Public Health England

Protecting and improving the nation's health

Resource E: Action mapping tool

Supporting guide

A tool to understand your current and future actions for tackling obesity locally

This resource is part of Public Health England's wider whole systems approach to obesity programme. Please search to find the main guide and additional resources.

25/07/19

Contents

Introduction

Most local authorities implement actions for the prevention and treatment of obesity.

Various actions are being taken by local authorities to tackle obesity, but the extent to which these actions are joined up is not always clear.

A whole systems approach to obesity aims to help better align current and planned actions, to maximise effectiveness and efficiency.

Before developing a whole systems approach, it is important to understand how your local authority currently approaches obesity.

A first step in phase 2 (Building the local picture) is to document and critically reflect on your actions on obesity.

The action mapping tool enables you and your colleagues to map current and planned actions on obesity.

Purpose of the action mapping tool

1. Collate key information about local actions on obesity.

2. Map current and planned actions against causes of obesity.

3. Understand where current actions are being invested and where future efforts may need to be targeted.

4. Self-assess actions and key performance indicators (KPIs) against anticipated outcomes.

This supporting guide provides assistance for those completing the action mapping tool.

How to use the tool

People with a broad oversight of the local obesity agenda are best placed to lead on the completion of this tool. It should be completed through interaction with your colleagues (from across sectors and organisations).

There are two options for completing the tool.

Option 1 (slide 9 to 15)
By the end of this process you will have:

- mapped your current and future (planned) actions against the Wider Determinants of Health model

Option 2 (slide 16 to 21)
By the end of this process, you will also have:

- evaluated the likelihood of meeting your intended outcomes through the actions
- determined which sectors are currently involved in the obesity agenda
- documented the type of evidence used to commission actions

Note: This option builds on option 1.

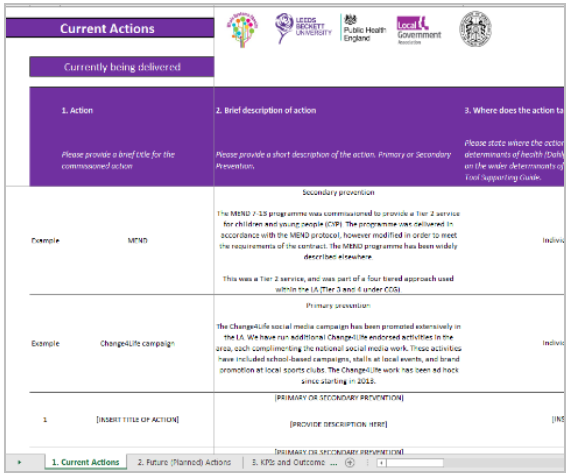
Action mapping tool

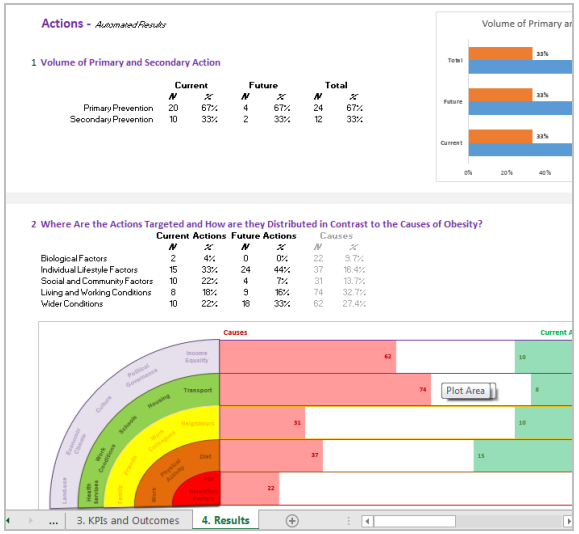
Action mapping tool: Overview

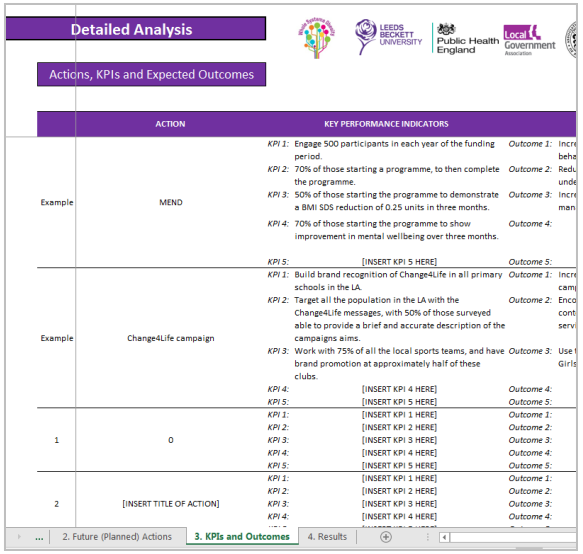
This tool is a pro forma with 4 sections:

1. Current actions
2. Planned actions
3. Key performance indicators and outcomes
4. Results

The remainder of this guide explains how to complete both available options.







