Childhood Obesity in Hammersmith & Fulham, Kensington & Chelsea and Westminster

Joint Strategic Needs Assessment (JSNA) Report

December 2015

www.jsna.info/

Synopsis

This report describes the extent and nature of childhood obesity in the boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster and summarises:

- How childhood obesity is defined
- The causes and consequences of childhood obesity
- The local prevalence of childhood obesity
- The national response
- The local response

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1. Introduction

1.1 Purpose of the report

The World Health Organisation regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obesity has a substantial impact on the health of children, both now and in the future.

The causes of obesity are multi-factorial: there is no single effective solution. Tackling obesity requires a whole systems approach across the entire social, environmental and cultural environment and requires partnership between government, science, business and civil society.

This Joint Strategic Needs Assessment (JSNA) explores the causes and consequences of childhood obesity and provides a local picture the prevalence in our local communities, identifying those groups who are most at risk. The JSNA also aims to capture range of existing programmes of work which support the development of healthier environments and identify further opportunities that can further focus our joint efforts to tackle this issue. The report will also serve as a baseline against which progress will be measured.

1.2 The definition of overweight and obesity

Overweight and obesity are terms which refer to the excess accumulation of body fat. The classifications of overweight and obesity are different for adults and children.

In adults, overweight and obesity is usually measured using Body Mass Index (BMI). BMI compares the distribution of weight with respect to a person's height (Table 1).

Table 1: Classification of BMI in adults (WHO, 2004)

Classification	BMI (kg/m2)
Underweight	Less than 18.5
Healthy Weight	18.5 - 24.9
Overweight	25 - 29.9
Obese	30 – 34.9

In children, the relationship between BMI and overweight or obesity varies according to age and gender. Therefore, overweight and obesity are defined with reference to age and gender specific BMI distributions. The Department of Health uses the 1990 growth reference (UK90) charts to interpret a BMI result in children and young people.

When measuring a population of children, weight status is defined using slightly lower cut off points than the clinical cut off points in order to capture those children who may be on the borderline of being overweight or obese (Table 2). This supports the planning of adequate services for the whole population.

Table 2: Classification of overweight and obesity in children

	Individual children (clinical definition)	Groups of children (population monitoring)
Classification	**BMI centile range**	**BMI centile range**
Healthy Weight	Between 2nd and 90th BMI centile	Between 2nd and 84th BMI centile
Overweight	Between 91st and 97th BMI centile	Between 85th and 94th BMI centile
Obese	At or above 98th centile	At or above 95th centile

1.3 Childhood obesity prevalence in England

Two data sets are currently used to estimate the prevalence of childhood obesity: the **Health Survey for England** (HSE) and the **National Child Measurement Programme** (NCMP). A comparison of the two surveys is shown in Table 3.

The HSE is a series of annual surveys designed to monitor trends in the nation's health and health related behaviours. Each year, there is also a particular focus on a population group, disease or condition. Topics are repeated at appropriate intervals in order to monitor changes with time.

The NCMP measures the height and weight of school children in reception class (aged 4-5 years) and year 6 (aged 10-11 years). NCMP participation rates over the past 3 years are shown in **Appendix A**.

Table 3: Comparison of the Health Survey for England (HSE) and National Child Measurement Programme (NCMP)

	Health Survey for England	National Child Measurement Programme
Frequency	Annual	Annual
Year established	1991 (although children have only been included since 1995)	School year 2005/2006
Who takes part	Sample of households across England	All school children in Reception & Year 6 state schools (who don't opt out)
Total number included in most recent survey	In 2013 (Nationally): 2,185 children (aged 2-15) 8,795 adults	In school year 2013/2014 (Nationally): 1,101,611 children
Data captured (specific to childhood obesity)	Obesity and overweight prevalence across England	Ward level overweight and obesity prevalence in Reception and Year 6 (*aggregated data over 3 years can be shown by school)
Summary	Covers a wide age range of children, however the sample size is smaller	Large sample size, however only measures a narrow age range

According to the HSE (2013), 30% children aged 2-15 years were classed as either overweight or obese: this is one of the highest rates in Europe.

The 2013-2014 NCMP demonstrated that in England, one in five children (22.5%) aged 4-5 years old is overweight or obese, and one in three children (33.5%) aged 10-11 years is overweight or obese (Figure 1). The percentage of obese children in Year 6 (19.1%) is over double that of children in Reception year (9.3%).

