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The role and status of evidence and innovation in the Healthy Towns programme in England: qualitative stakeholder interview study

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Abstract

Background—In 2008 the Healthy Community Challenge Fund commissioned nine ‘Healthy Towns’ in England to implement and evaluate community-based environmental interventions to prevent obesity. This paper examines the role of evidence in informing intervention development, innovation, and the potential for programmes to contribute to the evidence base on the effectiveness of interventions that tackle population obesity.

Method—Twenty qualitative interviews with local programme stakeholders and national policy actors were conducted. Interview transcripts were coded and thematically analysed. Initial analyses were guided by research questions regarding the nature and role of evidence in the development and implementation of the Healthy Towns programme and the capacity for evidence generation to inform future intervention design, policy and practice.

Findings—Stakeholders relied on local anecdotal and observational evidence to guide programme development. While the programme was considered an opportunity to trial new and innovative approaches, the requirement to predict likely health impacts and adopt evidence-based practice was viewed contradictory to this aim. Stakeholders believed there were missed opportunities to add to the existing empirical evidence base due to a lack of clarity and planning, particularly around timing, in local and national evaluations.

CONTRIBUTORSHIP DG wrote the initial draft of the manuscript, coded and analysed data, and interpreted findings. SC conceived the study, contributed to analysis, interpreted the data and re-drafted the manuscript. AJ, SC, DO, MP and MW contributed to study design. ES, DO, MP, MW and AJ contributed to data interpretation and drafting of the manuscript. ES and KW collected data, conducted preliminary analyses and commented on drafts of the paper.

ETHICAL APPROVAL Ethical approval for the study was gained from the Queen Mary Research Ethics Committee (QMREC).

COMPETING INTERESTS None declared.

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Conclusions—A strong emphasis on relying on existing evidence based practice and producing positive impacts and outcomes may have impeded the opportunity to implement truly innovative programmes because of fear of failure. Building more time for development, implementation and evaluation into future initiatives would maximise the use and generation of robust and relevant evidence for public health policy and practice.

Keywords

Obesity; Public health policy; Health promotion; Health behaviour; Qualitative methods

INTRODUCTION

In 2007 the Foresight report Tackling Obesity; Future Choices[1] illustrated how adopting a 'complex systems' perspective is needed to successfully tackle the complex and multi-dimensional causes of obesity in a range of community settings. In particular, the report highlighted the potential influence of broader environmental factors on diet and physical activity behaviours that may lead to the development and maintenance of overweight and obesity.[1]

As a response to Foresight, and to help develop the relatively sparse evidence base for the effectiveness of environmental interventions embedded within a complex systems perspective, the government announced a £30 million investment in the Healthy Community Challenge Fund (HCCF) as a key platform of the Healthy Weight, Healthy Lives national obesity strategy.[2] The HCCF was conceived as a way to test 'whole-town' approaches to tackling the 'obesogenic' environment.[3] Local governments and primary care trusts across England were invited to submit joint bids for up to £5 million each for the opportunity to become a 'Healthy Town' (HT). On the basis of the proposals submitted, nine HTs were selected for funding to "*test and evaluate different approaches to making regular physical activity and healthy food choices easier for local communities, with the aim of preventing overweight and obesity in England*". [3]

However, it was noted by Foresight that there existed a real lack of evidence to guide and support the development of effective 'whole-town' community and environmental approaches.[4,5] In particular, there was a relative lack of evidence of the effectiveness of environmental and other population level interventions aimed at combating obesity. [4,5] It was in this context that HTs were expected to develop locally specific programmes and interventions for implementation and evaluation. However, other than a requirement to "*have processes in place to enable the collection of appropriate data to support the monitoring and evaluation process*", [6] limited guidance was included as to how each HT should put this into practice or the scope of what the evaluation should entail.

The example of the HT programme therefore poses broader questions about how interventions and programmes can be developed in policy areas where the evidence base is still in its infancy, where the rapid development of policy may outpace the evidence, or where there is a particular policy impetus to be seen to 'get things done'.[7-9]

With these broad questions in mind, we report on data gathered from interviews designed to collect information from the key stakeholders in the development and implementation of the HT programme at the national and local level. The aim of the paper is to first examine how evidence was sourced and used for programme development within the HT programme, and second to assess the potential for the HT programme to contribute to the evidence base on the effectiveness of environmental interventions in tackling obesity and obesity-related behaviours. While some of these debates have been rehearsed elsewhere[7,10] we focus on

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what stakeholders regard as evidence and the influence of these views on programme development and policy innovation.

