VERSION 7:15/4/13

health & wellbeing
looking after our borough

Tackling Obesity – A Framework for Action

INSPIRING A HEALTHY GENERATION

2013-2017

Dudley Metropolitan Borough Council

NHS
Dudley Clinical Commissioning Group

Forward

Enjoying good health and feeling well is important to everyone

Councillor Zafar Islam, Cabinet member for Health and Wellbeing, Chair of Dudley Borough Health and Wellbeing Board.

From April 2013, Dudley Council will take responsibility for the health & wellbeing of its residents, with the establishment of the Dudley Borough Health and Wellbeing Board to oversee and monitor progress. The Board brings together Dudley Council, the Dudley Clinical Commissioning Group, Healthwatch Dudley, the NHS Commissioning Board and partners in the voluntary and community sector. By working in partnership we want to reduce health inequalities in the borough and make sure Dudley is a place where everyone can feel well and have the best health possible through every stage of their lives.

Tackling obesity is a priority for the Board and all of its partners as it can cause a number of health issues such as diabetes, high blood pressure, high cholesterol and it can reduce life expectancy. **Our vision is to** create an environment and culture where adults and children in Dudley Borough have the opportunity to maintain a healthy weight. **Our aim is** to halt the rising trend in obesity in adults and to reduce the levels of child obesity by making changes to the environment and by encouraging people to have healthier lifestyles.

Tackling obesity is everyone's business. We can all do something to reduce the levels of obesity in the borough, personally and professionally, and I urge you to sign up to this strategy and look to contribute in any way you can.

Contents

1. INTRODUCTION

Obesity reduction has been a long-standing priority for Dudley Borough. In November 2004 a multi-agency Obesity Task Group was set up to develop an obesity reduction strategy for Dudley, and 'Tackling Obesity - A Framework for Action in Dudley' (2005-2010) was launched in July 2005. The strategy was broad based introducing a tiered framework for action across the continuum of prevention and treatment, which was integrated into key local plans and strategies and has resulted in the implementation of a number of new interventions and services.

2005 Framework for Action in Dudley Borough:

Tier 1: Can people choose healthy options: making it easier for people to make healthy choices by developing a supportive physical, social and cultural environment.

Tier 2: Do people want to choose healthy options? : working with individuals, communities and populations to develop knowledge, skills, attitudes and social norms that encourage people to actively choose healthy lifestyles.

Tier 3: Can people reduce their risk: support for people who are already overweight or obese to help them lose weight and reduce their health risks.

During 2011 an Obesity Health Needs Assessment was conducted and reviewed the vision and framework of the local strategy, the policy context, the national and local data on obesity, stakeholder views, the services and interventions that had been implemented locally and evidence of emerging interventions. The recommendations from this have been used to develop this updated Obesity Strategy and improvement plan for 2013 to 2017.

Obesity reduction remains a national priority. There have been a number of national reports and policy guidance published since the original 2005 Obesity Strategy was developed.

- The Foresight Report (2007) which modelled obesity prevalence at current rates to 2050.
- Healthy Weight, Healthy Lives- A Cross Government Strategy for England (2008)
- National Institute of Clinical Excellence: The Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children (2006)
- Healthy Lives, Healthy People – Our Strategy for Public Health in England (2010)

In 2011 the Coalition Government published its national obesity strategy: Healthy Lives Healthy People- A Call to Action on Obesity. This set two new national ambitions for obesity reduction:

- A sustained downward trend in the level of excess weight in children by 2020
- A downward trend in the level of excess weight averaged across all adults by 2020

Obesity reduction remains a local priority for all partners. From April 2013, a new Health and Wellbeing Board has been established for Dudley Borough. It has updated its understanding of all health issues in the Borough including obesity through its Joint Strategic Needs Assessment which is called *All About Dudley Borough.* This was the basis for the Health and Wellbeing Board's first Joint Health and Wellbeing Strategy where lifestyle factors which lead to obesity were highlighted amongst its priorities. Our Obesity Strategy coheres with this overall framework. Childhood obesity reduction is also a priority in Dudley Clinical Commissioning Group's Commissioning Strategy.

In order to achieve a sustained reduction in obesity, all partners must play their part and contribute to the 5 year improvement plan.

This refreshed obesity strategy aims to give a brief overview of the progress in Dudley Borough, the revised framework for action, vision, principles and objectives and a refreshed improvement plan taking us to 2017.

2. WHY IS TACKLING OBESITY IMPORTANT?

There is a great deal of evidence which demonstrates that obesity increases an individual's risk of premature death.

A number of large scale studies show a 'J-shaped' association between body mass index (BMI) and risk of death (figure 1). A definition of obesity and the different categories are included in Appendix 1. A recent comprehensive review of 57 international prospective studies found that overall, moderate obesity (BMI 30-35 kg/m^2) reduces life expectancy by an average of three years, while morbid obesity (BMI 40-50 kg/ kg/m2) reduces life expectancy by 8-10 years. This 8-10 year loss of life is equivalent to the effects of lifelong smoking.

Obesity increases the risk of dying from a number of diseases (see Table 1):

Figure 1: Relationship between obesity and Mortality

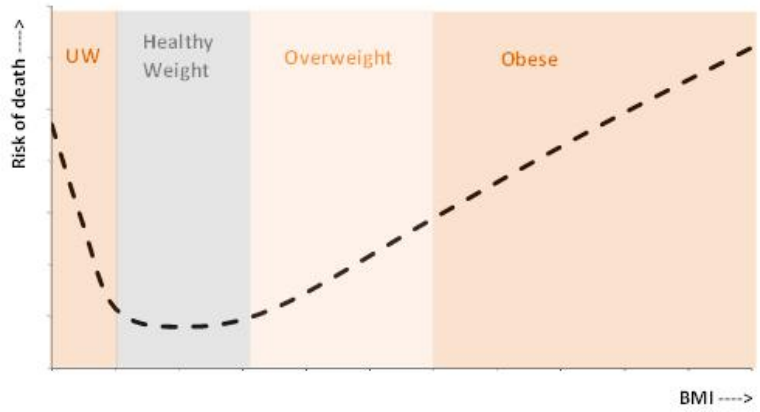


Table 1: Estimated Mortality Ratios For Selected Obesity Related Diseases by Sex, Disease and BMI (NB: the higher the ratio, the higher the risk of mortality)

	Mortality Ratios by BMI			
	Men		Women	
	30-39	40+	30-39	40+
All causes	1.46	1.87	1.46	1.89
Diabetes	3.51	5.19	3.78	7.90
Coronary Heart Disease (CHD)	1.55	1.95	1.58	2.07
Cerebral Vascular Disease (Stroke)	1.54	2.27	1.40	1.52
Cancer	1.14	1.33	1.23	1.53

Obesity also impacts on people's quality of life, by increasing the risk of developing many chronic health problems such as coronary heart disease, diabetes, kidney failure, osteoarthritis, back pain, high blood pressure and cancer. Psychologically, people who are overweight or obese have lower self esteem, higher levels of depression and increased rates of isolation. Obesity may compound problems which lead to the need for the provision of care.

Overweight and obese children are more likely to become obese adults, and have a higher risk of premature death and disability in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity – for example, raised blood pressure, fatty changes to the arterial linings and hormonal and chemical changes such as raised cholesterol and metabolic syndrome – can be identified in obese children and adolescents. Type 2 diabetes, previously considered an adult disease, has increased dramatically in overweight children as young as five. Evidence has also shown that being overweight is the biggest reason for children being bullied at school.

Obesity also increases the health risks to mothers during pregnancy and to the unborn child.

Definitions of obesity are detailed in Appendix 1.

3. OUR VISION AND PRINCIPLES FOR DUDLEY BOROUGH

Our vision is to create an environment and culture where adults and children in Dudley have the opportunity to maintain a healthy weight:- To enable all those living and working in Dudley to live a healthy and active lifestyle within a healthy environment supported by appropriate services.

Our aim is to halt the rising trend in obesity in adults and to reduce the levels of child obesity from 23.4% (2006) to 18.5% by 2020, (as measured in 10 and 11 year old children).

Our Vision and aim is underpinned by some general principles which all our organisations working to make our vision real will embrace:

Our Principles:

- We believe that reducing obesity is a priority for everyone- at both strategic and delivery levels. The strategy will create 'leadership for change' across all sectors with personal and political buy-in fostered at all levels. Major policy decisions and plans will be 'health checked' to ensure synergy and that their outcomes do not compete with the tackling obesity agenda.

- We will tackle the obeseogenic environment – developing an environment that supports active lives and enables people to eat a healthy balanced diet.

- We will tackle the underlying health inequalities that contribute to the pattern of obesity across Dudley Borough.

- We will promote healthy behaviours – to support a cultural shift and empower people to make behaviour changes to improve their own health.

- We will invest in workforce development – to support a cultural shift and enable the workforce to support themselves and the public in healthy behaviour change

- We will invest in prevention to increase the capacity of evidenced based programmes.

- We will maximise outcomes from treatment services to ensure cost effectiveness of services for adults and children.

4. THE LOCAL OBESITY PICTURE

The key findings from the Obesity Health Needs Assessment conducted in 2011/12 and the Joint Strategic Needs Assessment (2012) are summarised below. The complete Obesity HNA and JSNA are available on request from the Office of Public Health.

1. **Adult obesity prevalence in Dudley is increasing** although levels are lower than England (figure 2) and the West Midlands Region. In 2009 the prevalence for England was 23% compared to 21% for Dudley and 29% for the West Midlands Region. Prevalence in England in 2010 rose to 26%. In numbers terms, 51,317 people are obese and 138,532 are overweight or obese in Dudley. At current rates of increase, Dudley will have 24.9% of adults obese by 2016. More females are obese, while more males are overweight. The health inequality gap for obesity widened locally between 2004 and 2009. Obesity prevalence is highest in the 45 to 64 year age categories.