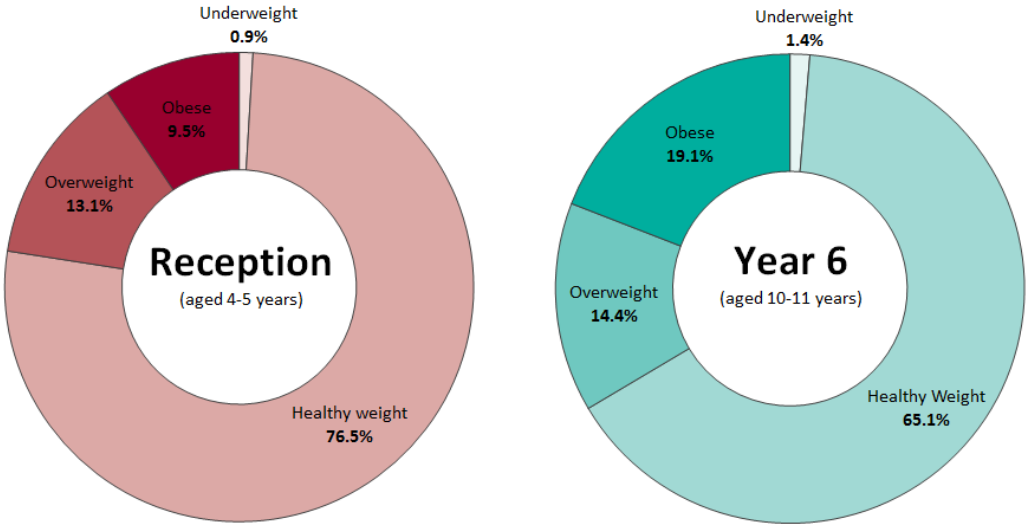


Figure 1: Weight status of children in England by age (NCMP, 2013/2014, Public Health England)

While the proportion of children who are overweight has remained largely unchanged since the mid-1990s, there has been a significant increase in those who are obese over time (Figure 2).

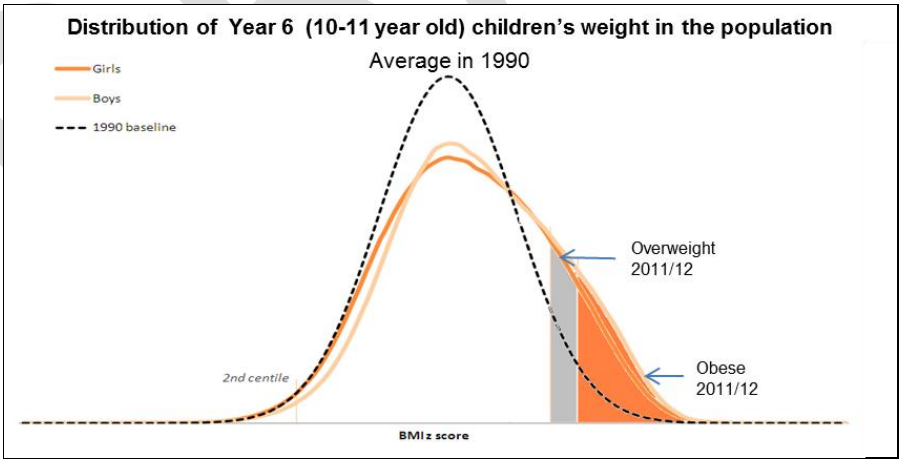


Figure 2: The increase in children's weight from 1990 to 20011 in England

Levels of childhood obesity are predicted to further increase: it is suggested that by 2050, 70% of girls and 55% of boys could be overweight or obese (Foresight, 2007).

1.4 Childhood obesity prevalence in London

Levels of childhood obesity are significantly higher in London than England as a whole and are continuing to increase. As shown in Figure 3 below, London has the highest rate of childhood obesity of any major city in the world (London Health Commission, 2014). In contrast to London, New York has seen a decline over time, following the implementation of collaborative multi-agency and city-wide focussed efforts.

