CAWT
Obesity Planning Workshop Report
July 2009

turning complex problems into simple solutions

This project is part financed by the European Union's European Regional Development Fund through INTERREG IVA Cross Border Programme managed by the Special EU Programmes Body

Summary of Key Recommendations

A summary of the key recommendations resulting from the CAWT Obesity Workshop held on 26 June 2009 in the Armagh City Hotel is noted below. These relate to:

- Project Structure
- Project Promotion, Referral Mechanisms and Engagement
- The Community Development Approach, and
- Evaluation.

Section 1 of this report provides a Background to the project. Section 2 provides an overview of the Workshop and Section 3 provides an overview of the key workshop findings.

Project Structure

1 There should be 4 sites for each aspect of the project in the first year of the pilot phase. These should ensure a rural/urban and NI/RoI split. The selection of the pilot sites should be based on deprivation levels, obesity levels, current provision, and appropriate community/health infrastructures.

2 The Project should build on and complement existing services and structures which have proven successful in terms of engaging the target group and having a positive impact, but not duplicate related services.

3 To aid the selection of pilot sites a mapping/research exercise should be undertaken in the CAWT area to identify areas of deprivation/obesity/overweight, and existing services, structures and gaps.

4 A scoping exercise of effective, evaluated obesity related programmes should be undertaken to source appropriate programmes which may be applicable across the CAWT area. This will also ensure the incorporation of models of good practice and lessons learned.

5 The project should:

- encourage co-operation between existing successful initiatives and the new initiatives developed through the funding to maximise the potential for sustainability and learning purposes
- further foster links between relevant health professionals and statutory organisations (such as education and local Councils) and community and voluntary representatives both to engage target groups and deliver key elements of the project
- ensure relevant health professional input into the programme delivery.

Project Promotion, Referral Mechanisms, Engagement

6 The project should be promoted positively to avoid any "stigma" and be of a non-competitive, and fun nature focusing on family activities.

7 In the management element, referrals should be made by key health professionals, such as school nurses, for those considered overweight/obese and who are willing to take action to address the issue. However there should be links with others operating in the community and voluntary sector who may be best placed to identify and engage the target group. Clear referral pathways need to be established.

8 Promotion of the prevention element and referrals should be encouraged directly with families, and through community and voluntary organisations engaging with families.

9 In the engagement of participants, the prevention element should focus on targeting early years children through the establishment of strong links with existing early years scheme/teams. The project should complement existing early years provision.

10 The management element should be targeted at families with children within a slightly older group, such as 8-11 years. Again, targeting through referral sources, schools and community organisations.

11 Scheme incentives should be attained through partnership delivery with, for example, local Councils, and have funder approval.

12 Six months is considered a reasonable timeframe for the management programme with a more flexible timeframe for the prevention programme, based on individual needs. The project should include follow-on engagement on a periodic basis to enable effective monitoring and evaluation on lifestyle changes.

The Community Development Approach

13 The project should recognise the importance of incorporating the "social" and "health" models in the development and delivery of each of the elements. This should be reflected on two levels:

- with the community sector being acknowledged as a referral/engagement mechanism through a cascade delivery mechanism, e.g. tendering for appropriate aspects of the project.
- with the community sector being acknowledged as part of the project structure - through the establishment of a community/voluntary, Community Development, sub group which has representation on the Project Board.

14 Any sub contracting process of the programme delivery should be able to demonstrate local partnership working and delivery in the process of stakeholder engagement. This should also allow for flexibility across the CAWT area to reflect

the differing environments while building on expertise through engaging local communities and acknowledging the work related to obesity which has already been undertaken.

Evaluation

15 In terms of measuring, monitoring and evaluating, the project should focus on looking at the impact/change relating specifically to those who have been involved, by adopting a person centred plan approach.

16 Baseline measurements for participants should also be taken at the outset, during and at the end of the programme so that they can measure their own progress in quantitative and qualitative terms. Quantitative measurements should include BMI, physical fitness levels, self esteem. Qualitative measurements should include questionnaires on perceptions on healthy eating, healthy messages, shopping habits, etc. Individual goal setting and monitoring should be encouraged. A range of measures and measurement tools are outlined in section 3.6.4 and 3.6.5.