Figure 2:

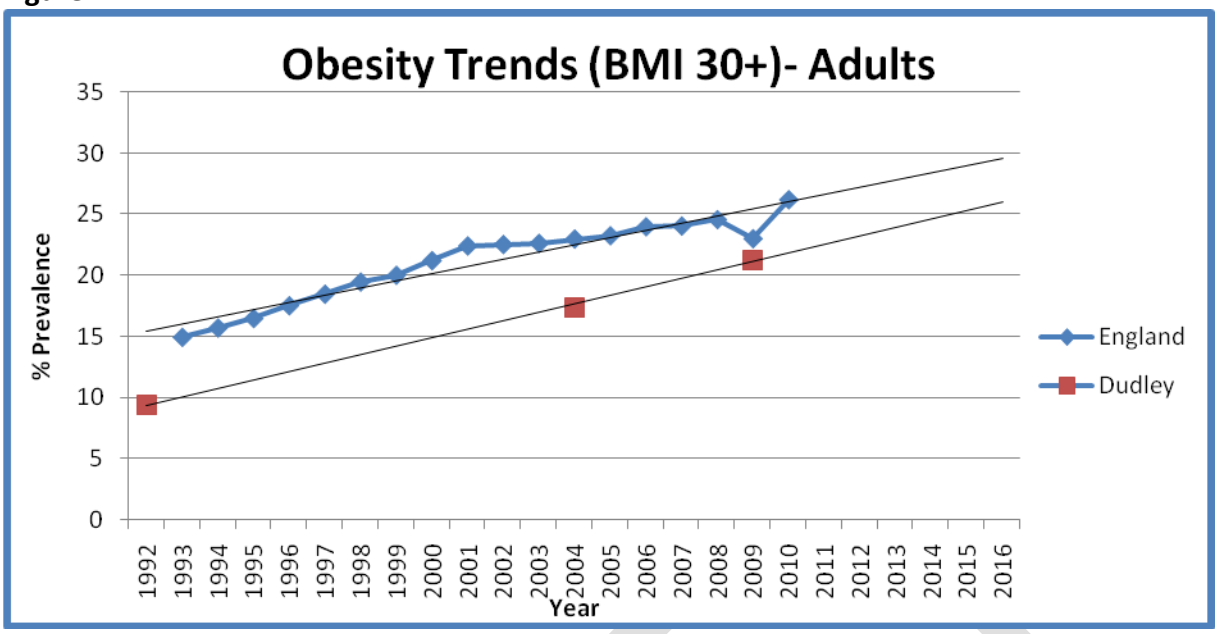


Figure 3 shows the increasing trend in obesity for Dudley Borough between 1992 and 2009. Figure 4 shows how obesity prevalence varies across the wards in Dudley Borough and matches the pattern of deprivation across the Borough.

Figure 3:

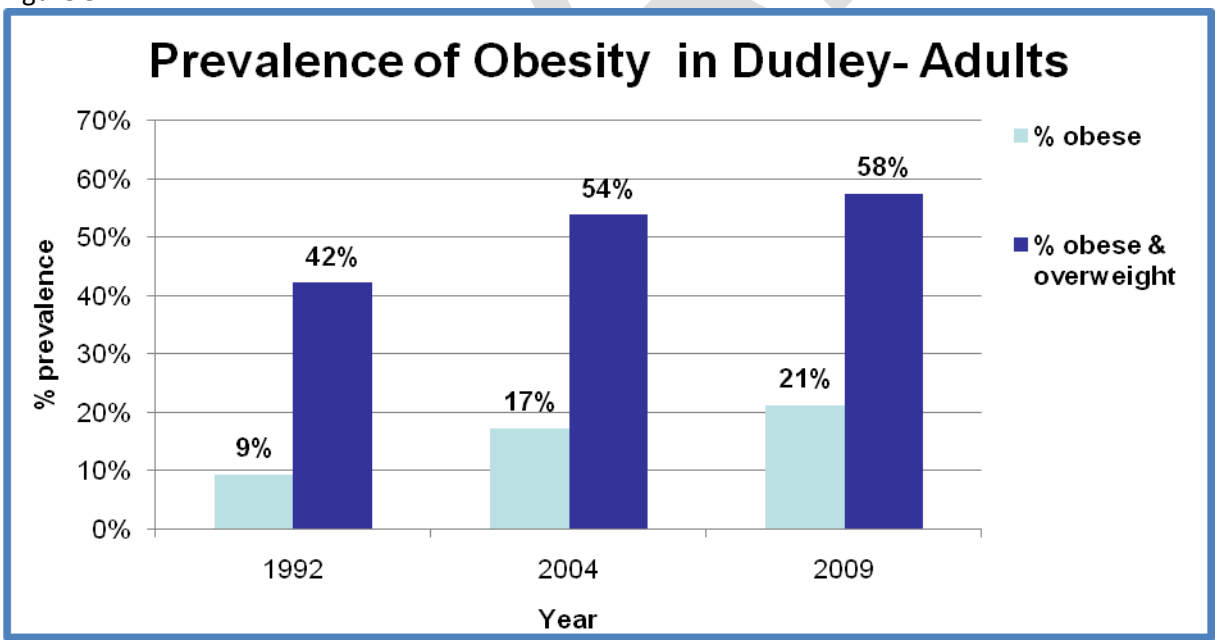


Figure 4: Prevalence of Obesity by Ward in Dudley Borough[1]

2. **The levels of child obesity in Dudley Borough is higher than the England and West Midlands Region average, although the rate of increase may be halting locally and nationally.** 8,313 children are estimated to be obese and 15,481 are overweight and obese in Dudley[2]. Between reception and year 6, the prevalence of obesity doubles. (11% of reception year aged children and 23.2% of year 6 children were obese in 2011/12- table 2 and 3). Children who are overweight in reception go on to become obese at year 6. More boys than girls are obese in both age groups. Obesity levels are higher in more deprived areas. A large proportion of children who are overweight or obese perceive that they are the right weight for their height- 28% of boys and 17% of girls. This shows how being overweight is now accepted and seen as 'normal'. **Childhood should remain a priority group for action in Dudley Borough**

   Figure 5 shows Dudley Borough's progress against a locally set target to reduce levels of child obesity to 18.5% in 10/11 year olds by 2020.

[1] 2001 ward boundaries have been used as they are population based (2001 census) and therefore allow more direct statistical comparisons.

[2] Obesity HNA (2012) Dudley. Office of Public Health

Figure 5: Dudley Borough Progress in Reducing Child Obesity

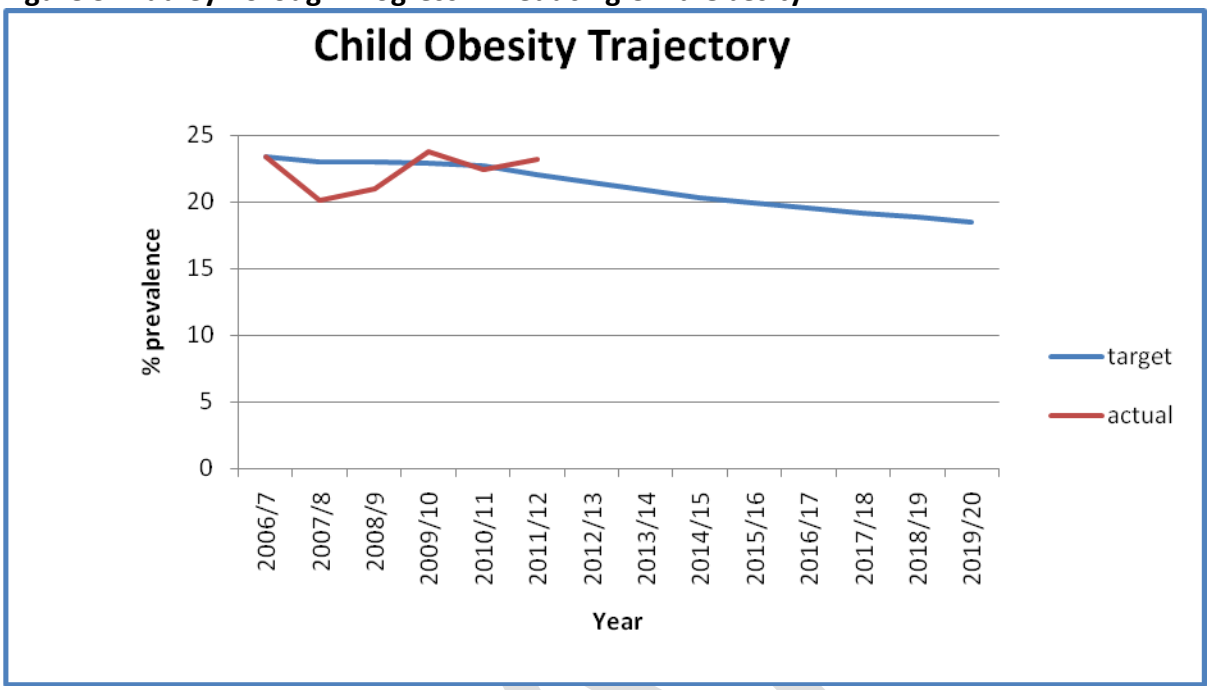


Table 2: Prevalence of Obesity in Year 6 Pupils (aged 10/11 years) in Dudley Borough

	2006/07 (%)	2007/08 (%)	2008/09 (%)	2009/10 (%)	2010/11 (%)	2011/12 (%)	% point average yearly change
Dudley	23.4%	20.1%	21.0%	23.8%	22.4%	23.2%	-0.04
West Midlands	19.1%	19.6%	19.8%	20.5%	20.5%	21.2%	+0.42
England	17.5%	18.3%	18.3%	18.7%	19%	19.2%	+0.34

Table 3: Prevalence of Obesity in Reception Year (aged 4/5 years) in Dudley Borough

	2006/07 (%)	2007/08 (%)	2008/09 (%)	2009/10 (%)	2010/11 (%)	2011/12 (%)	% point average yearly change
Dudley	11.4%	11.4%	9%	10.2%	10.7%	11.0%	-0.08
West Midlands	10.4%	10.0%	10.1%	10.5%	10.1%	10.5%	+0.02
England	9.9%	9.6%	9.6%	9.8%	9.4%	9.5%	-0.08

Figures 7 and 8 shows the levels of child obesity by ward in Dudley Borough for 4/5 year olds and 10/11 year olds.

Figure 7: Prevalence of Overweight and Obese Children aged 4 and 5 in Dudley Borough[3]