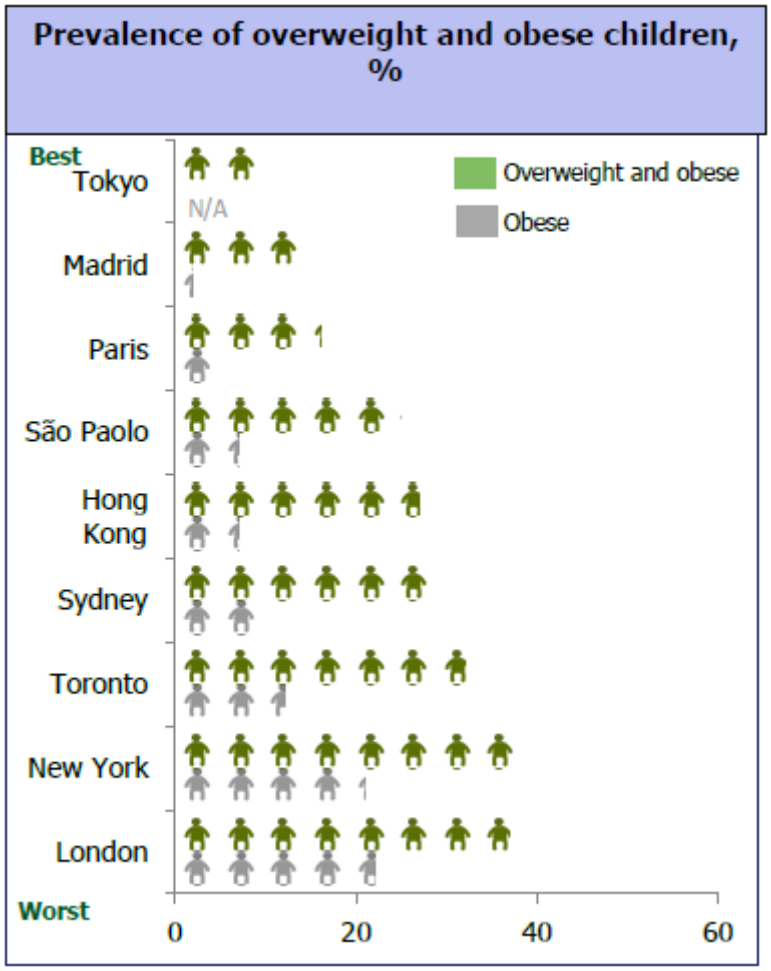


Figure 3: Prevalence of overweight and obese children in cities worldwide (London Health Commission, Global Cities Analysis, 2014) ** In Tokyo, obesity is classed as BMI≥25 instead of 30, therefore separate overweight/obesity measures are difficult to obtain

2. What causes childhood obesity?

Evidence shows that at a basic level, obesity is caused by an intake of calories in excess of calories expended. However, obesity is a complex problem with a range of influences and determinants which makes it difficult for people to adapt their behaviour to make changes to their diet and lifestyle. There is no single effective solution.

The obesity systems map depicted in the Foresight Report (2007) illustrates how a complex interplay of factors drives this imbalance of calorie intake and calorie expenditure **(Appendix B)**. More than 100 variables are identified that directly or indirectly affect obesity outcomes. These variables were grouped into seven themes and are briefly summarised in Table 4 below.

Table 4: Description of the thematic clusters of the obesity systems map

Theme	Description of Theme
Individual Physiology	An individual's biological make up
Food Consumption	The quantity, quality and frequency of an individual's diet
Food Environment	The influence of the food environment on an individual's food choice, for example, a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables at home
Societal Influences	The impact of society, for example the influence of media, education, peer pressure or culture
Individual Psychology	For example, a person's individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences
Activity Environment	The influence of the environment on an individual's activity behaviour, for example a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and shower
Individual Physical Activity	The type, frequency and intensity of activities an individual carries out, such as cycling vigorously to work every day

Tackling obesity requires a whole system approach across a wide range of issues and partnerships; from planning roads, to promoting cycling and maximising the use of open spaces; to working with local businesses to provide healthy menu options, and developing workplace initiatives that support staff to improve their health and increase activity levels.

Swinburn et al., (2011) depicted the key drivers of the global obesity epidemic and present an overview framework for understanding population level obesity determinants and solutions (Figure 5). The framework highlights the strengths of policy led interventions which may offer larger effects as a result of their sustainability and ability to affect the whole population (including hard to reach groups), but recognises that these may be difficult to implement. By contrast, health education programmes which focus on individual behaviour change may be easier to implement, yet are often less sustainable and reach fewer people.