Mapping actions

Mapping actions: Option 1

This section explains how to complete option 1 of the action mapping.

The action mapping tool is required for this option.

Your actions are automatically mapped against the Wider Determinants of Health model on completion.

Completion of this option provides stakeholders with a basic understanding of actions undertaken across the local area.

Option 1
By the end of this process you will have:

- mapped your current and future (planned) actions against the Wider Determinants of Health model

Time required: 2 – 5 hours.

Who: Through interaction with your colleagues (cross-sectoral)

How to identify which relevant stakeholders to work with on this task are included in the guide (slide 49)

Mapping actions: Option 1

Step 1: Current actions

- for option 1, only the first 3 columns in the current and planned action worksheets need to be completed
- the remaining 5 columns are required to be completed for option 2
- as a first step, work with colleagues to identify and list all the current actions that are being undertaken to prevent or reduce obesity
- provide a brief title (column 1) and description (column 2) for each action e.g. MEND, Change4Life campaign…

For example…

	1. Action *Please provide a brief title for the commissioned action*	2. Brief description of action *Please provide a short description of the action. Primary or Secondary Prevention.*
Example	MEND	Secondary prevention The MEND 7-13 programme was commissioned to provide a Tier 2 service for children and young people (CYP). The programme was delivered in accordance with the MEND protocol, however modified in order to meet the requirements of the contract. The MEND programme has been widely described elsewhere. This was a Tier 2 service, and was part of a four tiered approach used within the LA (Tier 3 and 4 under CCG).
Example	Change4Life campaign	Primary prevention The Change4Life social media campaign has been promoted extensively in the LA. We have run additional Change4Life endorsed activities in the area, each complimenting the national social media work. These activities have included school-based campaigns, stalls at local events, and brand promotion at local sports clubs. The Change4Life work has been ad hock since starting in 2013.

Mapping actions: Option 1

Step 2: Where is the action targeted?

- the third column asks you to indicate where the action is targeted with regards to the Wider Determinants of Health (Dahlgren and Whitehead, 1991) – see next slide for detail
- tip: when categorising the action, think about who or where the action is targeted
- on completion of this step, you can see how your actions map against the perceived causes of obesity

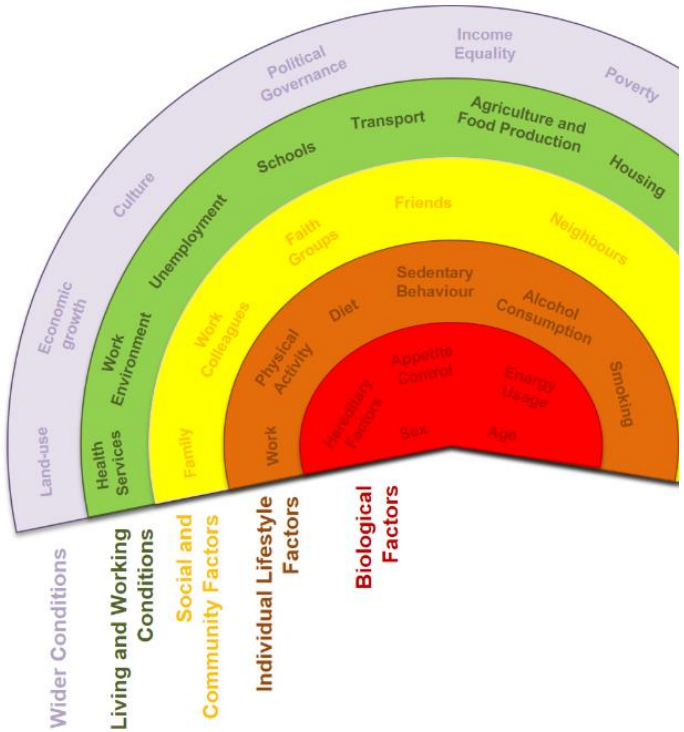
For example…

2. Brief description of action *Please provide a short description of the action. Primary or Secondary Prevention.*	3. Where does the action target? *Please state where the action targets with regards to the wider determinants of health (Dahlgren and Whitehead, 1991). Information on the wider determinants of health are provided in the Action Mapping Tool Supporting Guide.*
Secondary prevention The MEND 7-13 programme was commissioned to provide a Tier 2 service for children and young people (CYP). The programme was delivered in accordance with the MEND protocol, however modified in order to meet the requirements of the contract. The MEND programme has been widely described elsewhere. This was a Tier 2 service, and was part of a four tiered approach used within the LA (Tier 3 and 4 under CCG).	Individual Lifestyle Factors
Primary prevention The Change4Life social media campaign has been promoted extensively in the LA. We have run additional Change4Life endorsed activities in the area, each complimenting the national social media work. These activities have included school-based campaigns, stalls at local events, and brand promotion at local sports clubs. The Change4Life work has been ad hock since starting in 2013.	Individual Lifestyle Factors