17 Existing effective evaluative methods should be utilised.

18 Outcomes should be measured on the basis of:

- the change over time of participants' actions/attitudes as well as a weight/BMI
- potential savings to the health service in the long term
- effectiveness of the programme approach
- sustainability of habit changes following project participation

Some of the outcomes may only be realised in the long term and therefore "follow up" evaluation should be undertaken.

Adequate support should be available in relation to evaluating the health and well-being of participants.

1 Background

1.1.1 There is increasing concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The prevalence of obesity has risen up to three-fold in the last two decades. Half of all adults and one in five children in the World Health Organisation (WHO) European Region are overweight. Obesity levels in children across the island of Ireland are rising at an alarming rate. Statistics for primary 1 pupils in 2004 show that 13% of boys are overweight and 4% obese, compared to 20% of girls overweight and 7% obese. The trend is particularly alarming in children and adolescents, thus passing the epidemic into adulthood and creating a growing health burden for the next generation. Overweight and obesity contribute to a large proportion of non-communicable diseases, shortening life expectancy and adversely affecting the quality of life. More than one million deaths in the Region annually are due to diseases related to excess body weight.

The epidemic has built up in recent decades as a result of the changing social, economic, cultural and physical environment, which have created barriers to good nutrition and physical activity. With the ever increasing levels of obesity, the urgency of interventions and preventative measures are paramount for patient care.

Local governments have begun to address the problem of obesity as a priority in planning however, inter-sectoral action on obesity remains a challenge. It is possible to reverse the trend and bring the epidemic under control.

1.1.2 Co-operation and Working Together (CAWT) is the cross border health and social care partnership, comprising the Health Service Executive in the Republic of Ireland, the Health and Social Care Board, the Southern and Western Health & Social Care Trusts in Northern Ireland. CAWT's aim is to facilitate the partner organisations to work collaboratively in order to achieve the best possible health and social care outcomes for the population of the border area.

On behalf of both Departments of Health, CAWT is managing 12 cross border health and social care projects/services part financed by the European Union's European Regional Development Fund through the INTERREG IVA cross border programme managed by the Special EU Programmes Body.

CAWT with its partner organisations received approval on 10 June 2009 from both Departments of Health to proceed to consult directly with the wider community, voluntary and statutory sectors in relation to this three year cross border obesity prevention and management project aimed at young children and their families. As part of this engagement process a targeted planning event in the form of an Obesity Workshop was held on 26 June 2009 in the Armagh City Hotel.

1.1.3 Curbing the epidemic and reversing the trend in obesity is the ultimate goal of action in the Region (WHO European Charter on Combating Obesity, 2006). Visible progress, especially relating to children and adolescents, should be achievable in most countries in the next 4–5 years and it should be possible to reverse the trend by 2015 at the latest.

This Obesity project is the vision of many agencies. Many approaches have been tried and tested and have not had any impact on the rising levels of obesity.

The approach of this project would enable key stakeholders to have a targeted approach at community level on both sides of the border and give the opportunity to make a real difference to the lives of children and their families.

In line with CAWT this project would cover those populations within the following council areas: Derry, Strabane, Limavady, Omagh, Fermanagh, Armagh, Dungannon, Banbridge, Craigavon, Newry, Donegal, Sligo, Leitrim, Monaghan, Cavan and Louth.

The CAWT Obesity Project has two aspects:

- "Healthy Lifestyles" - A Community Approach to Prevention of Obesity, which is targeting 250 families within the early years setting, over the three year period. It is envisaged that this will be a 3 month programme based in the community setting.

- "Making a Difference" - A Family Approach to Managing Obesity, which is targeting 110 overweight/obese children aged 5-11 years and their families over the three year period (with a further impact on 520 people). It is envisaged that this will be a 6 month programme.

The project aims to make a difference to the health and lifestyle of those participating with a view to sharing the learning across the island of Ireland and integrating the knowledge into mainstream health and social care provision. It aims to lead to improvements in healthy eating, activity lifestyles and improved mental attitudes and promote positive mental health. This in turn should result in halting the rise in childhood obesity, better awareness of obesity related health messages, and better identification of healthy options. The Management programme should result in a clear referral pathway for overweight/obese children. It is also hoped that the project will result in improved joined up working between key professionals and sectors.