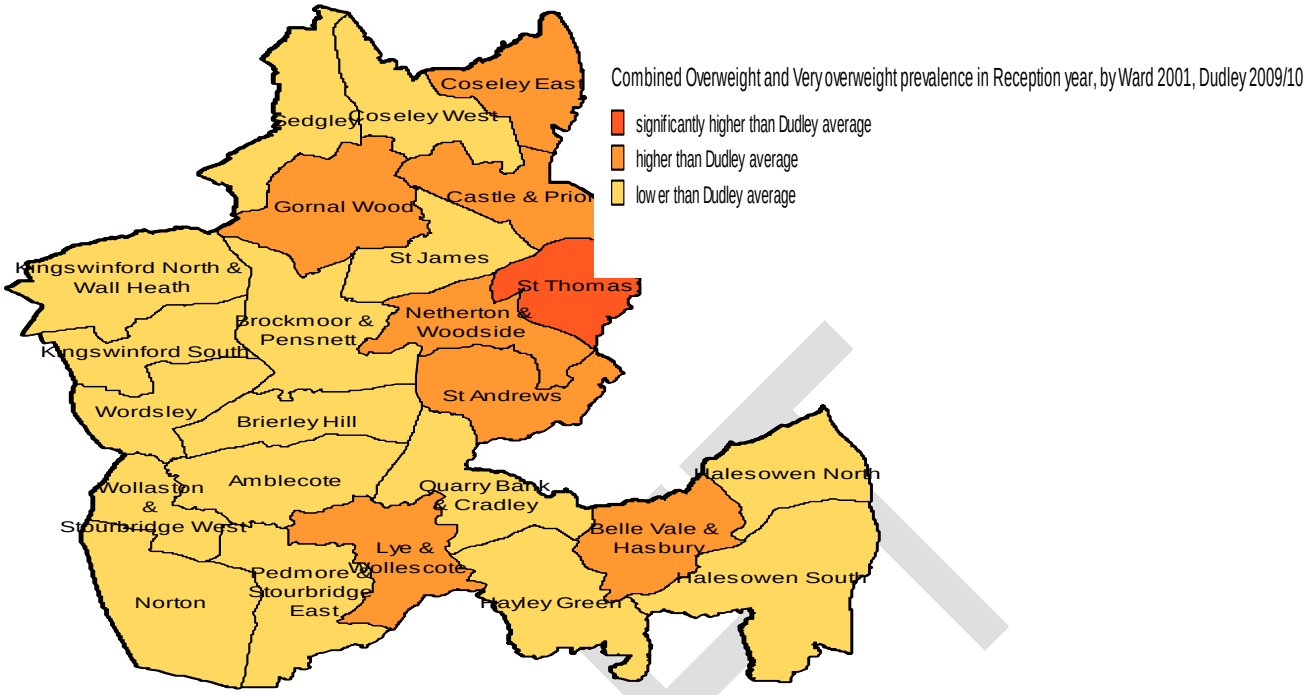
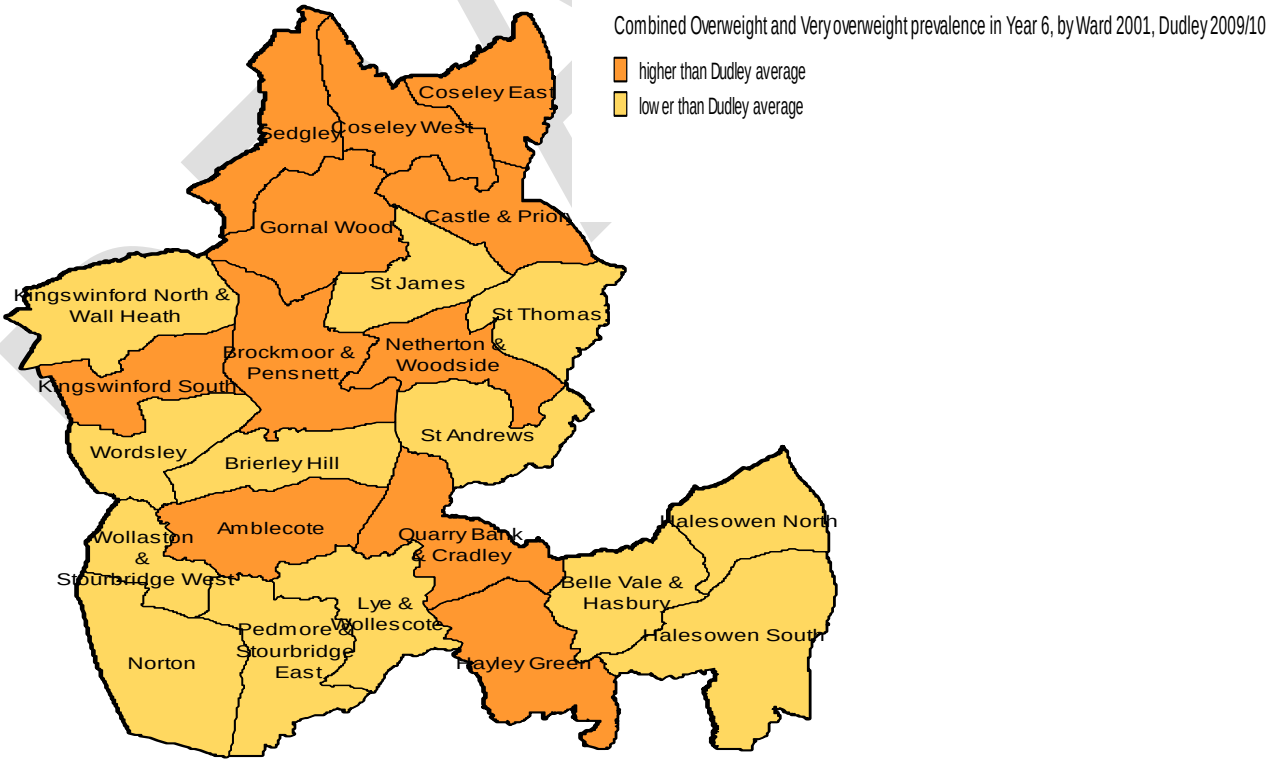


Figure 8: Prevalence of overweight and obese Children aged 10 and 11 in Dudley[4]



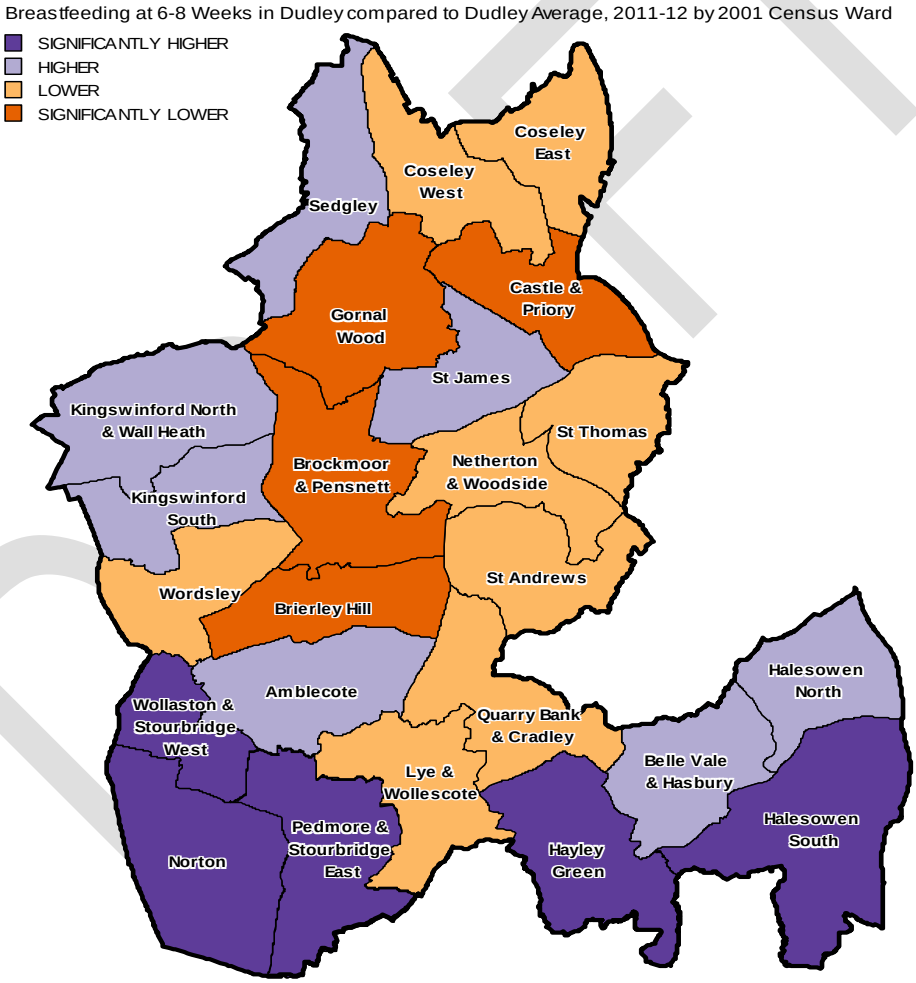
[3] 2001 ward boundaries have been used as they are population based (2001 census) and therefore allow more direct statistical comparisons.

[4] 2001 ward boundaries have been used as they are population based (2001 census) and therefore allow more direct statistical comparisons.

3. **Evidence shows that being breast fed protects a child from developing obesity in adult life, as well as helping the mother return to her pre-pregnancy weight[5]. Breast feeding initiation and duration rates in Dudley Borough are lower than the Regional and England rates. (Dudley initiation rates: 57.2% compared to 74.1% for England; Duration rates: 28.8% compared to 46.3% for England (2011/12).** The lowest rates are for young white mothers in deprived areas. Additionally although over half of years 8 and 10 school children believe that 'breast is best', only a third of them would commit to considering it. This is less than the current breast feeding initiation rate. The perception of breast feeding as more difficult to do than bottle feeding is an influencing factor.

   Figure 9 shows the prevalence of breast feeding duration at 6 to 8 weeks by ward in Dudley Borough.

Figure 9: Breast Feeding Prevalence By Ward[6]



Map produced by Public Health Intelligence, NHS Dudley
Topographic Data © Crown copyright and database rights 2011 Ordnance Survey 100050565

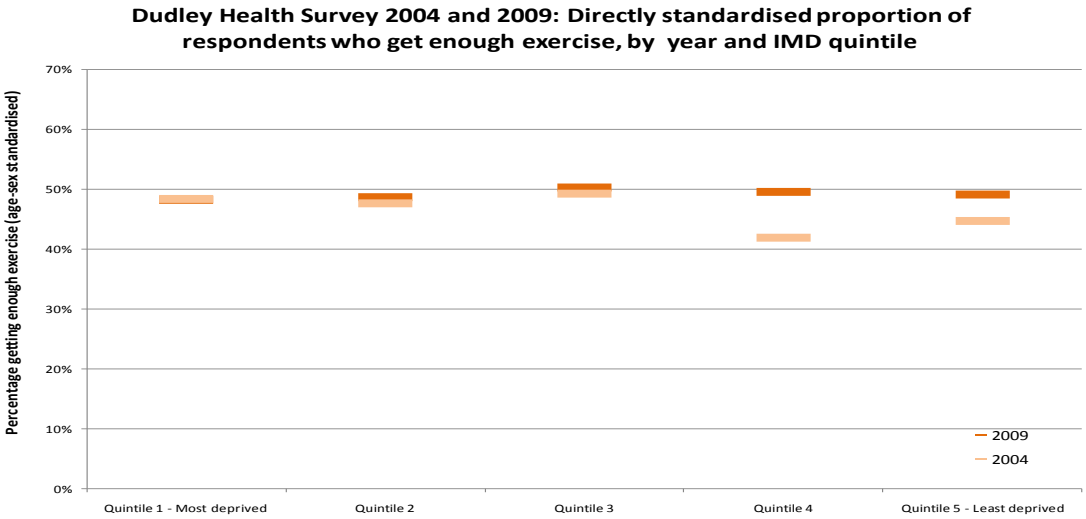
Source: Public Health Intelligence, Dudley PCT.

[5] Tackling Obesity –A Health Needs Assessment in Dudley. Office of Public Health

[6] 2001 ward boundaries have been used as they are population based (2001 census) and therefore allow more direct statistical comparisons.