Mapping actions: Option 1

Adapted from Dahlgren and Whitehead (1991)

- on the right, is an adapted version of the Wider Determinants of Health model
- all of the factors are seen to impact upon health
- from the individual-level biological factors, to the conditions in which we live, work, and play…to the wider conditions, which include cultural and political influences
- the causes of obesity and actions on obesity, can be mapped against these five levels



Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm, Sweden: Institute for future studies; 1991.

Mapping actions: Option 1

Step 3: Planned actions

- to be completed in the separate worksheet (2. planned actions)
- repeat the previous process, but work with colleagues to identify and list all the planned actions that have been agreed upon to prevent or reduce obesity in the next 3 years
- provide a brief title (column 1) and description (column 2) for each action for example, cycle pathways
- categorise where you think the action is targeted

For example…

1. Action *Please provide a brief title for the action to be commissioned*		2. Brief description of action *Please provide a short description of the action. Primary or Secondary Prevention.*
Example	Cycle Pathways	Primary prevention A cycle pathway infrastructure to be developed in to and out of the town centre. The cycle network is forecast to increase the number of active commuters within the locality, which will subsequently reduce the number of car users. The current number of active commuters has been stable over the last five years. This is part of a wider strategy to make the town centre a traffic-free zone, and additionally to transfer the town centre car parks to the periphery of the town. A media campaign in the LA will support the uptake of the cycle pathway network.

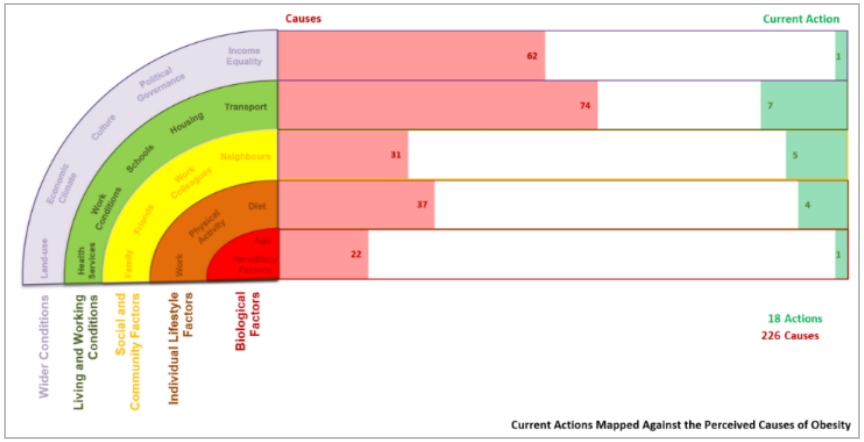
Mapping actions: Option 1

Step 4: Results

- after completing the first 3 columns of worksheet 1 (1. current action) and 2 (2. planned action), results will be automatically generated in worksheet 4 (4. results)

- these results highlight how your current and planned actions map against the Wider Determinants of Health model

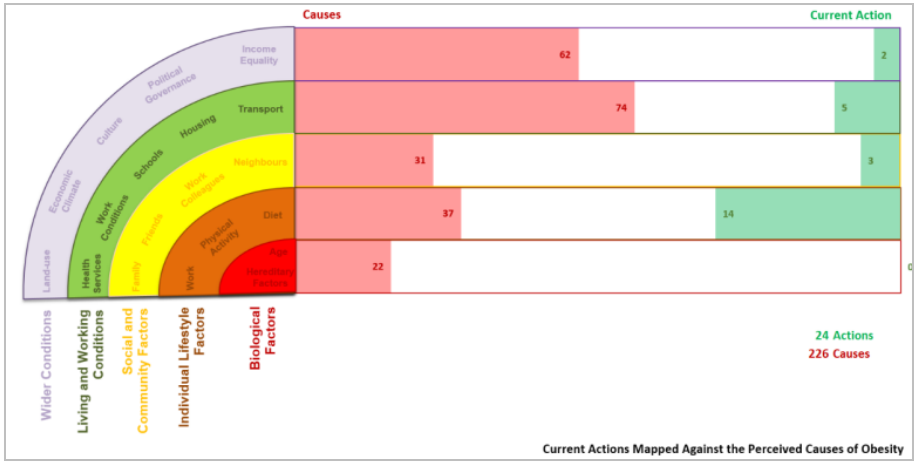
- the model also automatically displays how your actions map against the perceived causes of obesity. See Appendix A in this presentation (slides 26-29) for more information on the causes