METHOD

The nine successful HTs included a London borough (Tower Hamlets), three large cities (Manchester, Portsmouth and Sheffield), two medium-sized towns (Halifax and Middlesbrough), one metropolitan borough (Dudley), and two smaller provincial towns (Tewkesbury and Thetford). Overall the nine HTs implemented in excess of two hundred individual interventions, primarily focused on promoting healthy diet and physical activity. Each HT established a programme board to oversee and ensure delivery of the programme. Board stakeholders generally included representation from the Primary Care Trust (PCT), local authority, voluntary and community sector and academic sectors.

Participants

Participants were purposively selected to represent successful HT bid and management teams and key national policy actors involved in the implementation of the HCCF and the allocation of HCCF funds.[11] The final sample included nine HT programme directors, nine HT board members, and two national policy actors. In six towns where programme directors were not involved in programme development from the bidding and initial implementation stages, interviews were conducted with programme board members. One or two board members were interviewed in each of the towns. All participants provided written informed consent to be interviewed.

Procedure

Interviews were semi-structured, allowing the interviewers to explore emerging themes as well as salient issues in relation to the HT programme.[12] Interviews with stakeholders included questions surrounding the use of evidence in the development of HT interventions and the potential for the generation of evidence that might contribute to local or national policy. Interviews with policy actors explored the role of evidence in the genesis of the programme, the aims of the bid and selection process, and requirements for evidence generation through programme evaluation. The majority of interviews were face-to-face, with one conducted over the telephone. Interviews were conducted during July and October 2010 by two authors (ES and KW), and lasted between 50 and 110 minutes each. Interviews were audio-recorded and then transcribed verbatim.

Analysis

Thematic analysis[13] was guided by three broad research questions: [1] What was considered to constitute ‘evidence’? [2] What role had evidence played in programme and intervention development, and the stimulation of innovation? [3] What was the HT programmes’ capacity for evidence generation in order to inform policy and develop and refine environmental interventions to tackle obesity? Interview transcripts were coded and analysed thematically. Transcripts were read and coded by the two lead authors (DG and SC), using the broad research questions as an initial coding framework. Codes were abstracted, and resultant themes clarified through discussion. In addition, the coding process also generated a list of emergent themes within the context of the broad research questions. Themes were then discussed by DG and SC, and dominant themes related to the three broad research questions were identified and mutually agreed. These initial analyses were then explored with all authors, with the two lead authors refining the coding on the basis of group discussion. Throughout the analysis the interpretation was compared with the verbatim data.

FINDINGS

Accounts of sourcing evidence to support HT bid and programme development suggested that while the prevalence and causes of obesity were considered well documented, there was a lack of national practical and empirical evidence-based resources to support the design and implementation of interventions (see box 1). The use of evidence on the effectiveness of interventions was rarely mentioned by HT stakeholders, with national policy actors stating that research was not considered beyond that which was reported in the original Foresight report.[1]

What is considered as evidence?

HTs considered three main sources of evidence to inform bids and intervention development (see box 2). The first was anecdotal evidence, primarily produced within each town and largely based on local evaluations of existing interventions and previous public consultation. The second source was local routine data, such as those from travel surveys or the National Child Measurement Programme, which were used to identify gaps in existing provision. Thirdly, national policy and guidance documents such as the Foresight report, Healthy Weight, Healthy Lives, and National Institute for Health and Clinical Excellence (NICE) guidance were examined to ensure that interventions addressed barriers related to health inequalities and were in keeping with existing political priorities.

HT bid managers applied concepts and approaches that had been implemented elsewhere in England or were currently taking place in their own towns to inform HT intervention development. They predominantly relied on anecdotal evidence - which they considered abundant and influential - in governing their bid development, even though these data could not support robust inferences regarding what the likely effect on health outcomes might be. For example, the case for expanding existing programmes where an infrastructure was already in place was enhanced by the individual experiences and expertise of practitioners working within their respective fields. This was justified on the basis of the experiences and observations of professionals who had already delivered similar programmes within a community setting "*because not everything is written up nicely*".

An innovation - evidence paradox?

Because one of the aims of the HT programme was to pilot innovative interventions, some interviewees described the unique opportunity afforded by HT funding whereby new approaches could be developed and tested by taking a *"leap of faith"* and *"giving it a go"*, in order to produce evidence to inform the design of future programmes and policies.