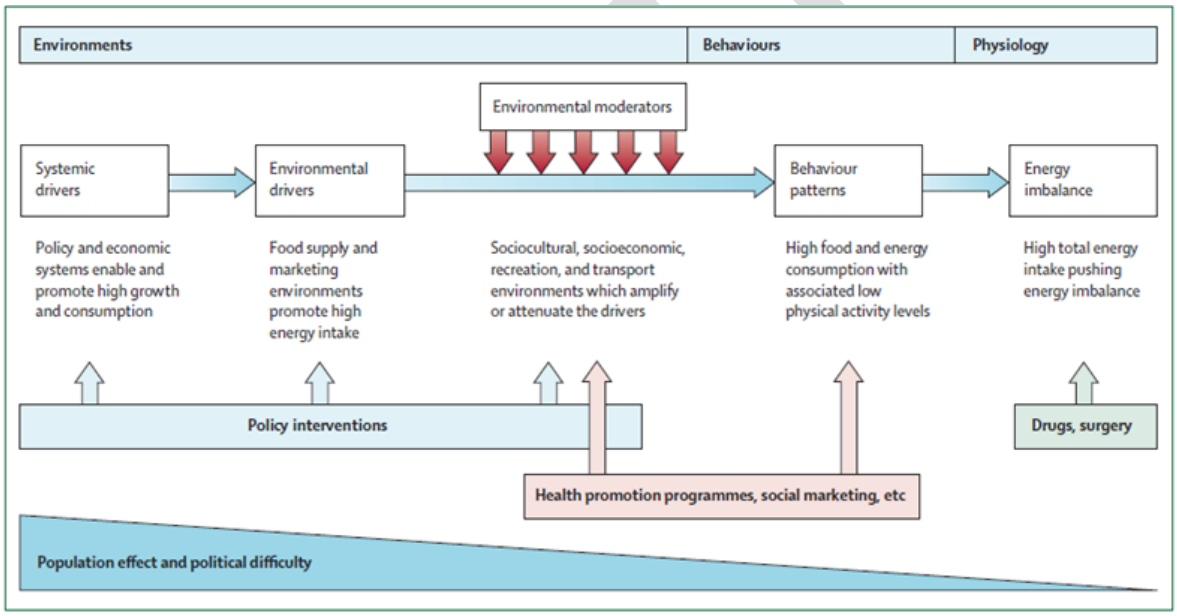


Figure 4: A framework to categorise obesity determinants and solutions (Swinburn et al., 2011)

3. Consequences of childhood obesity

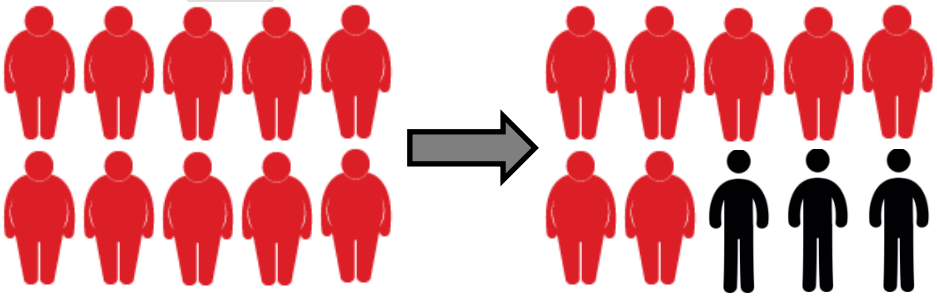
3.1 Impact on health

Childhood obesity presents a major challenge to health and wellbeing and is associated with an increased risk of premature mortality in adults, as well as poor health and development in children (Table 5). Childhood obesity also impacts on mental wellbeing, including increasing the risk of low self-esteem, anxiety, depression, bullying and poor educational attainment (De Neit et al., 2011).

Table 5: Health conditions associated with childhood obesity (London Health Commission, 2014)

Health condition	Evidence
Type 2 diabetes	Among children with Type 2 diabetes, 95% are either overweight or obese
Asthma	A 35% to 50% increased risk of being diagnosed with asthma for overweight and obese children respectively
Obstructive Sleep Apnoea	Incidence in healthy children is 1% - 3%, but can be up to 60% in obese children
Musculoskeletal complaints	Positive association between overweight children and lower back pain, musculoskeletal pain and injuries and fractures
Cardiovascular risk factors	67% of severely obese children have at least 1 risk factor and 56% have hypertension
Health related quality of life	Significantly lower for severely obese relative to healthy children and adolescents Physical, social and psychological functioning for severely obese children is similar to that of children with cancer

However, perhaps most concerning is the likelihood that this excess weight will continue through adulthood: overweight adolescents have a 70% change of becoming overweight or obese adults Simmonds et al., 2015). In adulthood, obesity increases mortality, and is a risk factor for a range of chronic diseases including type 2 diabetes, coronary heart disease and some cancers (Summerbell et al., 2005).