1.1.4 The project will be overseen by a CAWT appointed Project Board with representatives from the four CAWT partners, made up of:

- Dr Maura O'Neill (Chair) - Western Health and Social Care Trust

- Gerry Roddy - Health Service Executive Dublin North East

- Lynne Smart - Southern Health and Social Care Trust

- Anne McAteer - Health Service Executive West
- Brendan Bonner, Public Health Agency, NI

The project will be managed and delivered by the Project Manager, Claire McGinley.

2 Overview of the Workshop

2.1.1 The overall objectives of the workshop were:

1 To raise the profile of and share information on the Obesity Project

2 To begin the process of engagement with key stakeholders to influence the design/implementation of the project on specific areas

3 To provide an opportunity for key stakeholders to get involved in the project.

2.1.2 Workshop attendance reflected the targeted nature of the event and the multi-faceted nature of obesity, with representation from a wide variety of local stakeholders across the CAWT region currently involved in this area of work, or related fields. Appendix 1 provides a list of attendees and their associated organisations.

2.1.3 Workshop attendees participated in Group discussion and feedback sessions (section 3), a service mapping exercise, and were provided with the opportunity to register their interest to remain involved in the project. 50% of attendees confirmed their wish to be involved.

2.1.4 The Project Board and staff would like to thank all attendees for their extremely useful contribution, information sharing and feedback both in the group sessions and in the feedback session. There was a very high level of discussion and quality feedback from a wide range of perspectives across the CAWT area. This was particularly useful in terms of ensuring that all key angles were examined. The day provided a very useful learning experience for the Project Board and staff. The enthusiasm and involvement of attendees is greatly appreciated.

3 Workshop Feedback

3.1 Overview

3.1.1 This section provides an overview of the key issues highlighted during the day. These include comments recorded in each of the workshops and discussions during the feedback session. The next section (section 4) outlines the key findings and recommendations from the event.

3.1.2 The comments below generally relate to both the Management and the Prevention elements of the project unless it has been highlighted that a particular view relates to either one.

3.2 Question 1 - Identify key criteria to aid the selection of pilot sites

3.2.1 The discussions focused on the number of pilot sites and the criteria associated with the selection of sites.

3.2.2 In relation to the number of sites the general view was that the number of sites should ensure that the pilots allow for:

- some examination of the issues around the differences in structure, process and procedure within each jurisdiction
- some examination of the differences in running projects of this kind in rural and urban areas.

However, it was highlighted that there may still be differences in delivering in each setting in each jurisdiction so the overall view was that a rural and urban project should be piloted in each jurisdiction over the life of the project.

There was a view that the pilot projects would be much easier to manage and monitor if they were delivered in close proximity. However, the need to ensure pilots reflected the broader differences across the CAWT region was generally agreed and could be done so by ensuring a good geographical balance across the CAWT area.

3.2.3 In terms of where the pilots should be targeted the following issues were highlighted:

- It was generally agreed that the pilots should be targeted in areas of deprivation due to evidenced links between deprivation and overweight/obesity. However there were concerns that this might exclude some people who could benefit from the project but who do not live in a deprived area. While all children have a right to support in adopting a healthy lifestyle, the predominance of obesity is in areas of higher deprivation. It will be necessary to ensure links with key referral agents (see next question) are considered so that even if the project is "located" in a deprived area, others who need it can access it.

- While it was generally agreed that the project should build on existing services and structures which have proven successful in terms of engaging the target group and having a positive impact; the importance of recognising the need to deliver the project in areas of need with little infrastructure, was also highlighted. However it is important to remember that the focus of the project is on improving attitudes/actions towards overweight/obesity, and not on capacity building. It was therefore suggested that elements of "outreach" would need to be built in to the project design, to ensure that while it is building on existing services and infrastructures it is also "outreaching" to areas of need which have a weaker infrastructure.