While the opportunity to be innovative and pilot new interventions was welcomed by the towns, many were also aware of the political need to implement interventions that could not be seen to fail and could produce favourable outputs. In the initial bidding and implementation process, the Department of Health (DH) advocated for innovation in HT programme development and piloting, while also requesting detailed output plans (see box 3). This collation of detailed information on anticipated intervention outputs was viewed as being in conflict with the innovation element of the programme by some HT stakeholders. These stakeholders felt unable to predict what would work, and what the likely health impacts might be.

This emphasis on outcomes was heightened further during the HT funding period by a change in government during the life of the programme. The new government's austerity measures increased political pressure on the HT programme to evaluate impact and to produce evidence of effectiveness in order to justify the expenditure of public funds and make a tangible contribution to future evidence based practice.

Generating a legacy: missed opportunities and the potential for local learning

The sheer heterogeneity of HT interventions makes it difficult to synthesize findings across the whole programme, reducing the opportunity to evaluate programme level impact. There was a general view from HT programme directors and board members that a lack of clarity and planning around local and national evaluation created barriers to producing robust evidence on the health impact of interventions (see box 4). Interviewees suggested that the DH should have provided a stronger and more focused direction for evaluation at the start of the programme.

However, HT interviewees deemed process measures, such as demographic and performance indicators (e.g. attendance figures) as realistic outcomes to assess in the time available. They also viewed the generation of such data as a unique opportunity to produce local evidence on what worked to assist with future intervention selection. Even if interventions were not successful, the evidence would still provide a learning opportunity and help ensure any mistakes were not repeated in future interventions.

The evidence generation imperative

The HT programme was initially conceived as a learning programme intended to generate evidence to inform and substantiate future community-based initiatives for obesity prevention, and HT stakeholders were aware of this imperative (see box 5). Overall stakeholders viewed the timeframe for the HT programme as ambitious and too short to produce robust evidence of effectiveness. While HT stakeholders considered changes in obesity prevalence important, evaluation of impact was considered difficult to report during the funding period. The HT timeframe was recognised as being reflective of the unrealistic ‘quick fix’ political expectations of local authorities, policy makers and politicians. There was a desire among some HT stakeholders for longer term and more carefully considered evaluations that would provide more opportunity to better assess the impact of the HT programme.

DISCUSSION

The HT programme was conceived as an opportunity to design and test whole-town community and environmental approaches to tackling obesity, despite a limited and emerging evidence base.[3] Overall stakeholders believed that the evidence base underpinning programme development was poorly developed and instead filled the gaps using anecdotal and observational evidence. The programme was considered an opportunity to trial new and innovative approaches, but the requirement from local stakeholders and the Department of Health to predict likely health impacts and adopt evidence-based practice was viewed as in conflict with this aim. Stakeholders believed there were missed opportunities to develop the existing empirical evidence base due to a lack of clarity and planning, particularly around timing, in evaluation.

The existing evidence base

Accounts of the evidence sourced to support HT programme development suggests that stakeholders agreed there were a lack of national resources and an incomplete evidence-base on community and environmental approaches to reduce obesity prevalence.[14] This reflected findings of the Foresight report [1] which advocated for evidence generation on population approaches to obesity prevention. In the absence of a fully developed evidence base on intervention effectiveness, HT stakeholders largely drew on anecdotal evidence, consultation, local knowledge and practitioner expertise and routine local and national indicators to support HT programme development. This suggests a need to identify and generate ‘trusted’ sources of evidence for effective interventions that are transferable to

other contexts beyond the HT programme in order to complement locally specific information.[15,16] From the data presented here, it is clear that what is considered as evidence, how this is shaped by local context, and how this evidence then translates into local policy needs further interrogation. [8] For future obesity programmes this need could be met by the DH under changes to the public health system in England proposed by the current government.[17] Under the proposals, part of the DH's new role will be to act as an executive agency to provide expert and evidence based advice on health across England. This new role should enable the DH to gather evidence from stakeholders and synthesise findings to support local area implementation of obesity interventions.[17]

The innovation and evidence paradox

The paradox between the DH's advocacy for innovation and piloting in the HT programme, and a requirement for detailed reporting of outputs and to 'measure' intervention effectiveness was a source of tension for some stakeholders. While stakeholders did not dispute the need for evidence generation, the expectation that they should produce detailed evidence of 'success' or 'impact' of innovative interventions that were primarily designed to be formative was seen as contradictory. This, coupled with an implied expectation to work using existing evidence based practice, may have led to the reliance on tried and tested interventions being implemented or expanded rather than risk-taking with testing truly innovative programmes.