Overweight adolescents have a 70% chance of becoming overweight or obese adults

3.2 Economic impact

The costs of obesity are very likely to grow significantly in the next few decades. An obese child in London is likely to cost around £31 per year in direct costs which could rise to a total (direct and indirect) cost of £611 per year if they continue to be obese in adulthood (GLA, 2011). This projection is likely to be an underestimate, because of the probability that prolonged obesity has more serious and other health consequences.

It is estimated that the current generation of obese children will cost London at least £111 million per year in healthcare costs and productivity losses if they enter the workforce as obese adults (GLA, 2011). The estimated lifetime cost for those children in the three boroughs who become obese in adulthood is over £316 million (GLA, 2011).

Effective actions to tackle childhood obesity are vital given its causal relationship with a range of physical and mental health problems and its link to poor educational outcomes. Treating obesity is costly and evidence suggests that preventative interventions targeting children and young people pay off, with a return on investment of 6-10% expected across the economy from interventions implemented in early life (Strelitz, 2013).

4. Childhood obesity in the three boroughs

Nearly

1 in 4

children are overweight or obese in **Reception** (NCMP 2013/2014)

Over

1 in 3

children are overweight or obese in **Year 6** (NCMP 2013/2014)

On average across the three boroughs, rates of overweight and obesity are similar to the London average but higher than the England average (NCMP 2013/2014). Further analysis by borough reveals significantly higher levels of obesity in 10-11 year olds in Westminster (Table 6).

Table 6: Prevalence of excess weight by school year (NCMP 2013/2014)

Reception Year (4-5 year olds)					
	Hammersmith &Fulham	**Kensington & Chelsea**	**Westminster**	**London**	**England**
% children overweight	11.4	13.4	12.5	12.3	13
% of children obese	8.9	9.6	10.7	10.8	9.5
Total	20.3	23.0	23.2	23.1	22.5
Year 6 (10-11 year olds)					
	Hammersmith &Fulham	**Kensington & Chelsea**	**Westminster**	**London**	**England**
% children overweight	15.2	14.8	14.4	15.2	14.4
% of children obese	22.4	21.3	25.6	22.4	19.1
Total	37.6	36.1	40.0	37.6	33.5

The prevalence of obesity in Reception and Year 6 children in Hammersmith and Fulham, Kensington and Chelsea and Westminster is compared with other London boroughs in Figures 5 and 6 below.

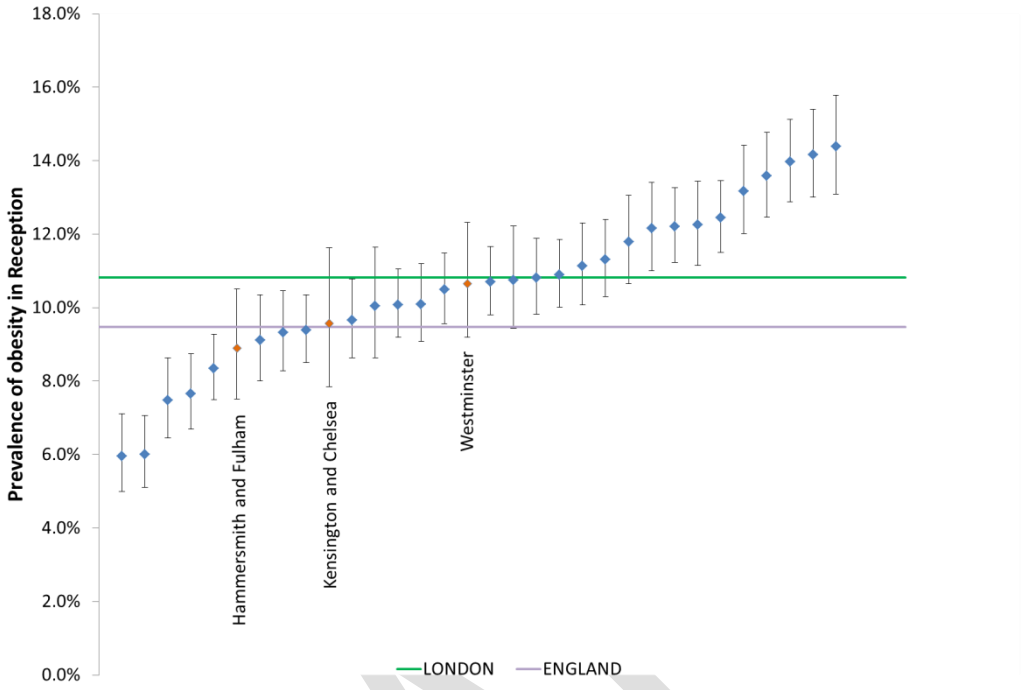


Figure 5: The proportion of Reception classified as obese compared to other London boroughs (NCMP 2013/2014)