- To ensure the approach of building on existing services and not duplicating provision, better co-operation and networking between those already providing relevant services was agreed. It was felt that this would be a means of taking on board lessons learned in existing initiatives. The importance and value of applying the lessons of not only local, but regional, national and global best practice models was also highlighted.

- In relation to the Prevention aspect of the project the need to link into early years settings (e.g. Surestart, Lifestart) and Primary Schools was stressed with the view that the earlier age group the project targets, the easier it will be to change attitudes and behaviour. These links are also important to ensure that the project complements work already being undertaken in early years settings.

- It was also highlighted that key health professionals need to be incorporated into the programme whatever the location or setting.

- It was emphasised that in relation to identifying pilot sites a mapping/scoping exercise needs to be undertaken to identify:

  - areas with higher levels of overweight/obesity
  - areas with a community readiness to implement
  - areas with a community capacity and infrastructure or access to one
  - areas where there are good existing services provided with evidence of success in engagement and impacts
  - areas where there are gaps where a service of this kind is needed

  Mapping of existing services is being undertaken as part of the project. Overall, it was emphasised that if the project were to adopt an open call approach, it would be important to

ensure that any application would clearly demonstrate local partnership working and delivery in the pilot area.

3.2.4 Some existing information sources and projects were highlighted as useful:

- NI - health and deprivation details at Super Output area
- NI - social asset study (NISRA)
- Clones-Erin East (Monaghan-Fermanagh)
- Blackwater Partnership
- North Leitrim Mens Project
- Springboard
- CAWT Accident Prevention Project.

3.3 Question 2 - Identify key criteria to aid the selection and continued engagement of children and families

3.3.1 Discussions focussed on engaging participants and identifying key referral sources, referral pathways, and referral criteria.

3.3.2 In relation to initial and sustained engagement of project participants the following issues were stressed.

- Awareness of the project needs to be promoted positively to ensure any negative "stigma" around obesity is minimised. Examples of awareness raising techniques included using community/church bulletins, community networks, papers, posters, leaflets, etc.
- The project needs to take a non competitive, fun and family focused approach to initially engage and sustain involvement (e.g. activities that involve the whole family to avoid a spotlight on the individual and to reflect the importance of parental influence while strengthening families).
- The importance of recognising participants placing in the "cycle of change" was also highlighted with the need to ensure, through screening, that families recognise the value of the programme and are willing to make changes to their attitudes and lifestyle. Securing families at this stage of the cycle would help to secure positive outcomes for the programme.
- The value of providing incentives to participants was discussed with the majority agreeing the benefit in offering these in areas such as reduced gym costs, or using leisure centres, etc.

This would aid initial engagement and may help to secure sustained involvement and lead to long term use of gym facilities/leisure centres. While others were cautious of the sustainability of incentives it was agreed that those secured through partnership delivery of the programme would be seen as adding value to the programme. The support of funders would be required to adopt such an approach.

- The programme needs to build in time to develop relationships which will ensure engagement and sustained involvement. 6 months was considered a reasonable timeframe for the management element with a shorter time frame for the prevention element. The need to have ongoing engagement with participants following the completion of the programmes to gauge the impact of the programmes was called for with, for example, re-engagement at 3, 6 and 12 month intervals (this is discussed in more detail in question 5).

- In recruiting numbers to the project it would be important to allow for an average drop off rate to ensure delivery of project outcomes.

3.3.3 In relation to referral sources, pathways and criteria the following issues were highlighted:

- In the case of the management element, referrals should be made by health professionals (GPs, Allied Health Professionals, pharmacists, school/public health nurses etc.). However, awareness raising through other partners such as community organisations, etc. might also be appropriate given that not all families would be in contact with health professionals in the community or have access to them through the school system. Clear referral pathways between potential referral agents are necessary.

- The base criteria for the management programme should be set somewhere between overweight and obesity.

- In relation to the prevention element it was stressed that the referral agents need to be wider than self referral acknowledging that many families would not recognise an issue around overweight/obesity. This reinforced the view that the project should be delivered as a proactive positive healthy lifestyle project.