The change in government during the HT programme added pressure on towns to produce evidence of effectiveness. This evidence imperative is now indicative of the current government's strategy for more high quality public health evaluation.[18] However, as the population determinants of obesity are complex and multi-factorial, governments should be realistic about the likely effects of single interventions and target setting[19] and allow for the formative piloting of innovative projects that are not necessarily driven by targets.

Generating evidence: addressing time and tension

The programme placed a special focus on its potential to generate an evidence base for the effectiveness of environmental interventions in a policy area where there has been a lack of evidence.[1,2] While reducing the population prevalence of obesity is a central goal of public health policy, interventions have often been implemented in ways that make it difficult to carry out impact evaluations.[4] Evaluation has tended to lack the level of analysis and detail required to measure health impacts that meet the expectations of government agencies, policy makers and politicians. Elements of this were recognised by stakeholders who cited the limited time allocated to plan and implement research as a major drawback, with evaluations often starting after interventions had been introduced precluding robust outcome evaluation. This is reflected at the HT programme bid stage where successful HT's were expected to prepare for programme delivery between November 2008 and January 2009, with the expectation to start in February 2009. [6] Although at stage 2 of the bidding process (September 2008) HT's were required to detail what monitoring and evaluation measures would be implemented if successful, no additional time or guidance of how local evaluation teams should be commissioned was provided by the DH for this process.

Stakeholders suggested that the minimal guidance from the DH on what constituted acceptable outcomes hampered research potential and the opportunity for further synthesis of evidence and practice across the nine towns. Furthermore, stakeholders felt that towns did not have the opportunity to develop long term impact evaluations beyond the three-years of HT programme funding. While some routine national measures (e.g. from the National Child Measurement Programme) may provide a general indicator of impact, stakeholders

would have welcomed the opportunity to measure the long term impacts of local programmes on obesity, and obesity-related attitudes and behaviours.

In order to generate robust evidence of effectiveness, the evaluation of population obesity prevention programmes should be commissioned before interventions begin to allow time for the collection of baseline data. Sufficient time to properly design and conduct evaluations that assess the impact of population interventions on the health of local communities should therefore be built in to the policy process. However, while interventions should be routinely evaluated in order to ascertain whether they are appropriately implemented, and are achieving the expected outcomes, careful consideration should be given to the purpose and priorities of any evaluation to avoid evaluating for evaluation's sake.[20]

An evidence legacy?

Although the range of HT interventions and approaches meant it would be extremely challenging to synthesize all findings across the entire HT programme, the outlook for local learning was still considered good. HT stakeholders believed the opportunity to develop interventions within their towns, combined with the funding for evaluation, was a positive step in obesity prevention. A range of supplementary evaluations carried out by locally commissioned research teams were viewed as useful in informing the selection and development of future health interventions and for local policy-making, particularly in times of austerity. Such a model for local control supported by local learning has been proposed by recent national obesity policy.[18] Local evaluations are thus thought important in order to enhance the ability of most HTs to devise a system of local commissioning and implementation of strategies to tackle obesity, tailored to the needs of that particular context.[18]

CONCLUSION

The development of innovative population-level programmes to tackle obesity is beset by tensions and contradictions. The mantra is that programmes and policies should be based on evidence of effectiveness, but often policy implementation is hampered by a lack of evidence of what works, and instead is driven by a political imperative to 'do something'.[7,15] If innovation is advocated by policy-makers, then innovative programmes and interventions should not be unduly constrained by the demands of evidence-based practice, but be implemented in such a way that the impacts of 'risky' programmes and interventions can be meaningfully evaluated in order to contribute to developing the evidence base.

The HT programme was viewed as an opportunity by stakeholders, but development was hampered by the lack of an evidence-base on the effectiveness of environmental interventions. Towns were generally positive about the possibility of generating locally specific evidence through evaluation to inform local level planning. However the potential for evidence generation and synthesis across the entire programme would have been greater if intervention development and evaluation had been better aligned. Future population-level obesity programmes should build in the necessary time and commitment to robust evaluation that includes an assessment of what outcomes are deemed important for policy and practice prior to programme implementation. The current findings pose a number of challenges as to how best to develop and support evaluation capacity in future interventions in order to form an input towards future knowledge translation practice, as without appropriate processes to develop the evidence base then this will be slow to develop and there will be little locally-generated knowledge to translate back to policy and future practice.