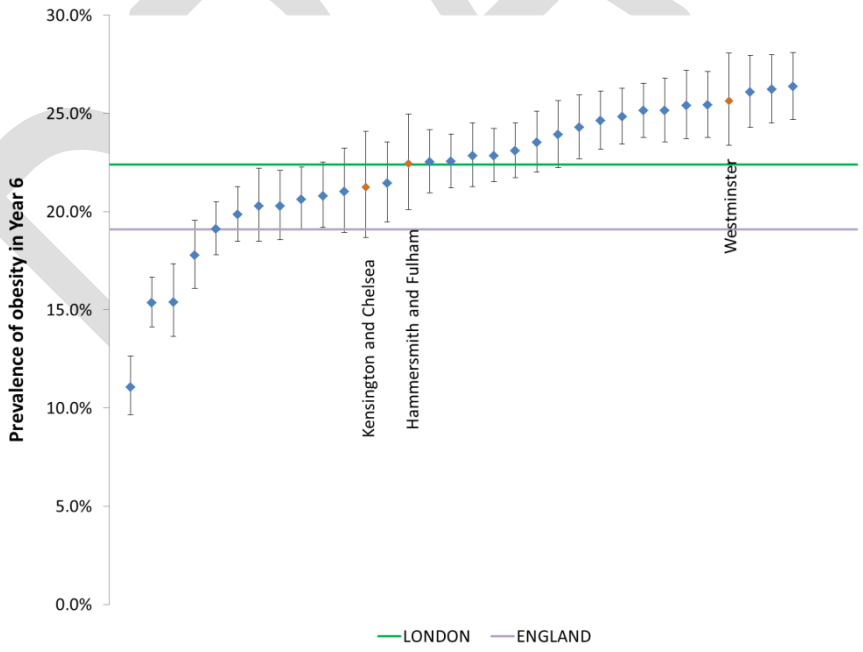


Figure 6: Proportion of Year 6 children classified as obese compared to other London boroughs (NCMP 2013/2014)

4.1 Childhood obesity prevalence over time

Across England, the prevalence of obesity in Reception age children is decreasing slightly (9.6% 2008/2009 to 9.5% 2013/2014). Across London, the trend is similar (11.2% 2008/09 to 10.8% in 2013/14), however rates are higher. Across the three boroughs, the prevalence of obesity among reception age children is mixed (Figure 7).

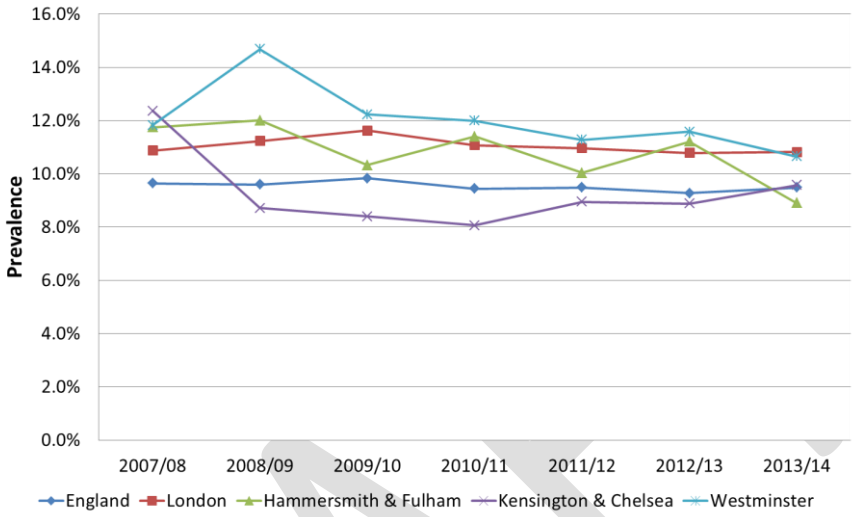


Figure 7: Obesity prevalence among reception age pupils across the three boroughs, compared to London and England averages from 2007/2008 to 2013/2014

Across England, the prevalence of obesity in year 6 children is increasing slightly (18.3% 2008/2009 to 19.1% 2013/2014). Across London, the trend is similar (21.3% 2008/09 to 22.4% in 2013/14), however rates are higher. Across the three boroughs, the prevalence of obesity among year 6 children is mixed (Figure 8).