- As mentioned before, targeting children at the early years stage in the prevention element was fully supported in order to change habits for life as soon as possible. There is a need to make strong links with existing early years projects/teams (e.g. Surestart, Lifestart, pre-schools, and community groups offering early years projects) to allow for the effective targeting of the right families and also to ensure complementarity rather than duplication.

- It was generally viewed that the management element should be targeted at a more refined age band within the proposed 5-11 year target group, due to the wide range in childrens' understanding and level of ability between the ages of 5 and 11 years. It was agreed that the slightly older age band of e.g. 8-11 years would be more suitable. At the 8-11 years stage children have a greater understanding of the issue and of their behaviour.

3.4 Question 3 - Identify any resources out there which could be adopted to meet part/all of the delivery programme

3.4.1 The discussions around existing provision/resources highlighted the following key issues:

- It was acknowledged that there are quite a number of initiatives already in operation which could be adopted/adapted to aid delivery of this project and from which key lessons could be learned. It is vital that the prevention and management elements build on already effective, evaluated, "off the shelf" programmes rather than research new approaches. (The project is funded to deliver and not to undertake research and should therefore recognise the wealth of obesity related resources available on both a local and a global scale e.g. in Canada, Scandinavia, and Australia, etc.).

- This project provides an opportunity to improve co-operation and collaboration and networking between existing initiatives.

- It was noted that while some areas within CAWT were already being served by obesity related programmes (e.g. Health Promoting Homes) there were gaps elsewhere. It would be valuable for the project to harness this expertise to aid other less served areas, possibly through the development of outreach partnerships. This approach which would harness the involvement of key health professionals and experienced community organisations as referred to before would serve to aid engagement and sustained participation.

3.4.2 Examples/suggestions of existing successful projects highlighted are noted in the Appendix 2. In addition, attendees posted information about initiatives they were aware of on the mapping sheets on the walls around the workshop room.

3.5 Question 4 - What Community Development approach would best work across the CAWT region, recognising the different environments within CAWT

3.5.1 The need to ensure that the "social model" is adopted alongside the "health/medical model" within the project to ensure robust participation and effective outcomes was viewed as essential. This would require the engagement of a range of community organisations and the adoption of community development approaches. This was viewed as vital given that promoting healthy lifestyles is a multi-faceted issue requiring social, cultural, non threatening, and enjoyable approaches to be adopted, particularly in engaging those who are hard to reach. A community development approach will, through its local delivery, improve engagement and participation by reducing the potential "stigma" of being involved in a project of this kind, and aid the sustainability of the project by embedding it in the community.

However, it was agreed that the need for appropriate links and involvement of key health professionals is vital to the project's success.

3.5.2 Involvement of the community sector is important on two levels:

- As a referral/engagement mechanism: Referrals from community organisations would aid participation in the prevention element given their reach into the local community. Delivery of the project on a local community level would be best placed through the tendering out of the projects to local community organisations. Where infrastructure is weak the need for local partnership working and delivery should be a requirement of any tender process, if adopted. Securing delivery through a local organisation would not only aid engagement and referral but also the embedding of the project into the community in the longer term.

- As part of the project structure: The need for representation of community organisations within the project structure was considered essential. The establishment of a voluntary and community sector subgroup was suggested as a mechanism of wider representation (representing the rural/urban, NI/RoI split). This subgroup could then feed into the Project Board. It was suggested that representation could be established through expressions of interest - perhaps through community networks and links with health initiatives which involve the community/voluntary sector such as Healthy Living Centres in NI and Community Partnerships and Sports Partnerships in RoI. Such an approach would help address concerns that involvement of the community and voluntary sector could be viewed as "tokenistic" when in fact it is vital for the success of the project.

The importance of including the education sector on the Board was also highlighted.

3.5.3 It was also considered important to ensure that the project encourages real and meaningful engagement and involvement with organisations who have demonstrated that they can work successfully within communities, particularly where voluntary and community sector activity itself is less well established. A cascading delivery mechanism such as tendering was viewed as a possible means of achieving this as well as sustainability, while demonstrating value for money. Such groups may be able to successfully tender for elements of the project's delivery and both community development and partnership approaches should be built into any process adopted.