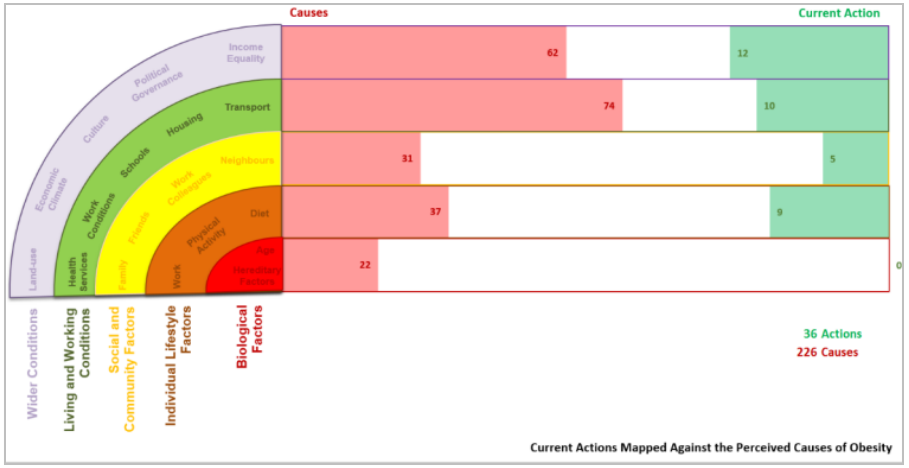


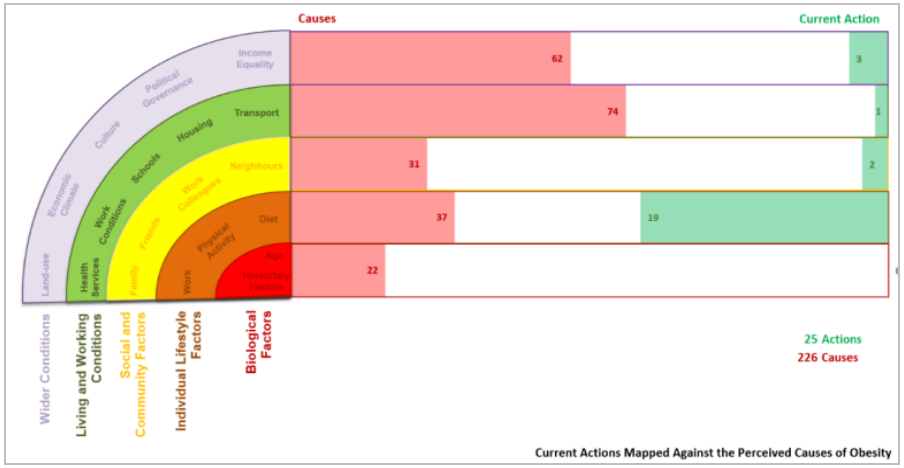
Further information on how to interpret your results is available on slide 22.

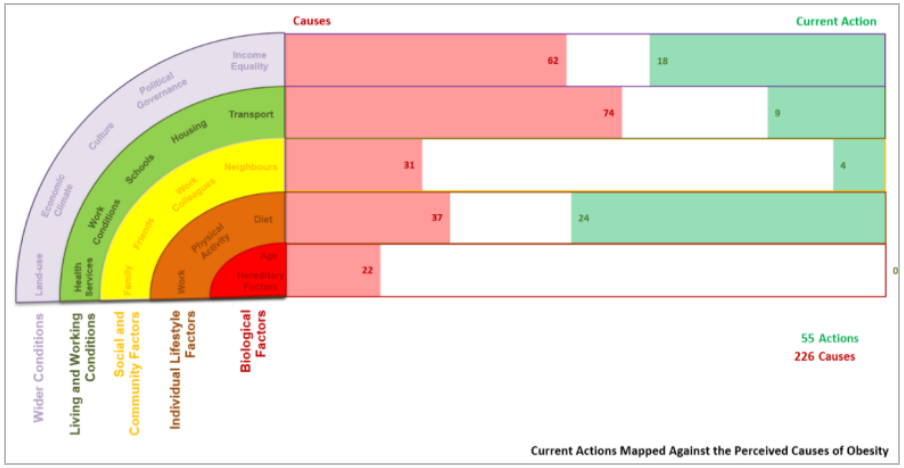
Mapping actions: Option 1

Examples from other local authorities









Mapping actions: Option 2

The next section explains how to complete the option 2 analysis.

