevention much earlier.

Members queried aftercare of surgery. Mr Samier outlined that there is a 2 year follow up procedure, in the first year the patient will be seen every three months and in the second year the patient will be seen twice. Following that 2 year period the patient will then be followed up by the GP, once a year for the remainder of the patient's life. If there are any problems later detected or arising then the patient will be go straight to the bariatric department. Mr Samier did state that the after care in private practice had no proper lifelong follow up.

Mr Samier did mention that he is working hard in building good relationships with GPs and do hold events to update GPs twice a year as they are at the forefront of engaging

with patients. The aim of the meetings is to promote awareness of the seriousness of obesity and for GPs to recognise obesity where it needs to be tackled earlier. As GPs will also know of patients families such as children, the GP can also be the forefront of tackling childhood obesity.

Psychological Element to Obesity

Mr Samier stated that the psychological element was part of the pathway for obesity. Where people fail to lose weight the GP would refer the patient to the Bariatric's Department, the patient would then fill in a questionnaire and part of that questionnaire assesses the patients mind frame, for instance whether they have self-harm thoughts and low self-esteem. The patient would then be referred to a psychologist who will assess if the patient is medically ready for intervention.

The psychologist has a key role before and after surgery and would assess the reasons of why a person puts on weight, for instance the cause of their stress or the effects of a person's environment.

Members questioned whether there was risk of patients becoming underweight. Mr Samier stated it was very unlikely however there is some recognition that a risk would be with women, having more self-image issues and again the psychologist would work with the patient to tackle this. If the GP felt as part of the follow up that this was the case then the GP can also refer the patient to the psychologist.

Mr Samier emphasised that when patients come to Bariatric Surgery it is generally after they have exhausted other methods of losing weight and at this point are motivated to have surgery to lose weight.

Members were informed that initially the service expected 100 referrals per annum but now are seeing 40 referrals a month.

Members queried how they could help and Mr Samier highlighted that relationships needed to be built with GPs and work towards preventative methods especially with children.

Actions

a) That Mr Samier be thanked for his attendance.
b) That the notes be compiled and circulated to Members in due course.
c) To make contact with Patrick Holmes.

Obesity Task and Finish Review Group
Wednesday29th May 2013

Present: Councillors Regan (in Chair), Donoghue, Mcnab, E. A. Richmond, S. Richmond and H. Scott.

Officers: Dr Coleby, Tees, Esk and Wear Valleys NHS Foundation Trust and Abbie Metcalfe, Democratic Services

Dr Coleby explained that the patients she usually works with have Body Mass Index (BMI) of under 15 who suffer from eating disorders and acknowledged that there was a commonalty between over eating and under eating and the issues that people have with relationship with food and the physical impact.
The range of BMI was explained as follows:-

18.5 under – underweight
18.5-25 – Normal Weight
26-30 – Overweight
31-35 – Obesity – class 1(more likely to develop Diabetes and other long term conditions)
36-40 – Obesity – class 2 (more likely to have serious impact of joints)
40+ – Morbid Obesity (more likely to have co-morbidity issues and require bariatric surgery)

Members discussed the classification of obese and comments were made about sports people who are considered obese due to muscle and the amount of food they consume to maintain their psyche.

The services that TEWV provide are in relation to patients with co-morbidity and difficult relationships with food. It was noted that many people have issues with food and putting weight on there are usually two types of weight gain. 'Normal weight gain' where the weight creeps on through unhealthy eating, being contented, etc and its dependant on lifestyle choices. The other type is the emotional relationship people have with food, due to anxiety, depression and people become sometimes become reliant on food. Food becomes a coping strategy and people eat to provide comfort or distraction. There are also societal changes which have had an impact on obesity as people rely on convenience food, no longer walk places and their physical activity is limited.

Quite often short term success is common and support and coping strategies are used, but patients often fail and end up requiring more intervention. Success will be achieved if patients have support from their loved ones and the community. People often want more support and are motivated at the beginning of the weight loss programme but sometimes become disengaged and disheartened if weight loss isn't as rapid as they believe it should be. There are limited resources and 12 sessions are available to support patients, the pathway also includes exercise programmes and offers

participants mutual support and camaraderie. Patients may stagger the sessions over weeks or months depending on their level of need and support required.