3.5.4 The limitations and constraints and risks associated with the community and voluntary sector need to be realised and appropriate support and guidance and back up provided where necessary. For such reasons, as noted above (and below), the project should perhaps target a strong infrastructure ensuring that appropriate "outreach" is in place to ensure delivery in areas with less developed infrastructure. Such outreach work should ensure successful community development and partnership approaches are adopted. Organisations tendering for the delivery of the project should demonstrate how these approaches are adopted.

3.5.5 In terms of Community Development approaches which could be adopted (and have been proven to work), the following were suggested:

- Training voluntary and community sector representatives to aid in the delivery of a project. This cascade approach which allows for longer term sustainability of project activities
- Ensuring local ownership and involvement which is key to success
- Building on groups which currently engage families such as GAA and other sporting organisations
- Taking whole community approaches - e.g. healthy towns, neighbours, summer challenges - build a vision of health for the whole community
- Adopting child friendly and family friendly approaches - going to the park, playing ball, walking the dog
- Ensuring awareness of other social problems such as alcohol misuse, etc.

It was highlighted that sub contracting to local delivery agents which can secure stakeholder engagement can also allow for flexibility across the CAWT area to reflect the differing environment across the CAWT area. This can also build on expertise through engaging local communities while acknowledging the work related to obesity already undertaken.

3.5.6 While the programme will have similar elements (around healthy eating, exercise, etc.) it will perhaps have to be delivered in different ways across the region to account for differences in structure and existing provision. This will allow for good learning about different approaches. However the principal goals will remain the same as will the principle of involving health professionals and community and voluntary sector representatives in established and "proven successful" settings.

3.6 Question 5 - How will we know that the project has made a difference and in this project area what evaluation approach/method works best?

3.6.1 A wide range of suggested evaluation measures were discussed and suggested.

3.6.2 In terms of WHAT to measure, it was generally deemed important to ensure that the project is not being measured against targets which it could not possibly influence, or which could be influenced by other factors. For example, it would not be appropriate to just look at levels of obesity/overweight as a whole and see whether or not there has been any

reduction because there are a wide range of factors outside of the project's control which could affect this. Rather, participants should be measured against themselves to determine whether participation in the project has had any impact in improving their health and wellbeing on a number of levels.

3.6.3 The suggested option of a "person centred plan" approach which would note changes over time would allow for participants' differing backgrounds/baselines and would measure like against like. It was noted that this could then be commented on as for example, "x% of people spent 20% extra time on physical activities and/or ate 10% more fruit/veg over 6 months and experiences a 20% reduction in weight/BMI". Baseline measurements for participants should also be included so that they set their own goals and measure their own changes and progress in quantitative and qualitative terms. In terms of quantitative measurements this would include recording measurements prior, during and after for levels of BMI, physical fitness and self esteem. In terms of qualitative measurements this would include recording measurements prior, during and after questionnaires on perceptions on healthy eating, healthy messages, shopping habits, etc. This should help to ensure that individuals are involved in setting and monitoring their own goals. Again follow up measurement should continue on a periodic basis to chart longer term lifestyle changes.

3.6.4 The key measures highlighted as important included both clinical and non clinical outcomes:

- numbers of people engaging (and background of those engaging - traditionally hard to reach?)
- changes in BMI
- changes in waist/arm sizes
- changes in eating habits
- changing in exercise habits
- changes in family activities
- changes in knowledge about healthy lifestyles (nutrition and physical activity)
- changes in mental health (the need to ensure an effective and evaluated tool would be used along with the need to clarify support should the outcomes require it was stressed)
- cost effectiveness (e.g. cost of this programme against cost of overweight/obesity to the health sector in the short/medium/long term)

- effectiveness of adopted approach re: partnership working, community development approach, etc.
- sustainability of habit following participation on the project

3.6.5 In terms of measurement/evaluation tools a range of suggestions were put forward. Most of these would involve measurement at the "before, during and after" stages. These included:

- food diaries/portion sizes (use of flash cards re: portion sizes)
- till receipts - increased purchase of healthy foods
- weight, BMI
- participatory research at community level
- visual questionnaires for kids
- use of person centred plans
- pre and post questionnaires, interview, focus groups - tailored to age groups
- drop out percentage (and identification of barriers to commitment)
- pedometers, excelometers
- cholesterol levels
- use of gyms/other sporting venues
- time spent undertaking physical activity
- delivery agents views on what works well/could be improved
- leverage - benefit "in kind" from other agencies
- contact with health services (though this could increase if people are more aware - particularly initially - rather than decrease)
- family interaction - do family now eat together?