The action mapping tool is required again here.

Results are automatically generated on completion of this analysis.

Completion of this option provides stakeholders with a detailed understanding of actions undertaken across the local authorities.

Option 2 (slides 16-21)

By the end of this process, you will also have:

- evaluated the likelihood of meeting your intended outcomes through the actions
- determined which sectors are currently involved in the obesity agenda
- documented the type of evidence used to commission actions

Note: This option builds on option 1.

Time required: Up to an additional 15 hours.

Who: Through interaction with your colleagues (cross-sectoral).

Mapping actions: Option 2

Step 1: Complete pro-forma

- work with colleagues to complete the remaining 5 columns (columns 4-8) in the action mapping tool
- the level of detail required for each column is explained in the tool
- there is sufficient space to enter up to five KPIs, outcomes, target groups, sectors involved and evidence considered
- drop-down lists are provided to make the completion of the pro forma quicker. Where drop-down lists are not provided please manually enter responses

Complete examples in the tool

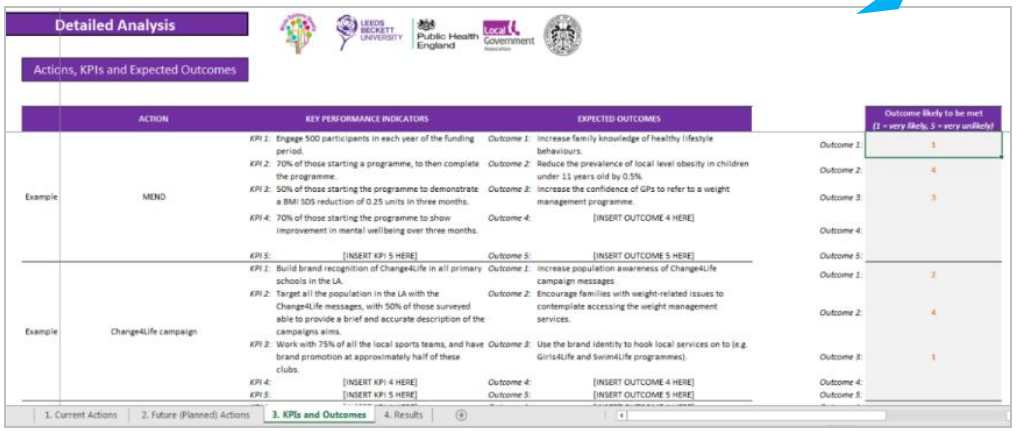
Completed examples and further information, are provided in the tool

Mapping actions: Option 2

Step 2: Alignment of KPIs and outcomes

- with the KPIs and Outcomes worksheet open, each KPI and outcome is automatically populated
- the column in grey (see far right) is the only column that requires completion in this worksheet
- starting with the outcome (for example, outcome 1), reflect with colleagues on the extent to which the outcome is likely to be met through implementation of the action – provide your response in the far right column
- use the KPIs to help facilitate this discussion

This column requires completion



Five response options are available:

1. Very likely to be achieved.
2. Likely to be achieved.
3. Uncertain that action will achieve outcome.
4. Unlikely to be achieved.
5. Very unlikely to be achieved.