4. **The percentage of adults taking the recommended levels of physical activity increased from 46% to 49% from 2004 to 2009, but more so in the least deprived than the most deprived areas.** As a result, activity levels are now similar across the deprivation quintiles in Dudley (figure 10). Black and minority ethnic (BME) groups, women and girls, older people and people who are overweight and obese have lower activity levels.

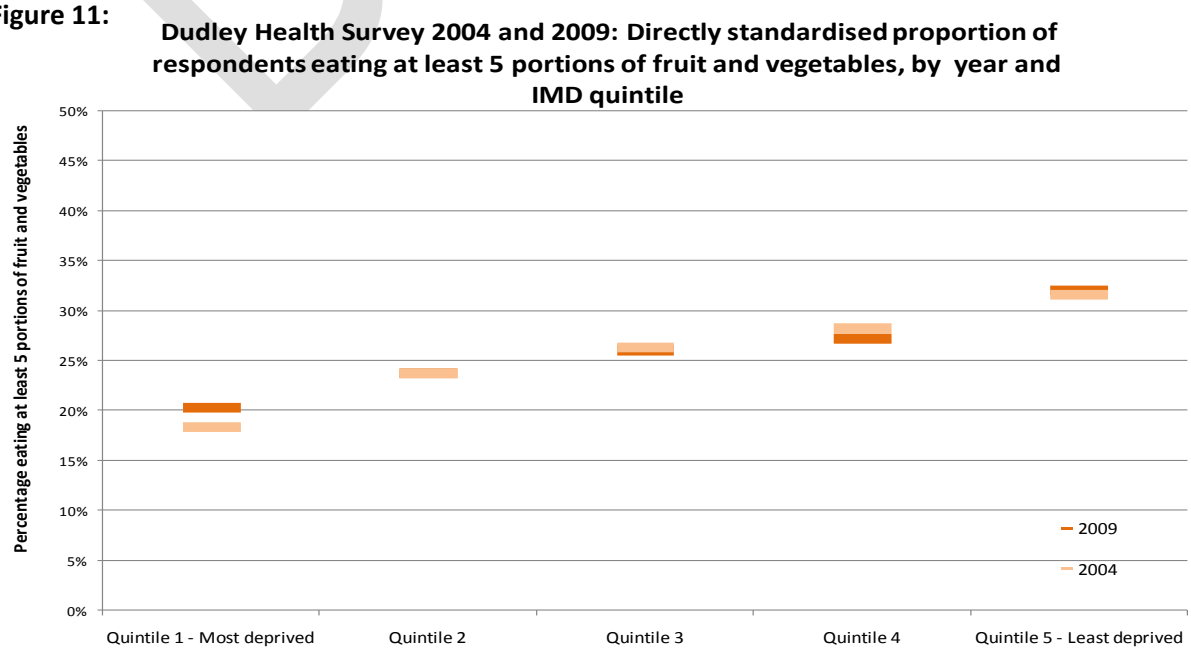
Figure 10:



5. **In children, national data shows us that 70 % of year 5/6 year olds get enough exercise nationally, which declines to 62% by years 8/10.** Girls activity levels drop off much more than boys. Less children cycle or walk to school in Dudley Borough than in previous years. Locally, physical activity levels has not been measured, but will now be included in the school lifestyle survey from 2013.

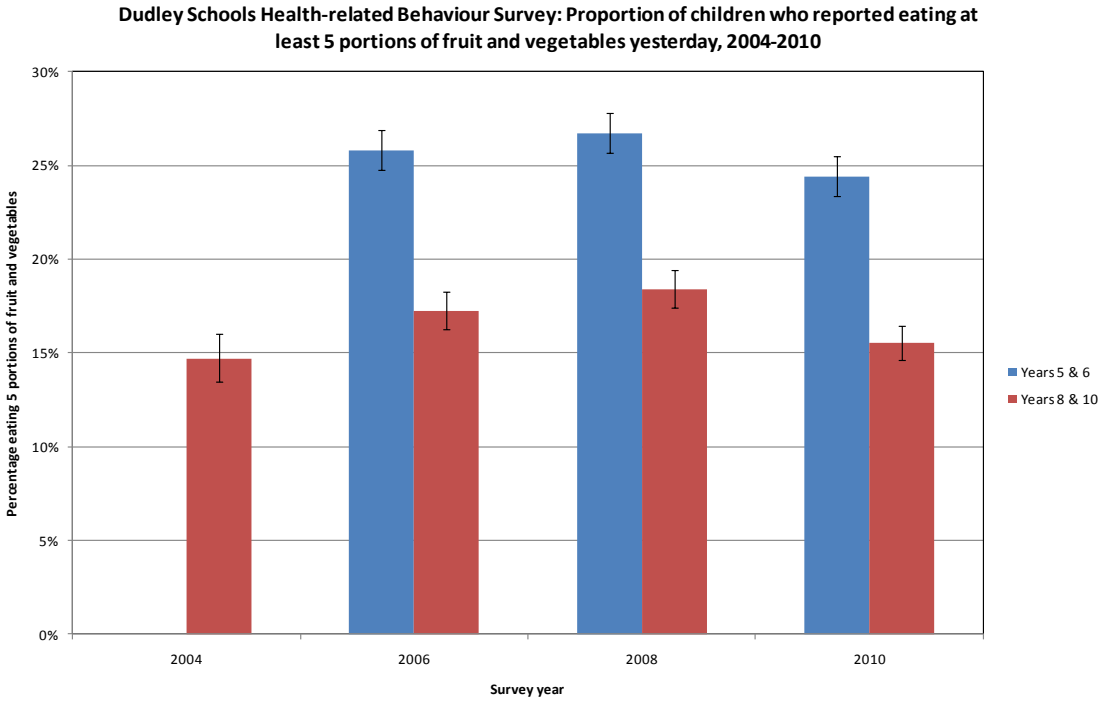
6. **5 a day fruit and vegetable intake has remained constant overall for adults over the last 5 years at 25.6% (2009), but has increased significantly in the deprived areas (figure 11)** . Males, black and minority ethnic groups and deprived areas have a lower prevalence of people eating 5-a-day. Significantly less males eat 5-a -day than females. 86.9% of the Dudley population eat a less than healthy diet, more so in deprived areas, although 66.1% of adults perceive they eat a healthy diet.

Figure 11:



7. **5 a day fruit and vegetable intake has increased slightly for children** since 2004, although there was a significant drop between 2008 and 2010. Five a day intake declines between school years 5/6 and 8/10 (figure 12). **Children remain a priority group for action in that they are consuming high levels of fatty and sugary snacks on a daily basis.**

Figure 12:



8. Dudley Borough **has 25-30% of its land as open green space** which provides a good potential for maximising the use of this for supporting healthy active living.

9. Within the NHS primary care setting, as part of the quality outcomes framework, GP practices are asked to record on their clinical systems their patients body mass index and identify who is obesity on a disease register. Currently, the level of obesity recorded by practices is 13.3% (34,260 adults) (March 2011), which is lower than the prevalence estimated from Dudley's lifestyle survey. This is an under-representation and shows that about 8% of the estimated prevalence of obesity in the borough is not being recognised and supported within the primary care setting and referred into weight management and lifestyle services. This is a national issue, although Dudley Borough practices have higher levels of recording than the West Midlands area (11.8%), and the England levels at 10.5%.

5. GROUPS MORE AT RISK OF DEVELOPING OBESITY

There are specific groups that are more at risk of developing obesity. Action to tackle obesity must address the needs of these high risk groups. **These should be added to the Dudley framework for action:**

Children from Low Income Families. Children living within households with the lowest level of household income have higher rates of obesity than children from households with the highest level of household income. There is almost a linear relationship between obesity prevalence in children and the Index of multiple deprivation 2007 score for the area in which they live. Child obesity in the most deprived 10^{th} is almost double that in the least deprived 10^{th} .

Children from Families Where at Least One Parent is Obese. Research has found that 24% of boys and 21% of girls aged 2-15 living in overweight/obese households are classified as obese compared with 11% and 10% in healthy/underweight households. The increased risk may be due to genetic and/or environmental reasons. Being obese as a child is a significant predictor for being obese as an adult.

Looked After Children /Care Leavers. Children in care are more likely to be overweight and obese compared with their peers. Research has found that 35% of looked after children's body mass index increases once in care. In Dudley Borough, the rate of children in care is much higher than for England at 93/10,000 aged under 18 compared to 59/10,000 respectively. There were 682 children and young people (0 to 17 years) being 'looked after' in Dudley Borough during 2012.

Young Parents (under 21). Young mothers of white ethnicity are significantly less likely to start breastfeeding than any other ethnic group. Babies who are not breastfed are 25% more likely to be overweight or obese in later childhood, which further compounds existing health inequalities associated with material disadvantage. Also young parents often lack the knowledge and parenting skills to implement a healthy lifestyle, putting themselves and their family at risk of obesity.

Adults who are Unemployed or in Semi-Routine and Routine Occupations. There are social group differences in obesity, particularly for women and children- 18.7% of women in managerial and professional households are obese compared with 29.1% in routine and semi-routine households. For children, 12.4% in managerial and professional households are classified as obese compared with 17.1% in semi-routine households. Obesity in adults is also associated with educational attainment – obesity prevalence is higher for both men and women who have fewer qualifications. The National Diet and Nutrition Survey found that 19-24 year olds ate the least fruit and vegetables than any other adult age group and are more likely to eat fatty and sugary foods and drinks. Research in Dudley with 16-19 year olds not in education, employment, or training, found that this group ate only 0.8 portions of fruit and vegetables, 29% had no breakfast and 59% regularly missed meals. 71% had sugary fizzy drinks at least once a day.

Older People. Increasing age is associated with the increasing prevalence of obesity. The ageing population experience a reduction in mobility and increased ill health, and are also less active. Both factors help to explain why the highest prevalence nationally of obesity occurs among the 55-64 and 65-74 age groups. In Dudley the highest prevalence is among the 55 – 64 age group.

People with Physical Disabilities. This is particularly in terms of mobility which makes exercise difficult.

People with Learning Disabilities. The literature reports increased prevalence of obesity and overweight among people with learning disabilities. People with learning disabilities are more likely than those in the general population to have avoidable diet related ill health and a shortened life expectancy. National research has also shown that less than 10% of adults with learning disabilities in supported accommodation eat the recommended 5 portions of fruit or vegetable/day. Carers of adults with learning disability have also been shown to have a poor knowledge of recommended dietary intakes.

People with a Mental Health Condition. Poor mental health can lead to unhealthy lifestyle choices and unhealthy weight management. In addition, major weight gain can be induced by antipsychotic drug regimes. Good nutrition and physical activity have an important role in the prevention and treatment of mental health conditions. Research has also shown that childhood psychological problems can increase the risk of obesity in later life. Children with early and persistent behavioural problems, particularly conduct problems, hyperactivity and inattention in early and middle childhood are at an increased risk of obesity in later life.