There are GP Practices in Darlington, where Practice Nurses lead on weight management and offer weight management support such as dietary and physical activity advice. It was highlighted that there is a gap in the level of services available between advice services and specialist services there was nothing in between. General lifestyle advice is available and there is an opportunity to be weighed on a regular basis.

Interestingly it was noted that at least 50% of women referred for bariatric surgery have gained weight and have had some experiences of sexual abuse in the past. A psychological assessment is carried out prior to bariatric surgery and also afterwards. After the surgery, coping techniques are explored to prevent them from continuing to eat to the level that they have been. Its aim is to ensure that patients do not return to the bariatric surgery and reasons behind their eating behaviours are explored and self-soothing skills are taught. Members were reminded that gastric bands are unsuccessful if patients return to their old eating habits and do not change.

Dr Coleby explained that humans are biologically programmed to store fat from sweet foods and people eat sweet foods to do this. The trick is to have a balance and by allowing treats within your diet as it stops being a secret and prevents binges. It was believed the culture of receiving treats comes from childhood and receiving treats/sweets as children from parents/care givers. Anxiety around relationships with care givers and food is sometimes an unconscious issue and it can be triggered at any time. References were made to the similarity between eating and smoking.

Abstainece is difficult when it comes to food as everyone needs to eat the issue is healthy eating. Caution needs to be taken around short term and long term harm that food can do there are current press articles suggesting that there is a link between childhood obesity and neglect.

Motivation for eating and for health reasons there may not be that they value importance or self-effort/power/benefit and control. Short term gain will look better and there is still the issue with large people and excess skin after dramatic weight loss is achieved.

Members discussed access to services and how GPs can sign post patients, if patients regularly visit the same doctor. Members believe that there is a lack of community support and more needs to be done to prevent long term weight issues and prevent people getting to the stage where they require bariatric surgical interventions.

Actions

a) That Dr Coleby be thanked for her attendance.
b) That the notes be compiled and circulated to Members in due course.
c) That Members submit any further questions/queries to the Democratic Officer as soon as possible.

d) That the Democratic Officer work on the Final Report of the Task and Finish Review Group and circulate it to Members as soon as possible.

TERMS OF REFERENCE

Title: Obesity Project **Start Date:** January 2013 **End Date:** 31st March 2013

Scrutiny: Health and Partnerships Scrutiny Committee

PURPOSE/AIM	RESOURCE
To consider the obesity pathway from initial diagnosis to ultimately receiving bariatric surgery, scrutinise the provision and services available and highlight any gaps.	Democratic Services Head of Cultural Services Director of Public Health Darlington Clinical Commissioning Group (CCG) County Durham and Darlington NHS Foundation Trust (CDDFT) Children and Young People Scrutiny Committee Catering Manager – Dolphin Centre Assistant Director of Development and Commissioning
PROCESS	**OUTCOME**
1. To receive an overview of the obesity pathway from representatives of The County Durham and Darlington Foundation Trust. 2. To consider the CCGs commissioning intentions around obesity 3. To consider the Councils services in place to combat obesity. 4. To critically assess whether there are any gaps in the provisions of services/support and after care. 5. To meet with a representative from the Work Place Health Promotion Team to discuss health promotion at work 6. To Meet with the Head of Cultural services and discuss the	1. To understand the levels of provision available. 2. To promote and raise awareness of services available in Darlington that encourage a healthier lifestyle 3. To have an understanding of the psychological elements to obesity 4. To establish the surgical and non-surgical treatments available for obesity

Physical Activity Strategy and the exercise programmes conducted in Dolphin Centre and Eastbourne Sports Complex from referrals for Patients 7. To meet with a Bariatric Surgeon to determine the number of patients referred to surgical methods for weight loss and the support and effectives post-surgery, 8. To have a combined meeting with Children and Young People Scrutiny Committee and meet with representatives from to determine facts around childhood obesity, the child measurement programme and how obesity is tackled in schools, the FISCH Programme and IMPACT register. 9. To establish from the Catering Manger how healthy eating is incorporated into catering	

COUNCILLOR ……………………………………………… CHAIR ………………………………..