Mapping actions: Option 2

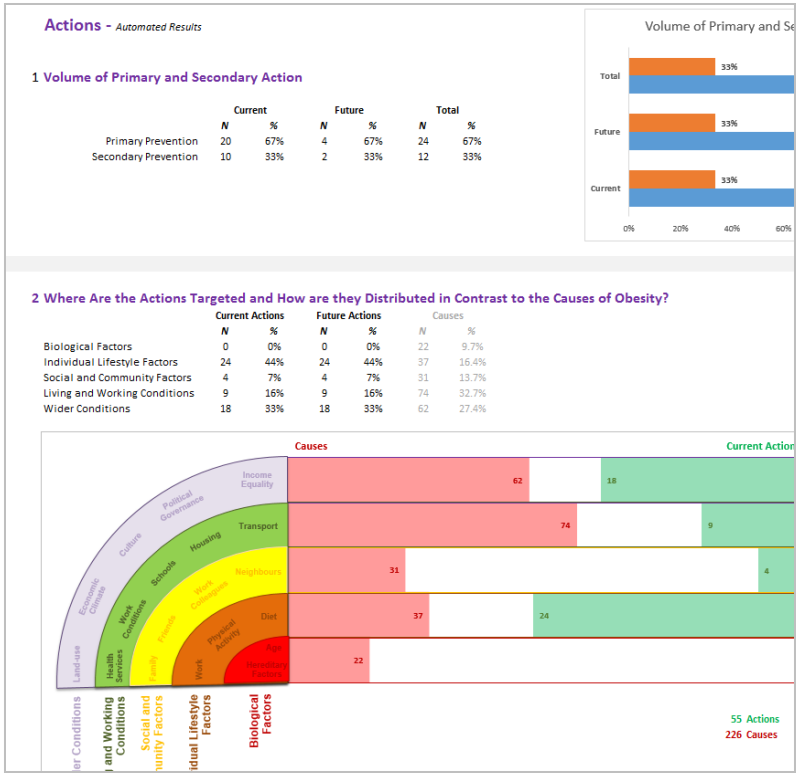
Step 3: Results

Once all of the outcomes have been assessed against their respective actions, open worksheet 4 (4. Results).

Automated results are available for 6 pre-determined questions:

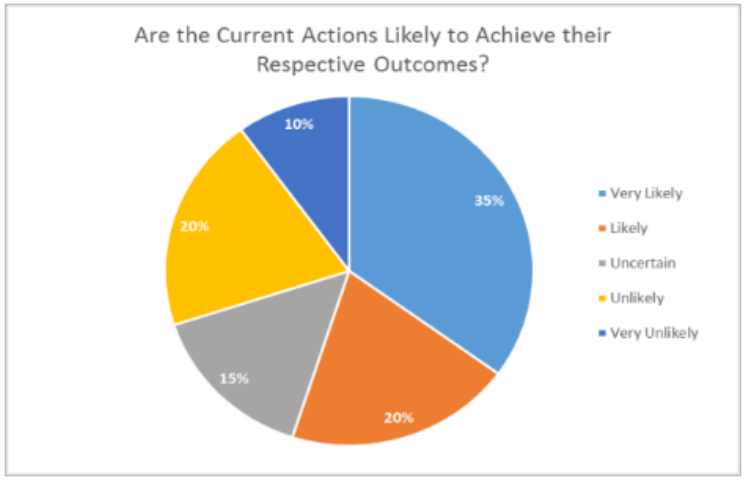
- volume of primary and secondary prevention actions?
- where are the actions targeted?
- are actions likely to meet their outcomes?
- who is primarily responsible for actions?
- who is associated with the actions?
- what evidence is considered when commissioning or delivering actions?