Individuals of an Asian Origin, Particularly of South Asian Origin. Obesity carries a greater risk of metabolic syndrome and its consequences in this ethnic group. Additionally research has shown that South Asians in the UK are more at risk of chronic disease and mortality at lower body mass index and waist circumference levels so it is particularly important for these groups to be aware of the health risk associated with a high body mass index. It is therefore of particular concern that South Asians have been shown to have more unhealthy diets and lower physical activity levels.

Ethnic Groups with a Higher Than Average Prevalence of Obesity. The highest prevalence of obesity is amongst Black African women, Black Caribbean women, Pakistani women, Black Caribbean men and Irish men. However, there is no straightforward relationship between obesity and ethnicity. Estimates of adult obesity prevalence vary according to the measurement used. Black African women have the highest prevalence when using waist circumference, Bangladeshi women when using waist-to-hip and Chinese men and women have the lowest prevalence whichever measure is used. Minority ethnic groups in the UK often have lower socioeconomic status which in turn is associated with a greater risk of obesity. People from minority ethnic groups may experience elevated levels of obesity – related stigma.

Prevalence also varies substantially between children of different ethnic groups. Data from the National Child Measurement Programme shows that obesity appears highest in Black African groups at 18% for boys and 16.3% for girls compared to White British levels of 9.6 % and 8.6% respectively for reception year children. Levels are also higher than White groups for Bangladeshi and Pakistani groups. A similar pattern is seen at Year 6. Minority ethnic groups of children aged 2-15 show highest obesity levels in Black African and Caribbean groups and lowest in Chinese and Indian.

A trend analysis of National Child Measurement Programme[7] data shows a rising trend in obesity for Bangladeshi boys and girls with no significant changes in any other ethnic groups.

6. WHAT IS ALREADY IN PLACE IN DUDLEY BOROUGH

The obesity Health Needs Assessment (2011) identified an impressive number of interventions and services that are contributing to the reduction in obesity in Dudley, across the public, voluntary and private sectors (see figure 13). Highlights include:

TIER 1: IMPROVING THE ENVIRONMENT

The **Healthy Towns** programme introduced from 2010 has seen the development of 5 healthy hubs in Dudley parks with connecting active travel corridors. It has encouraged a step change in infrastructure development in the borough making it easier for people to live healthy active lifestyles (figure 14). It has particularly encouraged women, families, and black and minority ethnic communities. This programme alongside the other activity programmes listed for Tier 1 delivered **3,075,034 thirty minute exercise sessions in 2010/11 which is equivalent to 11,827 people achieving the recommended 5x30 for every week of the year (5% of the total adult population).** The Local Transport Plan (3) and Dudley's successful bid into the Local Sustainable Transport Fund will bring further active travel developments into the borough over the next 4 years.

The Dudley Food for Health Award scheme aims to ensure that people in the Dudley Borough have increased access to healthy foods when eating outside the home by supporting caterers to improve healthy catering practices & provide healthy eating choices. **159 premises have the award (March 2011) -40 high street caterers (3.3% of the total number of establishments) and 119 non-commercial premises (33.4% of the total number of establishments) such as schools and nursing homes.**

During 2009 national nutritional standards for school food were reintroduced which have had a significant impact on the healthiness of the mid-day meal for many children. As part of this scheme the **Million Meals Campaign** was launched aimed to increase school meals uptake and 75% of schools in Dudley Borough are signed up to this.

Healthy food policy work is also evident ensuring that healthy food choices are available in specified settings for children and adults across the public sector. 70% of Dudley schools have a policy with the remainder working towards one. Most areas of the NHS have a policy, although there are some gaps and the Local Authority is piloting in one Directorate. The children's early years setting is looking to develop work in this area. (March 2012).

A healthy workforce is essential to help Dudley increase sustainable economic growth. Developing a healthy workplace programme within the public sector has been hampered by the major organisational and fiscal changes, although some progress has been made both

[7] A national programme that measures all children in school in reception year and year 10, and categorises their level of obesity.

FIGURE 13: PROGRAMMES FOR OBESITY REDUCTION

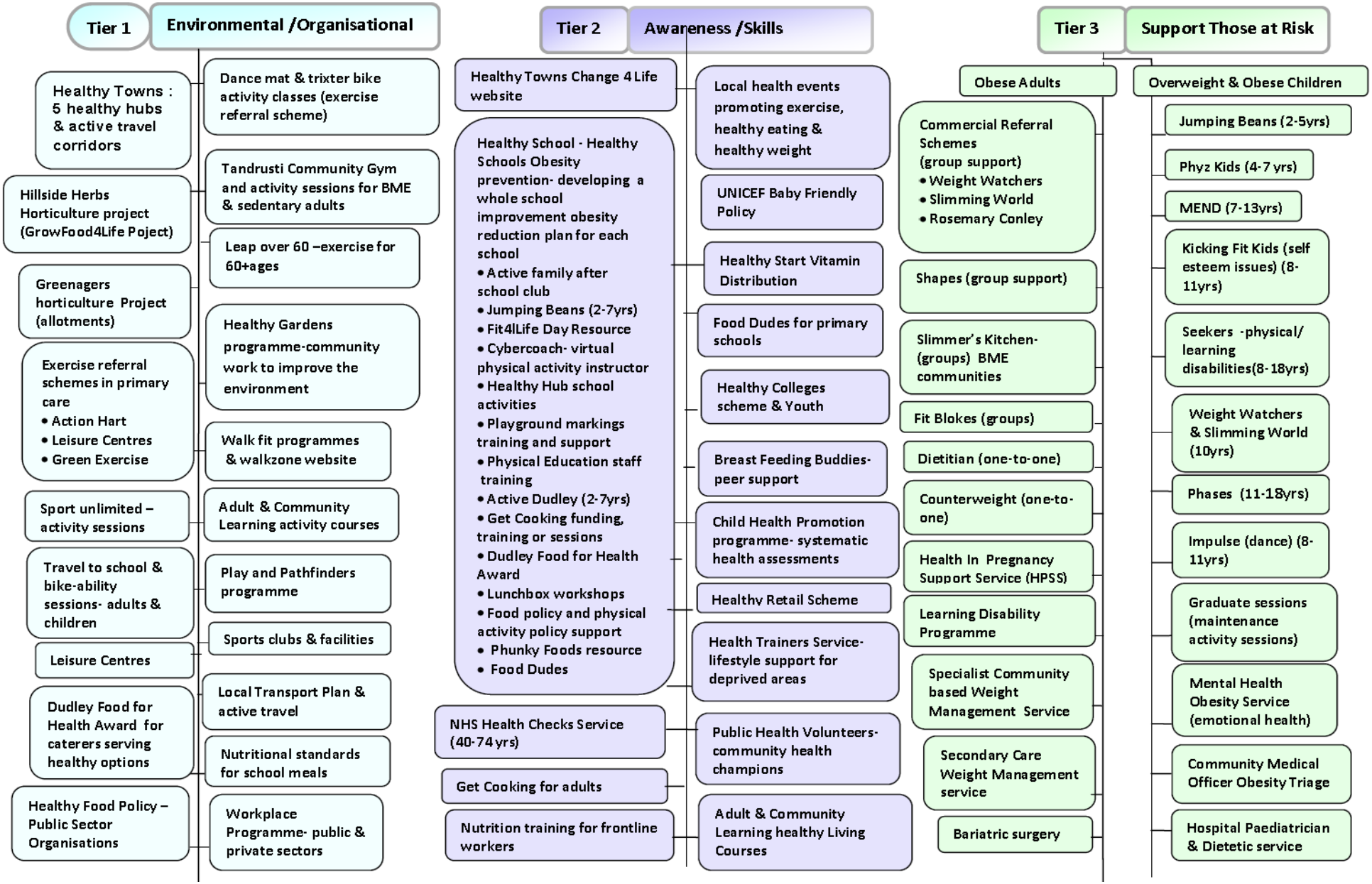
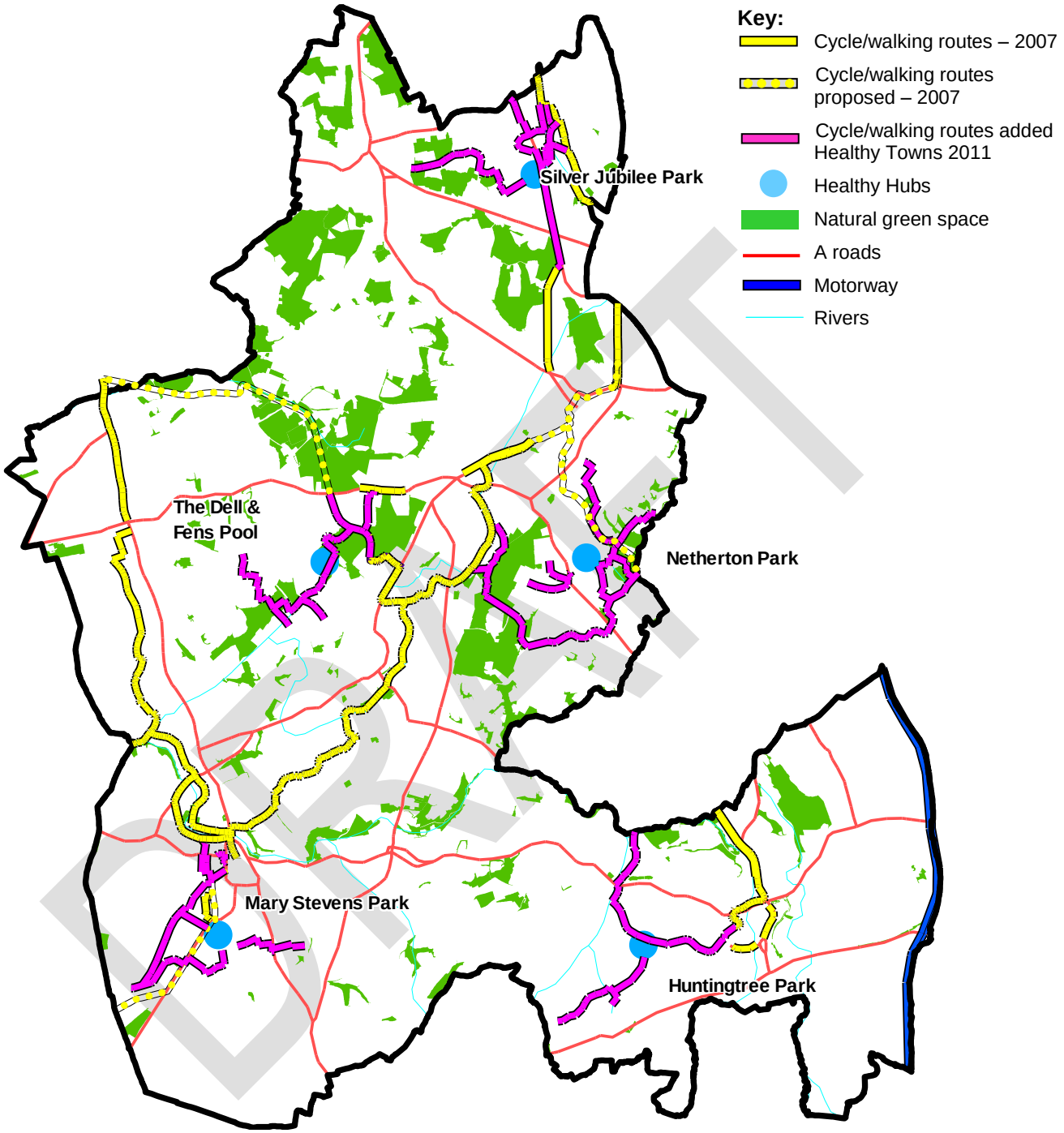


Figure 14: **Walking and Cycle Routes in Dudley Borough 2011**



Source: Dudley MBC, Traffic & Transportation
Map produced by Public Health Intelligence, NHS Dudley

within the public and commercial sectors (March 2012), and this will be a priority area for the refreshed obesity strategy.