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BOX 1

Sourcing evidence on the obesogenic environment

"We recognised at the end of the day we wanted to reduce obesity levels, and as you know the evidence base in terms of how best to do that is very, very poor, there's no model approaches anywhere to do that. […] I remember going through various relevant NICE guidance reports and I was thinking 'well it's all very interesting, but at the end of the day it doesn't really amount to much'. It says like well walking's a good thing, so we've got quite a big emphasis on walking in our programme. It doesn't really take you much further in terms of how to do it. So we felt we had to work that out pretty much ourselves. So certainly I think we were aware of the evidence base but we were fairly sceptical as to really how useful it was or is now frankly."

(Town B Programme Development Manager)

"To be honest I don't think there was an evidence base, there wasn't a clear sort of 'this is telling us we need something like this', I mean other than the Foresight report telling us we needed to have a comprehensive approach, there wasn't anything else."

(National Policy Actor 2)

"Well as I say some things definitely did have evidence, like the standard transport, travel data and in terms of accidents, travel to school, the high ratio of car-borne or whatever. So there was evidence there to support some projects, but I don't know how strong an evidence base was for all of those projects. I suspect not fantastically strong and that's something which with the evidence from this programme, and from the joint investment programme work that evidence-base will be there now going forward to some extent."

(Town F Programme Development Manager)

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BOX 2

What evidence informed intervention development?

"So the interventions were chosen based on evidence from what we know, that perhaps had been tried before either here or elsewhere, because not everything is written up nicely. We all say it far too many times - we are too busy doing the job to write up what we've done."?

(Town G Programme Development Manager)

"From reviewing the available evidence at the time, we recognised that walking-based interventions were said to be quite promising, active play similarly with children. Growing your own fruit and veg was something else we were keen to explore, although I don't think there's any particular evidence base. Also healthy food options was a fourth sort of component we were keen to see covered in the programme."

(Town B Programme Development Manager)

"So another way which informed the selection of topics or choices, but it happened at the strategy development stage, was that you looked at the evidence like Foresight. We looked at what are the barriers and we actually put that in our bid. For each area around environments we looked at the barriers and then said how our interventions would address the barriers."

(Town D Bid Development Managers)

"We've got quite a big food team in the city, working in health improvement, so they had done quite a lot of work on some of the interventions which we expanded. So there was evidence there that it worked and we had other things that we've had prior to this that didn't work, so obviously we didn't want to expand or use those or we knew we'd have to do more work to look at whether those could work in a different way. But everything we did, we ensured that it was evidence based."

(Town A Bid Development Manager)

BOX 3

Tension between innovation, politics and evidence generation

"The [outdoor facility] for instance, there's no evaluation been done on that… There's three or four of them that were put in the country, but there isn't any real evidence base to say 'Spend £150,000, that outdoor facility will work.' But the Department of Health had been clear that some of the things were for piloting; some things were to give them a go. […] There is an assumption that more people will cycle if you sign it right, if you promote it right, if you give people opportunities but actually the evidence isn't there that in 10 years' time you will have more and more cycling. […] it's more than a leap of faith, but if you give people the opportunity to be more physically active, if you promote it right, if it comes with something that the community wants to do, it has more viability and more potential to work."

(Town H Bid Development Manager)

"So you know I read into this bid that I think the government had deliberately put aside a pot of money to actually try some new things which were not evidence based in order to try and produce evidence of the kind that it doesn't work or it does work or like that, which I think was a challenge…"

(Town F Bid Development Manager)

"We have had it emphasised to us over and over again that this is a pilot, we just want to see how it progresses, we're learning from this. But actually my instinct told me that at some point it was going to be about bums on seats, which actually has happened because it has tightened up a lot more in terms of outputs, how many people have you had going through and that's because of this, […] the politics of having a new government and all that sort of thing, in fighting to get the funding and that's happened."

(Town B Programme Development Manager)

"I think we wanted a bit more understanding really because the government on the one hand they were saying 'Look, be very creative, be very exploratory, be very developmental, let's learn lessons from all of this', yeah that was one of their angles which was great, we were very much in favour of that. However on the other side the same people were saying 'Look we want it all tied down in great detail, you know in the old style in terms of inputs, processes, outputs and stuff', and that didn't really match up to well."