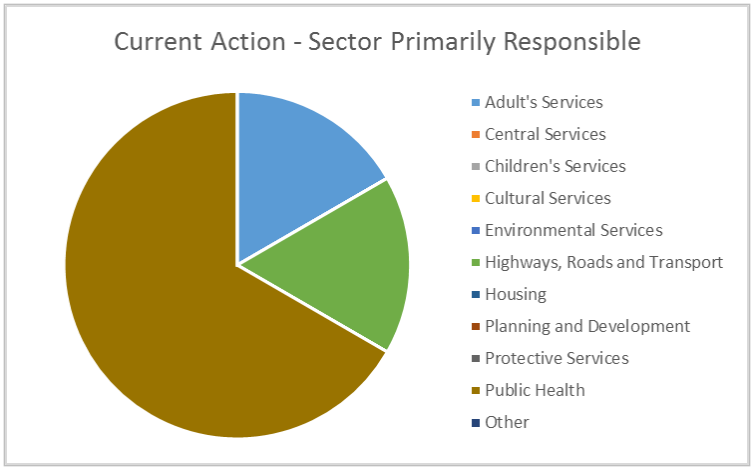
Open worksheet 4

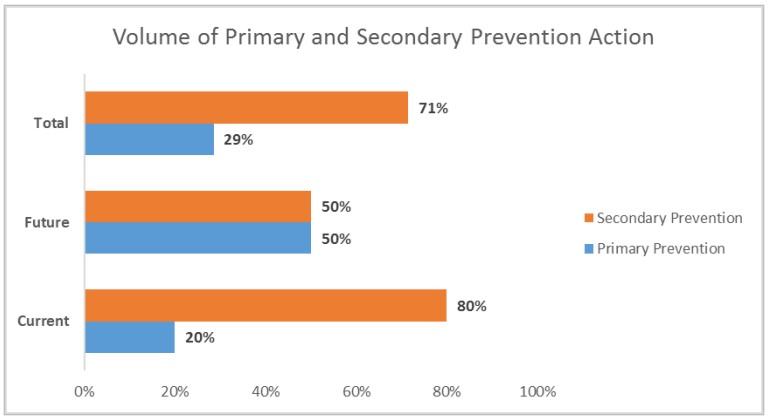


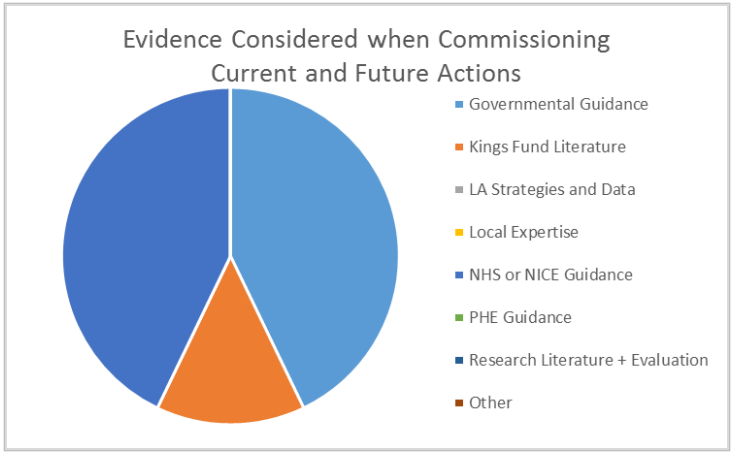
Mapping actions: Option 2

Example results include…









Mapping actions: Option 2

The automated results present a generic overview of the data within the action pro-forma.

Local authorities completing the option 2 analysis are expected to reflect on the picture presented of their current and future (planned) actions.

These analyses identify whether a wide variety of sectors are involved, if there is a balance of primary and secondary prevention, and if the outcomes are likely to be achieved.

Additional information:

Local authorities completing the tool may want to undertake additional analyses and share the tool and the associated results across the organisation.

This may bolster the starting point for a whole systems approach. Stakeholders should have a clear and detailed understanding of the actions undertaken across the local authority.

Interpreting the results

Interpreting the results

You should now have documented all actions and mapped these against the Wider Determinants of Health and the causes of obesity (Appendix A).

The following slides provide further detail on how to interpret your local map.

These maps illustrate:

1. The current level of action being undertaken to prevent and treat obesity.
2. Where efforts are currently invested to prevent and treat obesity.
3. How local actions map against the perceived causes of obesity.
4. The areas where local authorities could invest effort in the future.

Interpreting the results

Action versus causes

Your action map provides a representation of the current approach.

When the causes of obesity (see Appendix A) are mapped against the Wider Determinants of Health, the majority can be found within the Living and Working Conditions and the Wider Conditions levels.

The system mapping workshops (workshop 1 in phase 3) will help you identify the local causes of obesity and where it may be best to intervene in your local system.

The action map does not account for further detail associated with each action (for example, reach, effectiveness, cost, return on investment etc…), nor how actions work in combination.

It is unlikely that local authorities are able to influence the biological factors associated with obesity, as outlined in the local authority examples provided.

Interpreting the results: Planned action

Reflecting on your current approach, how does your action map look and do you see areas for development?

- who else needs to be involved in the obesity agenda? (link with your Network Analysis)
- are actions being taken across the Wider Determinants of Health?
- how could our current and future actions be strengthened?

In Phase 4 (Action), stakeholders will be required to think about additional actions that can be implemented to create a healthier system.

These stakeholders will be made aware of the actions current and future (planned) actions (such as, those outlined in the action mapping tool), so that any proposed actions can be aligned. Aligning actions will strengthen impact and reduce duplication of effort.

Appendices

Appendix A: Local causes of obesity

Perceived local causes of obesity were collected from five local authorities; a total of 448 causes were identified which were truncated into 155 unique causes.

The causes of obesity as determined by Foresight (2007) were also added if local authority had not mentioned them; an additional 71 causes were therefore added (shown in bold on the following slides).

A total of 226 causes were included in the model.

Each of the 226 causes – and their classifications against the Wider Determinants of Health model – are listed on the next two slides.

Butland B, Jebb S, Kopelman P, McPherson K, Thomas S, Mardell J, et al. Tackling obesities: future choices – project report. 2nd ed London: Government Office for Science 2007.

Appendix A: Local causes of obesity

Biological Factors
Addictive nature of food
Side effects of medication
Physical and mental disability
Sub-conscious eating
Appropriateness of embryonic & fetal growth
Appropriateness of child growth
Appropriateness of nutrient partitioning
Degree of optimal GI signalling
Degree of primary appetite control by brain
Extent of digestion and absorption
Genetic and/or epigenetic predisposition to obesity
Importance of physical need
Level of adipocyte metabolism
Level of available energy
Level of fat-free mass
Level of satiety
Level of thermogenesis
Non-volitional activity (NEAT)
Predisposition to activity
Resting metabolic rate
Strength of lock-in to accumulate energy
Tendency to preserve energy