TIER 2: RAISING AWARENESS AND DEVELOPING SKILLS

During 2011/12 there were 150 community events supported with health awareness that 12,127 people attended and 'health' interactions recorded with 3325 people. This represents 5% of the lowest deprivation quintile. Over 700 health checks were carried out during these events and 350 referrals to lifestyle services made. A healthy Towns web-site using the national Change4life brand has been launched which takes about 19,000 hits /year and in 2010, 4050 families in the Borough had also signed up to the Change4Life scheme.

Prevention programmes for children and young people are well established particularly through the primary school setting. 100% of schools have 'healthy school' status. A dedicated obesity prevention programme has been funded for the school setting which has seen the introduction of a range of interventions including policy work, resources and healthy living activities with a high level of uptake from schools, children's centres and pupils.

A Healthy college model has been developed and Dudley & Halesowen college have achieved healthy college status. King Edwards, Stourbridge and the Glass House are working towards healthy college status. Colleges choose the issues they wish to work on. Currently nutrition, physical activity and obesity are not priorities. Work is also in progress in Youth Services including healthier snack provision, tuckshops and the delivery of Get Cooking! and sport and physical activity sessions.

There is a Public Health volunteers programme where volunteers can support people in the community to make a lifestyle change and raise awareness of key messages with 46 active volunteers (March 2012) giving over 650 hours of their time. Volunteering programmes for Sport are also in operation.

Healthy living services for adults include 'Get Cooking! - a cook and eat programme, healthy living courses delivered through the Council's Adult and Community Learning Service, in the Directorate of Adult, Community and Housing Services, and the Health Trainers service – a new national behaviour change service launched in Dudley in 2010. Overall these programmes reach approximately 2500 people (1% of the total adult population) each year. The NHS Health checks service, launched in 2010, gives a health check to all adults aged between 40 and 74 and signposts to lifestyle services including those for healthy eating, physical activity and weight loss. This service delivers about 7000 health checks annually in Dudley Borough.

Training for front-line workers on the healthy living messages is delivered across health settings and the Local Authority. There are some gaps, specifically the primary and secondary care settings.

The primary care and community health settings are working towards accreditation for 'baby friendly status' for all community sites by 2015. The hospital maternity services have baby-friendly status. Breast-feeding training for key health professionals and a baby-friendly award set up for 'high street', commercial establishments is in place. 150 places have currently obtained this award (March 2012). A breast-feeding buddies programme has been resourced with 152 buddies trained in total, 59 still active and 1146 moms supported during 2011/12. The child health promotion programme has introduced a systematic measurement of child obesity within core package 5 at age 1.5 to 2 years. Children identified as obese are referred to child weight management services.

Healthy living messages are also supported through the commissioning of care services for adults who receive adult social care or create their own solutions for care needs in using personal assistants. This includes services for a range of people including those with mental health needs, and those with a learning disability or older people.

TIER 3: ADULT AND CHILD WEIGHT MANAGEMENT

Adult and child weight management pathways have been set-up with a number of services to meet diverse needs. 6380 adults were supported to lose weight during 2010/11, 12.9% of the target population with about 30% achieving 5% + weight loss outcomes. Anti-obesity drug prescribing and bariatric surgery procedures are low in comparison to similar English regions. This reflects the high level of alternative provision to support weight loss. 245 children were supported to manage their weight during 2010/11, 1.7% of the target population, with 66% of them completing the courses and 71% maintaining or reducing their body mass index.

The weight loss service outcomes compare favourably to similar programmes across the region and nationally, however there are issues of attendance, drop –out and weight loss maintenance for all services. The acceptance that a child is overweight remains a sensitive and difficult issue for parents to accept.

A service for obese pregnant women has been piloted and mainstreamed –the Health In Pregnancy Support Service, and this supported 116 women during 2010/11 with all those subsequently measured at follow-up achieving less than 10kg weight gain in pregnancy.

Adult and child services are in place for at risk groups including bespoke services for men, learning disability and black and minority ethnic communities for adults and learning disability for children. However there is not a systematic referral to the services for children with learning disability, as they receive no school entry check and are not measured as part of the national child measurement programme.

7. THE LIFECOURSE APPROACH

A person travels through their life where there are numerous events associated with each life-stage that can encourage healthy or unhealthy behaviours, for example marriage, having children or retirement. This strategy will take a "life course" approach **with a necessary focus on the early years of life and childhood** in order to maximise the impact of adopting healthy lifestyles at later stages in the life-course.

THE LIFE COURSE					
Pregnancy, and early years 0-4yrs	**Childhood 5-11yrs**	**Young Adulthood 12-24 years**	**Adulthood 25-59yrs**	**Active Retirement 60-74yrs**	**Aging Retirement 75+yrs**

8. HOW WE WILL COMMUNICATE AND CONSULT

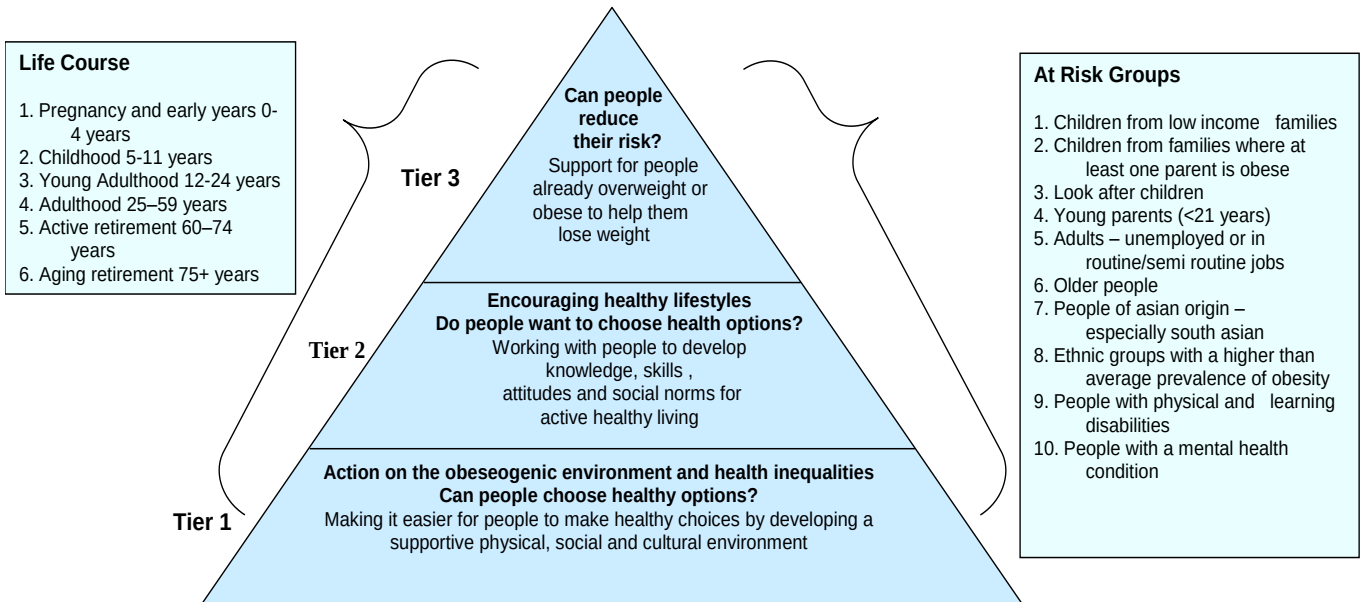
There was an initial consultation event in April 2010, the outcomes of which were included in the Obesity Health Needs Assessment and its recommendations, upon which this strategy is based. It is important to continue to consult and communicate widely as the strategy is implemented to gain commitment and raise awareness of the part that everyone has to play to take the strategy forward. This will be achieved by making use of the existing and newly emerging engagement networks such as Health Watch, NHS health forums, patient panels, Health Overview and Scrutiny Committee and Dudley Borough's extensive community group networks.

9. OUR FRAMEWORK FOR ACTION

Our delivery framework for obesity reduction is depicted in figure 15. This recognises the 3 necessary tiers for tackling obesity, across the life-course and at-risk groups.

Children, particularly the early years and primary school settings and looked after children remain a priority life-course group**; deprived areas, black and minority ethnic groups and people with physical or learning difficulties or mental health issues** remain priority 'at risk' groups.

Figure 15: Framework for Tackling Obesity



The strategic objectives for each tier are:

Tier 1: Environment: Making it easier to make healthier choices

- **Expand the reach and impact of programmes that increase access to healthy food.**
- **Further develop the transport infrastructure to prioritise active travel.**
- **Use the urban design and planning process to increase access to physical activity opportunities and access to healthy food.**
- **Increase structured delivery of physical activity programmes by 5%/year targeting the most deprived areas and black and minority ethnic women.**
- **Industrialise workplace wellbeing programmes across all sectors in Dudley Borough.**

Tier 2: Lifestyles: Knowledge, skills and attitudes

- **Develop and sustain public health campaigns to raise the public consciousness on healthy living.**
- **Focus on the early years and primary school ages to foster healthy habits from an early age.**
- **Increase the number of mother's breast feeding at 6 to 8 weeks.**
- **Increase the number of people accessing the lifestyle services and health improvement programmes.**

Tier 3: Obesity treatment pathways for adults and children

- **Increase referrals to the child weight management pathway.**
- **Improve long-term outcomes from both the adult and children's weight management pathways.**
- **Increase referrals from secondary care and mental health to the adult weight management pathway.**
- **Increase referrals and improve outcomes for children and adults with learning difficulties who are obese.**
- **Maintain anti-obesity drug prescribing and surgical treatments for obesity at 2011/12 levels.**

A key conclusion of the Obesity Health Needs Assessment was that robust initiatives and services were developed between 2005 and 2010, and are progressing in Dudley Borough, however, the impact on the headline public health outcomes such as a reduction in obesity, have not yet been realised. This is because:

- The interventions implemented to tackle obesity are new programmes and have not yet achieved their full implementation.
- Lessons learned from tackling smoking behaviour, tell us that it takes longer than 5 years for the impacts of public health programmes to come to fruition.
- Some of the programmes have limited resources and are achieving only a small 'reach' and therefore a smaller impact at the population level.