(Town B Programme Development Manager)

"We want to know what your outcomes are… I think, we all struggled with that because what we were saying is, 'you can do pilots and tests and what doesn't work is as important as what does work, but we want to know what you think your outcomes are' […] I can understand that we want outcomes, because that's important, but to do that in three years, realistically is not going to happen. This is a longitudinal, hopefully, attitudinal change… So I think that, we could have done with some help around what do you class as an outcome and what do you class as cost-effective and I think we asked for workshops around that originally, but we did not get them."

(Town H Bid Development Manager)

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BOX 4

Generating a legacy for Healthy Towns

I. Missed evaluation opportunity

"I think if you are giving away £30 million you should be really clear at the beginning: 'This is what we expect the evaluation to look like.' We know that there are individual nuances within each project, but actually it's the evaluation… it is as important as the product that we are delivering and the services that we are delivering. And I think that they just said: 'If you evaluate it that will be fine'. I think we've lost something around what works in this process because people have done it differently […] I think there was a real potential to get some real good evaluation out of this."

(Town H Bid Development Manager)

"A lot of our evaluation will be about process but we clearly need to… we have attempted to try and at least head towards some outputs and some outcome evaluation measures. But as you can appreciate it's a real challenge because we've got something like 30 different projects across four themes doing a whole range of different things, all trying to achieve something slightly different […] We clearly couldn't end up with nor afford, nor would it be right, to evaluate each one in terms of the outcomes."

(Town F Bid Development Manager)

II. The potential for local learning

"Obviously with all the budget cuts, I think it will help us to be very clear about how we choose to spend our money in the future. So it will actually enable us to be clear about what really works well and using that as evidence for why we should do things and why we should not do things. So I think that's going to really have an impact on our local policy and practice."

(Town A Bid Development Manager)

"So if something hasn't been a particularly good project or it hasn't delivered the outcomes we wanted as long as we've learnt from that, the success will be our learning and making sure we don't make the same mistakes again. So I see everything as a positive, an opportunity to review what we've done and to ensure we take some learning from it."

(Town I Programme Development Manager)

"We've got a model of best practice here and what we need to do is again leave that as the legacy for healthy towns about what is possible. We now have the evidence, you know we were saying there's not a lot of evidence, we have it locally now and it's about utilising that evidence and pushing it out there and saying right what else can you do."

(Town B Programme Development Manager)

BOX 5

The evidence generation imperative

"I think it is not unreasonable to say that two and a half, three years should be enough evidence for us to really be able to make some informed judgement about whether we should continue to put a lot of money into this. You know it would seem to me to be inappropriate to say, oh well of course you can't judge these things after two or three years, you have to go on for 10 years, I'm sorry I don't think you can do that."

(National Policy Actor 1)

"What really is the impact of what you've done? […] We can model answers saying oh it might be this or it might be that, or evidence might suggest that it might be this but you know it isn't always a way of convincing people, they need those hard facts […] I mean that's an issue for public health in general."

(Town B Programme Development Manager)

"I think one of the things that we've all said, is that it's quite difficult after a year to start seeing very much of that long-term impact happening and that's going to really take longer than that. And I think that's an issue in itself in a way because within organisations like local authorities, and I suppose the same with central government, people want to see the change happening quickly. They're not actually terribly patient about waiting."

(Town D Programme Development Manager)

"Two and a half years to produce the evidence for the kind of big scale outcomes and there was town wide measures to improve physical activity and reduce obesity. I think that was a little bit too ambitious."

(Town F Bid Development Manager)

"You're only evaluating it for three years and that would be one of my issues. I would have said, well, we've got a good evaluation, we would love to continue our evaluation over another five… we'd like to do this survey even every other year, for another three times […] and that would give us maybe a five to ten year evaluation. We've got a three year evaluation which is possibly skewed because the activities are on-going at the time we were promoting it […] How do we know that would be a sustained lifestyle change in five years' time, which is what we are looking for?"

(Town H Bid Development Manager)

What is already known on this subject?

Environmental interventions to improve diet and encourage physical activity are currently being promoted by policy makers as a way to tackle population obesity. However there is a very limited evidence-base for the effectiveness of these interventions for practitioners and other stakeholders to draw on.

What does this study add?

When programmes aim to trial new and innovative approaches, the requirement to predict likely health impacts and adopt evidence-based practice may be in conflict with this aim. As a result there may be missed opportunities to add to the existing empirical evidence base.

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Policy Implications

Policymakers should allow more time in the policy development process for programme planning, local implementation and evaluation in order to maximise the opportunities for innovation and evidence generation to support the development of population obesity policy.