Individual Lifestyle Factors
Alcohol consumption
Competing time demands – individuals
Cooking skills
Diet quality
Eating out of home
Emotional wellbeing
Food budgeting skills
Health literacy
Knowledge of local physical activity opportunities
Level of screen time
Level of sedentary behaviour
Levels of active travel
Personal motivation
Quality of sleep
Quantity of sleep
Reason for eating
Self-efficacy in physical activity
Smoking cessation
Social media use
Unhealthy lifestyle habits
Unstructured meal times
Uptake of school sport
Volume of food consumption
Appropriateness of maternal body composition
Conscious control of accumulation
Degree of innate activity in childhood

Demand for indulgence/compensation
Effort to acquire energy
Food literacy
Force of dietary habits
Functional fitness
Learned activity patterns in early childhood
Level of domestic activity
Level of recreational activity
Psychological ambivalence
Rate of eating
Tendency to graze

Social and Community Factors
Actual community safety
Breastfeeding rates
Celebratory events
Cohesiveness of community
Community identity
Family eating behaviour
Family income
Family physical activity culture
Financially-driven food choices
Focus on sport vs. health
Food as reward
Child care at home
Infant feeding practices
Parental education
Parental recognition of child weight

Parental role modelling
Parental weight status
Parenting style and skills
Pester power
Quality of packed lunches
Safe physical activity environments
Social isolation
Social motivation
Unhealthy food availability at home
Uptake of school meals
Weaning period
Children's control of diet
Desire to resolve tension
Face to face social interaction
Opportunity for team-based activity
Parental control

Living and Working Conditions
Access to vending machines
Active travel infrastructure
Air quality
Appeal of local facilities/spaces
Appeal of school meals
Availability of public transport
Availability of role models in school
Available Physical activity opportunities
Cake culture
Car use

Choice availability in supermarkets
Community prospects
Cooking equipment availability
Cost of food in workplace
Facilities available at work (food)
Facilities available at work (physical activity)
Fast food promotions
Food availability
Food education at school
Food formulation
Hidden ingredients
Inclusivity of PE offer
Length of work breaks
Amount of homework
Level of occupational physical activity
Level of personal free time
Local food production
Long working hours
Mandatory lunch breaks
Number of children in school sport
Number of local, desirable employers
Organisational motivation and behaviours
Price promotions on food
Prioritisation of health at school

Appendix A: Local causes of obesity

Prioritisation of physical activity in curriculum
Quality of food offer at work
Quality of green/outdoor space
Quality of school meals
Quality of transport links
Road safety
Rural isolation
Safety of public transport
Salaries
School allocation
School prioritisation of learning
Sedentary jobs
Shared accommodation
Shift working
Single person households
Snack availability at work
Social pressure at work
Space in schools for physical activity
Supermarket packaging
Time and capacity to teach about healthy lifestyles
Traffic levels
Travel policies
Unemployment
Volume of school physical activity
Volume of school PE
Work pressure
Workplace policy

Desire to differentiate food offerings
Effort to increase efficiency of production
Energy-density of food offerings
Fibre content of food and drink
Food exposure
Level of female employment
Nutritional quality of food and drink
Opportunity for unmotorised transport
Palatability of food offerings
Pressure on job performance
Pressure to cater for acquired taste
Purchasing power
Standardisation of food offerings

Wider Conditions
Access to fast food
Access to food
Access to mental health services
Body image
Capital/city pull
Competing time demands – council
Consistency of health-related messages
Consumerism
Convenience culture
Convenience of food offerings
Cost of food

Cost of healthy vs. unhealthy food
Cost of physical activity/sport
Cultural food preferences
Cyclability
Demand for unhealthy food
Energy drink culture
Fad-diet culture
Food advertising
Food culture
Health offer of high streets
Inclusivity of sport
Industry driven food offerings
Industry promotion of bottle feeding
Normalisation of obesity
Physical activity not perceived as important
Physical activity undesirable for children
Perceived community safety
Personal interaction via social media
Portion size
Safe routes to school
Social behavioural norms
Socioeconomic status
Sponsorship of sporting events
Stigmatisation of obesity
Technological revolution
Volume of green space
Volume of healthy food shops
Volume of out-of-home food offerings

Walkability
Winter daylight hours
Acculturation
Ambient temperature
Conceptualisation of obesity as a disease
Demand for health
Desire to maximise volume
Desire to minimise cost
De-skilling
Effort to increase efficiency of consumption
Food variety
Individualism
Level of infections
Market price of food offerings
Pressure for growth and profitability
Pressure to improve access to food offerings
Reliance of labour-saving devices
Reliance on pharma remedies
Reliance on surgical interventions
Social depreciation of labour
Social rejection of smoking
Societal pressure to consume
Sociocultural valuation of physical activity