It must be acknowledged that some of these changes may only occur over the longer term and so evaluation needs to include post project "follow up". It was also considered important to ensure that any follow up spot checks are undertaken at a consistent time of the year (e.g. activity levels and healthy eating may be more likely in the summer months compared to

Christmas). As suggested in section 3.3.2 above the project could build in contact with participants at regular intervals during and after their involvement to monitor changes and progress, ideally through planned events.

Consideration should be given to ensuring existing evaluative methods are utilised. In fact throughout the programme it is envisaged that activities which have proven successful through evaluation are adopted.

4 Recommendations

4.1.1 Having reviewed the discussion the main recommendations are as follows:

Project Structure

1 There should be 4 sites for each aspect of the project in the first year of the pilot phase. These should ensure a rural/urban and NI/RoI split. The selection of the pilot sites should be based on deprivation levels, obesity levels, current provision, and appropriate community/health infrastructures.

2 The Project should build on and complement existing services and structures which have proven successful in terms of engaging the target group and having a positive impact, but not duplicate related services.

3 To aid the selection of pilot sites a mapping/research exercise should be undertaken in the CAWT area to identify areas of deprivation/obesity/overweight, and existing services, structures and gaps.

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5 The project should:

- encourage co-operation between existing successful initiatives and the new initiatives developed through the funding to maximise the potential for sustainability and learning purposes
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- ensure relevant health professional input into the programme delivery.

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6 The project should be promoted positively to avoid any "stigma" and be of a non-competitive, and fun nature focusing on family activities.

7 In the management element, referrals should be made by key health professionals, such as school nurses, for those considered overweight/obese and who are willing to take action to address the issue. However there should be links with others operating in the community and voluntary sector who may be best placed to identify and engage the target group. Clear referral pathways need to be established.

8 Promotion of the prevention element and referrals should be encouraged directly with families, and through community and voluntary organisations engaging with families.

9 In the engagement of participants, the prevention element should focus on targeting early years children through the establishment of strong links with existing early years scheme/teams. The project should complement existing early years provision.

10 The management element should be targeted at families with children within a slightly older group, such as 8-11 years. Again, targeting through referral sources, schools and community organisations.

11 Scheme incentives should be attained through partnership delivery with, for example, local Councils, and have funder approval.

12 Six months is considered a reasonable timeframe for the management programme with a more flexible timeframe for the prevention programme, based on individual needs. The project should include follow-on engagement on a periodic basis to enable effective monitoring and evaluation on lifestyle changes.

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13 The project should recognise the importance of incorporating the "social" and "health" models in the development and delivery of each of the elements. This should be reflected on two levels:

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15 In terms of measuring, monitoring and evaluating, the project should focus on looking at the impact/change relating specifically to those who have been involved, by adopting a person centred plan approach.

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- the change over time of participants' actions/attitudes as well as a weight/BMI
- potential savings to the health service in the long term
- effectiveness of the programme approach
- sustainability of habit changes following project participation

Some of the outcomes may only be realised in the long term and therefore "follow up" evaluation should be undertaken.

Adequate support should be available in relation to evaluating the health and well-being of participants.

5 Next Steps

5.1.1 The discussion and recommendations will be reviewed by the Project Board at its next meeting in August with a view to incorporating these into the development of the overall Obesity Project Plan.

5.1.2 Project Updates will be available through the project web page www.cawt.com/obesity on a regular basis.

5.1.3 The mapping of obesity related services will be accessible on the project web page www.cawt.com/obesity. Please forward any new or additional service information to update this exercise through the web site e-mail service.