The action plan in Appendix 2 **builds on the programmes and initiatives set up over the last 5 years,** with a view to maximise their reach and impact. This will ensure that the next 5 years secure real positive changes in the headline public health outcomes.

10. HOW WE WILL IMPLEMENT OUR STRATEGY

Dudley requires strong leadership and interventions on an industrial scale if it is serious about tackling the causes of obesity.

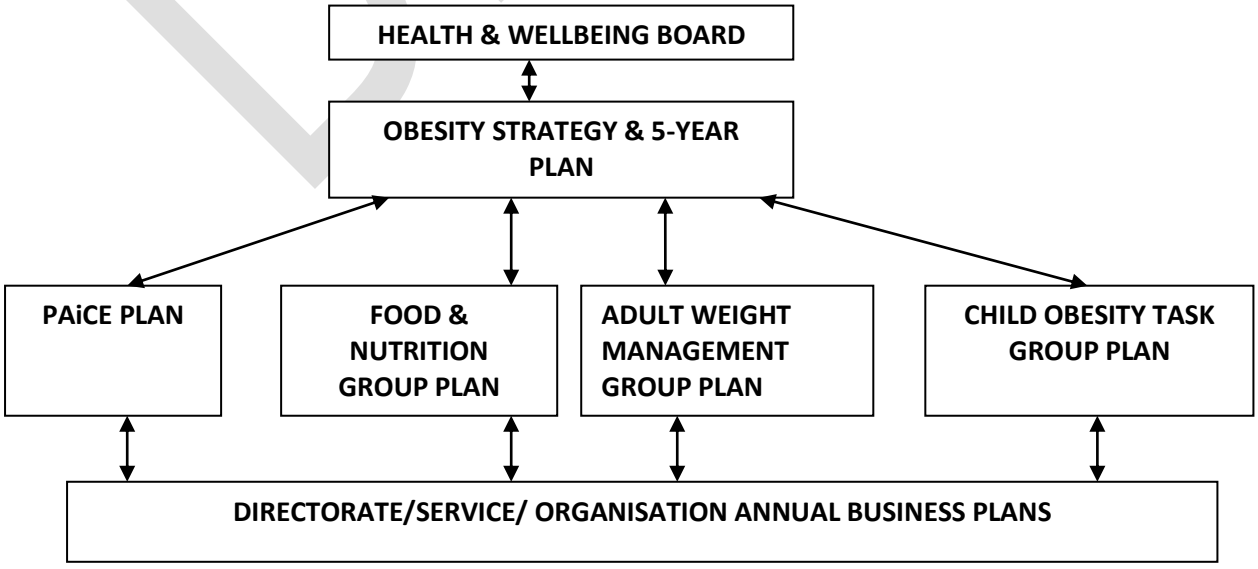
The actions to tackle obesity are broad ranging and can only be achieved by a whole range of partners working together in a coordinated and planned way. The strategy will impact on many action plans that are already being delivered through existing multi-agency partnerships.

There are important roles for all statutory agencies including all Local Authority Directorates and the Clinical Commissioning Group. There are also important roles for key providers such as the Black Country Partnership Foundation Trust, Dudley Group NHS Foundation Trust, the Mental Health Trust, and also the voluntary and private sectors.

The next 5 years will be more challenging due to the tight fiscal environment. These issues may hinder progress. Financial pressure means the action plan should focus on redesign and synergy to improve effectiveness rather than rely on additional investment.

Obesity is everyone's business, hence the five year improvement plan in Appendix 2 will be delivered through all partnership groups, and sectors in Dudley Borough. The key deliverables will be driven through the following partnership groups:

- PAiCE (Physical Activity in the Community Environment)
- Food and Nutrition Steering Group
- Adult Weight Management Group
- Child Obesity Task Group



High levels of alcohol intake and poor emotional wellbeing are also key factors that can impact on people's weight. This obesity reduction strategy is therefore also supported by actions within the Alcohol Reduction Strategy and Mental Health and Emotional Wellbeing action plans for Dudley Borough.

11. HOW WE WILL MEASURE OUR SUCCESS

The obesity strategy delivery will contribute to the delivery of the Joint Health and Wellbeing Strategy coordinated by the Dudley Borough Health and Wellbeing Board. Progress will be monitored by the Health and Wellbeing Board via an annual report and progress against the agreed Public Health Outcomes detailed in table 4 and taken from the National Public Health Outcomes Framework for England 2013 to 2016. A dashboard of indicators will be produced for monitoring purposes.

Table 4: Public Health Outcomes for Obesity Reduction in Dudley Borough

Indicator	2010/11 Baseline (where available)	Measurement & Benchmark
Long-term Targets		
Child obesity- prevalence of excess weight in 4 to5 and 10 to 11 year olds and gap between the most deprived and least deprived quintiles **Target: to reduce obesity prevalence by 4.7% in 10/ 11 year olds by 2020**	24.5% (4/5 yrs) 36.4% 10/11yrs)	National Child Measurement Programme (NCMP) PH outcomes
Adult obesity prevalence and obesity prevalence gap between the least deprived and most deprived quintile. **Target: To maintain the 2009 level of obesity in the Dudley adult population up to 2017.**	21% (2009)	Dudley lifestyle survey, Health Survey for England (HSE) Yearly
Medium Term		
Percentage of infants breastfed initially & duration at 6-8 weeks **Target: To increase the prevalence of breast-feeding at 6-8 weeks to 40% by 2015.**	28.7%	Child Health Information System PH Outcomes
Percentage of adults achieving 150 minutes of activity/week and % gap between the least and most deprived quintiles **Target: 1% increase in prevalence by 2017 to 55%** **Health equality gap difference between 1 and 5th quintile to remain at 0% or less**	54% (2009) 0% (2009)	Dudley lifestyle survey HSE, Active Peoples Survey
Percentage adults meeting 5- a- day fruit and vegetables guidelines and % gap between the least and most deprived quintiles **Target: 1% point increase in prevalence by 2017 to 26.5% – Health equity gap difference between 1st and 5th quintile to remain at 5.6% or less**	25.6% (2009) 5.6% (2009)	Dudley lifestyle survey HSE

Percentage of children achieving recommended physical activity levels and % gap between the least and most deprived quintiles	To be set from 2012/13 school survey	Dudley School Lifestyle survey HSE
Percentage of children eating recommended amounts of fruit and vegetable levels **Target: Increase of 5% points in prevalence by 2017 for years 5&6 to 29.4% and by 4% for years 8 and 10 to 19.5%**	24.4% 15.5%	Dudley School Lifestyle survey HSE
Sickness absence: 1. Employees with at least one day off sick in the previous week 2. Yearly working days lost to sickness absence 3. Rate of fit notes issued per quarter	Not known Not known Not known	To be agreed nationally
Short term		
Utilisation by people of green space for exercise/health reasons: Percentage of people reporting a visit to green space for health/exercise over previous 7 days	19.7% (Mar 2009 to Feb 2012)	MENE survey PH outcomes
Percentage of children who walk or cycle to/from school (School Year 8 and 10)	58.9%	Dudley School Lifestyle Survey
An increasing number of local workplaces participating in the workplace wellbeing charter scheme.	Baseline data to be set in 2014	Local workplace data
Percentage offered and the uptake of NHS health checks by those eligible Target: 20% of 5 year cohort offered yearly, uptake 50%	18.6% (Offer) 44.1%(uptake)	Service data PH Outcomes
Activity hours delivered for structured physical activity programmes in the borough- 5% increase/year	3,075,034	Collated service data
Percentage year on year increase in adults and children treated through the weight management pathways	6380 adults 245 child attendees	Collated Service data
Percentage year on year increase in people attending healthy eating sessions	2542	Collated service data
Yearly volume of anti-obesity drug prescribing to be maintained at 2010/11 levels or less	4724 (total items)	PH service data
Yearly activity data for bariatric surgery to be maintained at 2011/12 levels or less	58	NHS Information Centre

12. APPENDICES

Appendix 1: DEFINITION OF OBESITY

Obesity is defined as an excessive amount of body fat in relation to lean body mass.

There are a number of measures of obesity. The proxy measures of fat include: weight, the body mass index (BMI), waist circumference and the waist-to-hip ratio.

The BMI has become the most widely used measure and is considered the universal gold standard. It remains the best correlate of body fat, and is likely to have the lowest operator variation.

The BMI is calculated using the following formula and reference tables exist for both metric or imperial units.

$$BMI = \frac{\text{weight kg}}{(\text{height})^2 \text{ m}}$$

BMI Does Have Limitations:

The BMI does not distinguish between fat and lean body mass. Hence those who have lower than average body fat with a higher than average lean body tissue e.g. athletes may often be defined as overweight when using their BMI.

BMI readings can be misleading for African-Caribbean men who, it has been found, have a greater than average bone density.

The loss of height which occurs with age may account for an increase in BMI of 0.7 kg/m² in men and 1.6 kg/m² in women making fat assessment more difficult in the elderly.

BMI does not take body shape into account, which varies between individuals, the sexes and ethnic groups. The 1999 Health Survey of England found that although Indian, Pakistani and Bangladeshi men had a relatively low prevalence of obesity, they conversely had a high prevalence of raised waist to hip ratio. BMI alone would not identify the increased cardiovascular risk in this ethnic group unless the individual was grossly overweight.

In summary it is recommended that for the clinical measurement of obesity, that BMI be used for adults, using the classifications in Table 1.

BMI for age using UK90 country specific reference charts and cut offs in Table 2 is the best measure for children as body fat in children is not a static measure, but changes during childhood, and is different between the sexes.

These cut-offs have high specificity and moderate sensitivity for identifying the fattest children. They are also clinically meaningful in identifying an individual who will have persistent obesity and act as predictors for the presence and clustering of cardiovascular risk factors.

Table 1:
Classification of obesity based on BMI and risks of co-morbidities: Adults

Category	BMI (kg/m²)	Risk of co-morbidities
Underweight	<18.5	Low – but risk of other clinical problems increased
Healthy weight	18.5 – 24.9	-
Overweight	25.0 – 29.9	Mildly increased
Obese class 1	30.0 – 34.9	High
Obese class 2	35.0 – 39.9	Very high
Obese class 3	>40.0	Extremely high

Table 2:
Classification of obesity based on BMI-for-age curves (UK90): Children

	Clinical measure
Overweight	> 91st centile
Obese	> 98th centile

Appendix 2: TACKLING OBESITY IMPROVEMENT PLAN

The improvement plan does not reflect all activity in the borough that reduces obesity, but details new developments and new ways of working that are to be implemented to meet specific gaps identified from the Obesity Health Needs Assessment. Activity that is already embedded through the preceding obesity strategy action plan (2005 to 2010) will continue.