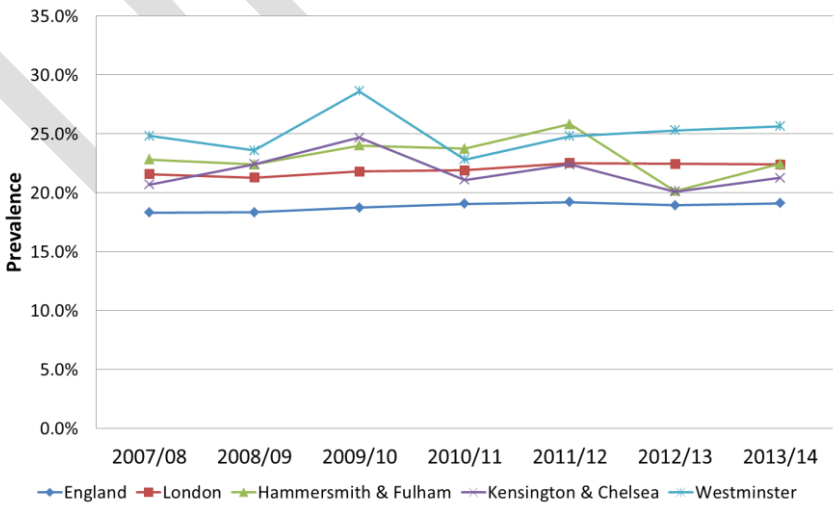


Figure 8: Obesity prevalence among year 6 pupils across the three boroughs, compared to London and England averages from 2007 to 2013/2014

4.2 Deprivation

High levels of obesity are associated with high levels of deprivation. Opportunities to make healthy choices and achieve a healthy weight can be particularly limited in more deprived areas due to factors including income poverty, restricted availability to access to healthy food and fewer options for children to be physically active.

The Income Deprivation Affecting Children Index (IDACI) is an index of deprivation, which measures the proportion of children under the age of 16 that live in low income households. As demonstrated in Figure 9, there is a significant association between IDACI and childhood obesity across the three boroughs; as the levels of deprivation increase, so does the prevalence of childhood obesity.

The Child Poverty JSNA for Westminster, Kensington and Chelsea, and Hammersmith and Fulham (2014) details further indicators relating to child poverty, including borough and ward level estimates of child poverty and numbers and characteristics of groups most at risk locally.