Appendix 1
CAWT Obesity Planning Workshop 26/06/09
Attendee List

	NAME	TITLE	ORGANISATION
1	Bronagh Donnelly	Locality Action for Children Coordinator	Action for Children
2	Mary Breslin	Coordinator of Nutrition & Older People	Brandywell & Bogside Health Forum
3	Nadine Crotty	Sports Coordinator	Cavan Sports Partnership
4	Sadie Bergin	Communications Manager	CAWT
5	Joanne McDermott	Admin Support	CAWT
6	Claire McGinley	CAWT Obesity Project Manager	CAWT
7	Brigid McGinty	Programme Manager	CAWT
8	Jessica Perry	Regional Coordinator	Chest Heart & Stroke NI
9	Therese Laverty	Sports Inclusion Disability Officer (SIDO)	Donegal Sports Partnership
10	Gerry Roddy	Health Promotion Manager/CAWT Obesity Project Board	HSE-DNE
11	Susanne Shevlin	Senior Community Dietician	HSE-DNE
12	Tara Kearns		HSE-DNE
13	Emma Ball	Community Dietician Manager	HSE-West
14	Dr Caroline Mason	Principal Medical Officer	HSE-West
15	Anne McAteer	Health Promotion Officer/CAWT Obesity Project Board	HSE-West
16	Tracey O'Neill	Public Health Intelligence Officer	Institute of Public Health (Ireland)
17	Kieran McCartney	Active Lifestyle Officer	Limavady Borough Council
18	Catherine Smyth	Public Health Nurses	Louth Community Services

19	Mary Browne	Sports Coordinator	Louth Local Sports Partnership
20	Oliver McCaffrey	Programme Coordinator	Oak Healthy Living Centre
21	Seamas Heaney	Project Director	Old Library Trust, Healthy Living Centre
22	Brendan Bonner	Investing for Health Manager/CAWT Obesity Project Board	Public Health Agency (Western Area)
23	Cathy Mullan	Health Promotion Commissioner	Public Health Agency (Western Area)
24	Lyn Donnelly	Investing for Health Manager	Public Health Agency (Southern Area)
25	Marita Hennessy	safefood Fellow	safefood
26	Gerard Rocks	Head of Health Promotion	SHSCT
27	Sandra Glover	Community Food Coordinator	SHSCT
28	Sinead Harte	Community Dietician	SHSCT
29	Lynne Smart	Promoting Wellbeing Specialist Lead / CAWT Obesity Project Board	SHSCT
30	Jacinta Linden	Project Coordinator	South Down Family Health Initiative
31	Alan Curran	Sports Partnership Officer	Southern Sports Partnership
32	Fiona Teague	Active Families Coordinator	Western Group Environmental Health
33	Claire Holmes	Community Dietician	WHSCT
34	Avril Morrow	Health Promotion Officer	WHSCT
35	Dr Maura O'Neill	Head of Health Promotion/Chair CAWT Obesity Project Board	WHSCT
36	Shauna Robinson	Nutritionist	WHSCT
37	Gillian Irvine	Management Consultant	Williamson Consulting

Appendix 2

Question 3 - Successful Projects Highlighted during Workshops

- GP Exercise referral programme
- Community Pharmacy obesity management programme (12 weeks) - recently launched in the Western Area
- Cook It (family support workers have been trained up in HSE areas)
- US - CATCH
- Health Promoting Homes
- Active Families programme - a tool kit already in place (preventive)
- Munch Box
- Healthy Breaks
- Food for Thought
- Breakfast Club
- Summer Scheme
- Active for Life
- Fresh (Lisburn) - SE Trust
- Over to You project - targeted at obese kids of 11-12 years (8 week programme - nutrition and physical activity) which is more focused on management (BMI assessment)
- “kid zone” and peer support progammes developed by HLC
- Body Balance - cross border programme - to train practice nurses to offer weight management advice. This has been evaluated and is currently being updated for further roll out.
- Oral health, breast feeding, physical activity work in Local Authorities

- Top Tots
- Playing Together
- Traditional sports tasters - pathways to local clubs
- Dig it and eat it
- Healthy steps to life
- Weigh to Health
- Good Food Tool kit
- Bantas tutors
- Parent and play workshop
- Healthy food made easy

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