AREA/LEAD	ACTION	LIFE-STAGE	AT RISK GROUP
LEADERSHIP AND MANAGEMENT			
1. Corporate Leadership Lead Directorate: Public Health Partners: All	• Obesity reduction is everyone's business- directorates and partners to sign up to specific actions by April 2013. • A process of 'health impact assessment' introduced to key policy and decision making processes across all Council directorates by April 2014.	All All	Universal Universal
TIER 1: ENVIRONMENT: MAKING THE HEALTHY CHOICE THE EASY CHOICE			
2. Planning Lead Directorate: Urban Environment Partner: Public Health	• Develop a supplementary planning guide for health to increase access to healthy food and physical activity options by October 2013. • Implement an approach to make use of the prohibited streets application process to tackle street vending of unhealthy fast food by September 2013.	All All	Universal Low income
3. Leisure & Culture Lead Directorate: Urban Environment Partner: Public Health Clinical Commissioning Group (CCG), British Rowing	• Embed healthy hubs delivery teams into Council by March 2014. • Integrate the Park Ranger Service with the Sports Development Service & extend staff placement to hub sites by March 2014. • Develop water-based physical activity opportunities by September 2013. • Establish out-door gyms in more parks and open spaces as funding becomes available. • Achieve green flag status in 5 parks by December 2015. • Evaluate costs and benefits to offering free swimming to	All	Universal Low income Black & minority ethnic groups

	targeted groups e.g. pregnant women, families • Develop physical activity opportunities for people with physical disabilities and low mobility by April 2015.		
4. Transport: Lead Directorate: Urban Environment Partners: Public Health CCG British Cycling	• Implement the LTP3 active travel actions and the Brierley Hill active travel partnership programme by April 2015. • Further develop Dudley Borough's walking and cycling strategy & action plan for next five years. • Fund and develop programmes to promote and support cycling in the borough. • Utilize all external/internal funding opportunities to expand and develop active travel opportunities in Dudley Borough.	All	Universal Low income
5. Healthy Food Access Lead Directorates: Urban Environment & Public Health	• Increase delivery of the 'Dudley Food for Health Award' (DFHA) to 60 new high street premises achieving an award with a further 40 engaged and working towards the award year on year by March 2014. • Increase delivery of DFHA to 30 non-commercial sites year on year by developing and implementing a self assessment delivery approach for DFHA for non- commercial sites by April 2015. • Develop and commission a 'retailers award' to support retailers in stocking healthy food options to start from April 2013. • Work with local food business to implement a local response to the national PH responsibility deal. • Work with local food manufacturers and support lobbying to national food manufacturers to reduce the fat, trans fat, sugar and salt within their products.	All	Universal Low income Looked after children

	• Work with the local food banks to ensure a supply of healthy food options • Explore opportunities for further support to promote healthy food policy and food provision within looked after children residential homes, respite and foster care homes by April 2016.		
6. Workplace Health Lead Directors: Public Health & Human Resources Partners: All	• Deliver a workplace health programme throughout the Council by March 2014. • Roll out the workplace food policy to all Council Directorates by March 2014. • Promote and support partners and local business to adopt the Healthy Workplace Charter – a minimum of 20 workplaces/year from April 2015	Adults of working age	Universal Routine & manual workers
TIER 2: LIFESTYLES: AWARENESS, KNOWLEDGE AND SKILLS			
7. Public Awareness Lead Directorate: Public Health Partners: All Council directorates, Dudley Council for Voluntary Services Council Communications	• Develop and implement yearly ongoing mass marketing campaigns covering physical activity, active travel, healthy eating and weight management health behaviours by March 2013. • Develop and implement service awareness marketing campaigns by September 2013. • Raise awareness of health at a minimum of 110 community health events per year.	All	Universal Low income Obese parents Unemployed & routine & manual workers Older people Black & minority ethnic groups Physical, learning & mental health difficulties
8. Community Health Improvement Lead: Dudley Council for	• Fund and develop Asset Based approaches to improve health and wellbeing with local communities. • Expand public health volunteers to contribute to delivery of the physical activity, nutrition and weight management	All	Low income

Voluntary Services, Public Health, CCG	public health programmes. • Develop the community health champions programme in relation to physical activity, nutrition and weight management.		
9. Workforce Development Lead Directorate: Public Health & Human Resources Partners: All	• Implement 'Making Every Contact Count' & Healthy Living Champions in the Council, NHS- primary & secondary care, mental health and learning disability, carers sectors, the fire service, police and other partners including the voluntary sector by April 2015, to increase referrals to lifestyle services for adults, children and young people.	All	Universal & Low income Unemployed & routine & manual workers Older people Black & minority ethnic groups Physical, learning & mental health difficulties
11. Breast-feeding and Baby friendly Lead Directorate: Public Health Partners: Black Country Partnership Foundation Trust, Dudley Group Foundation Trust, Clinical Commissioning Group	• Conduct social marketing to identify behaviour triggers of mothers to take up breast feeding, and implement findings by March 2013. • Continue to implement the breast feeding buddy support system in the community and the maternity unit. • Implement the baby friendly award to increase the number of public breast feeding sites from 150, by 30 year on year.	Young mothers Early years -0 to 2 years	Universal Low income Obese parents Young parents Black & minority ethnic groups
12. Early Years Lead Directorate: Children's Services and	• Increase sites distributing healthy start vitamins and instigate marketing campaigns to trigger uptake by April 2013. • Develop and deliver an early years health charter in Private,	Early years- 0 to 5 years	Universal Low income

Public Health	Voluntary and Independent (PVI) nurseries by April 2013, aiming to achieve 50% of nurseries with the Charter by March 2017.		
13. School Age: Lead Directorate : Children's Services, Public Health and Adult, Community and Housing Services	• Implement food dudes in all primary and special schools by April 2017. • Investigate a way forward for ensuring access to key healthy lifestyle programmes to children educated at home by April 2014. • Formalise pathways into lifestyle services for looked after children by April 2014. • Formalise pathways into lifestyle services for travelling families by April 2014. • All schools to be implementing the 'whole school approach to obesity prevention' as part of the healthy school programme by April 2017. • Continue to develop health promotion programmes within children's centres • Maintain children's play services offer for the borough especially for Looked After Children, Learning Disabilities and targeted communities.	Childhood -5 to 11 years Young adulthood	Universal Children with mental/physical or Learning Difficulties.
14. Young Adults- youth services Lead Directorate: Chidren's Services-Youth Services	• Expand obesity prevention with particular focus on targeted youth work groups (Looked After Children & Learning Disabilities). • Analyse young people's responses re health as part of the Youth Survey and identify actions for implementation with specific focus on access to health services for young people within preferred settings. • Embed the food policy (vending/snacks) within each youth	Young adulthood	Low income children Looked after children

	centre. • Ensure healthy eating, physical activity and associated factors including alcohol awareness are identified within youth service curriculum targets. • Key workers to receive training including Healthy Living Champions.		
15. Young Adults- Further education Lead: FE Colleges, Public Health	• Continue to support Dudley's Healthy FE Colleges to maintain their Healthy College status and include a focus on healthy eating, physical activity and weight management. • Support colleges to explore opportunities to develop staff health and wellbeing programmes. • Examine and consider the development of a focus on 16 to 24 year olds not in education, employment or training by April 2016.	Young adulthood	
16. Adult Healthy Living Lead Directorates: Public Health & Adult, Community and Housing Services- Adult & Community Learning Library Services	• Expand the range and industrialise the healthy eating services on offer by April 2013. • Maximise the health trainer service contribution to the healthy eating service offer. • Increase pedometer loans from libraries to 150 per year. • Maintain adult learners in health and sport at 1000/year.	Adulthood (40 to 74) Active retirement Aging retirement	
17. NHS- Primary prevention Lead: Public , Clinical Commissioning Group	• Develop and implement plans to increase the uptake of health checks from 40% to 55% by April 2017. • Increase the uptake of lifestyle services from health checks year on year.	Adulthood (40 to 74)	Adults Black & minority ethnic groups Adults with physical, mental or learning difficulties

	• Work with mental health commissioners to ensure contracts include the physical health needs of patients in relation to healthy living and weight management by April 2014. • Work with mental health service providers to put mechanisms in place to ensure access to healthy living services for mental health patents by April 2015. • Consider the development and implementation of an 'obesity prevention charter' for mental health service in-patient facilities by April 2015. • Consider the development and implementation an 'obesity prevention charter' for short-break residential for people with disabilities by April 2015.		
TIER 3: WEIGHT MANAGEMENT SERVICES			
18. Learning Disability: Lead: Black Country Partnership Foundation Trust /Public Health	• Develop a systematic process to identify overweight and obese children with learning difficulties in the borough by April 2015. • Develop a pathway of services for children with Learning difficulties by September 2013. • Continue the implementation of the adult learning disability charter and fully engage partners by April 2017. • Increase the number of learning disability participants attending services who lose weight and maintain their weight by April 2016.	All	Learning Difficulties
19. Adult Weight Management pathway	• Implement plans to reduce the proportion of patients who lapse from services, across the pathway by April 2014. • Increase the number of patients who meet their 5% weight loss target by April 2014.	Young adulthood Adult hood Active & aging	Adults Black & minority ethnic groups Adults with physical, mental health or learning difficulties

Lead :Public Health Partners: Clinical Commissioning Group, Dudley Group NHS Foundation Trust	• Design and implement a weight maintenance approach for patients who complete level 2 services to improve long-term weight loss outcomes at 12 months by April 2015. • Commission insight work into the awareness and appropriateness of services with black and minority ethnic communities by 2013 and increase uptake by April 2015. • Implement a phone texting maintenance model by April 2013. • Develop a web based maintenance model by April 2016. • Further pilot counterweight to test short and long term outcomes by April 2014. • Redesign the community specialist weight management service to deliver 250 patients/year from 4 clinics by September 2013. • Maternity weight management: Increase the number of women gaining only the appropriate amount of weight in pregnancy by April 2014. • Implement routine weighing throughout pregnancy by April 2017.	retirement	Older people
20. Child weight management pathway Lead: Public Health Partners: Clinical Commissioning Group, Black Country Partnership Foundation	• Commission social marketing on the National Child Measurement Programme (NCMP) and implement findings by September 2013. • Develop a web based resource that families can access for information, advice on manageable changes at home and as a recruitment tool to services by September 2013. • Reduce the number of people who do not attend appointments or respond to service offers by utilising client feedback and offering incentives by April 2014.	Early years Childhood Young adulthood	Children Black & minority ethnic groups Children with physical or , mental health difficulties Parents of obese children

Trust, Directorate of Children's Services	• Review under 2 age provision and implement finding by April 2014.
	• Increase the number of referrals to the child weight management services for children outside the NCMP age groups by April 2016.
	• Commission services for children of all ages by April 2015 with an immediate focus on teenagers.
	• By April 2015 offer tailored services for families in the following target groups:
	  ○ Families with complex needs
	  ○ Families who relapse
	  ○ Families at risk of drop out		