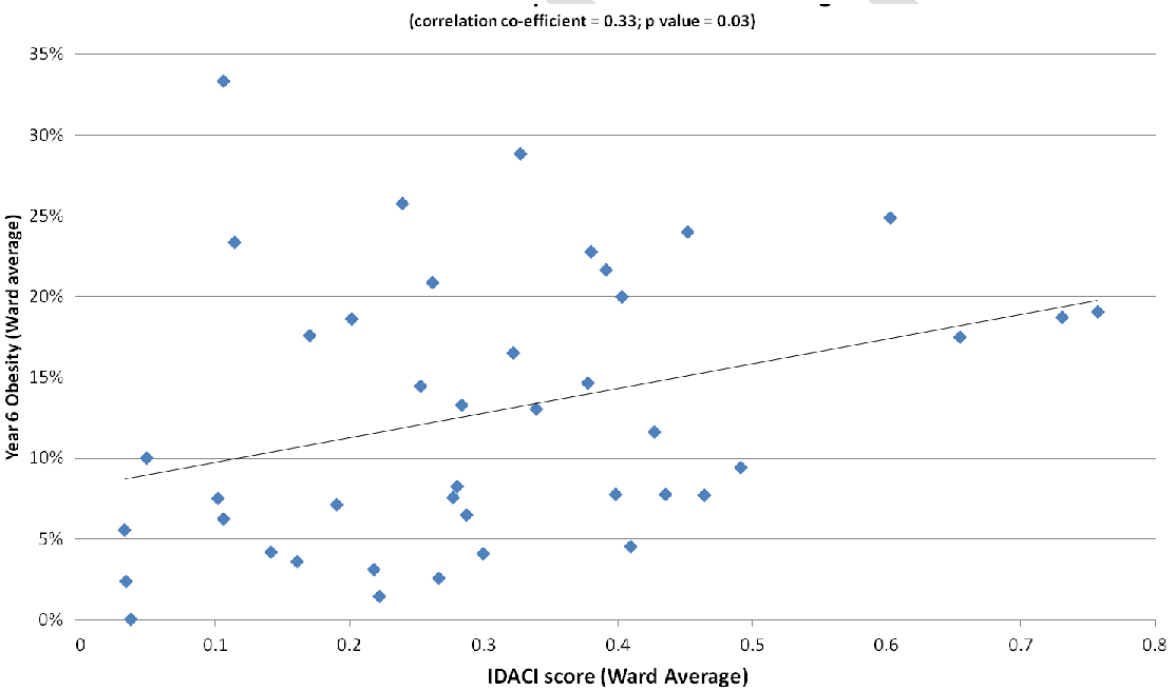


Figure 9: Association between income deprivation and year 6 obesity levels across the three boroughs by ward

4.3 Geographical variation

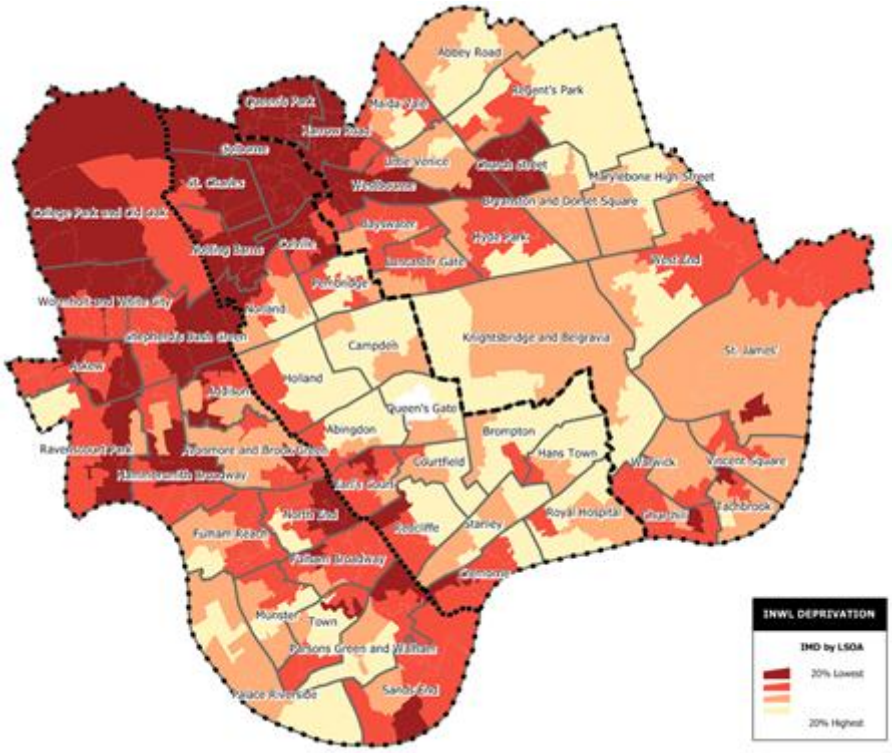


Figure 10: Levels of deprivation by ward across the three boroughs (Office for National Statistics, 2011)

Many wards in the north of the three boroughs score highly on the Index of Multiple Deprivation (IMD), with some parts of the northern area being among the most deprived in England (Figure 10). These correlate largely with prevalence of childhood obesity in Reception year (Figure 11) and Year 6 (Figure 12).

A summary of the five wards in each borough with the highest prevalence of childhood obesity in Reception and Year 6 is shown in Table 7 below.

Table 7: Top 5 wards childhood obesity during 2011/12 to 2013/14

	Hammersmith and Fulham		Kensington and Chelsea		Westminster	
	Reception	Year 6	Reception	Year 6	Reception	Year 6
1	Sands End	Wormholt & White City	Colville	Notting Dale	Church Street	Queen's Park
2	College Park and Old Oak	Shepherd's Bush Green	Holland	Dalgarno	Westbourne	Church Street
3	Town	Sands End	Golborne	Golborne	Churchill	Westbourne
4	Fulham Reach	North End	Notting Dale	Colville	Queen's Park	Harrow Road
5	Avonmore & Brook Green	Avonmore & Brook Green	Chelsea Riverside	Campden	Harrow Road	Churchill

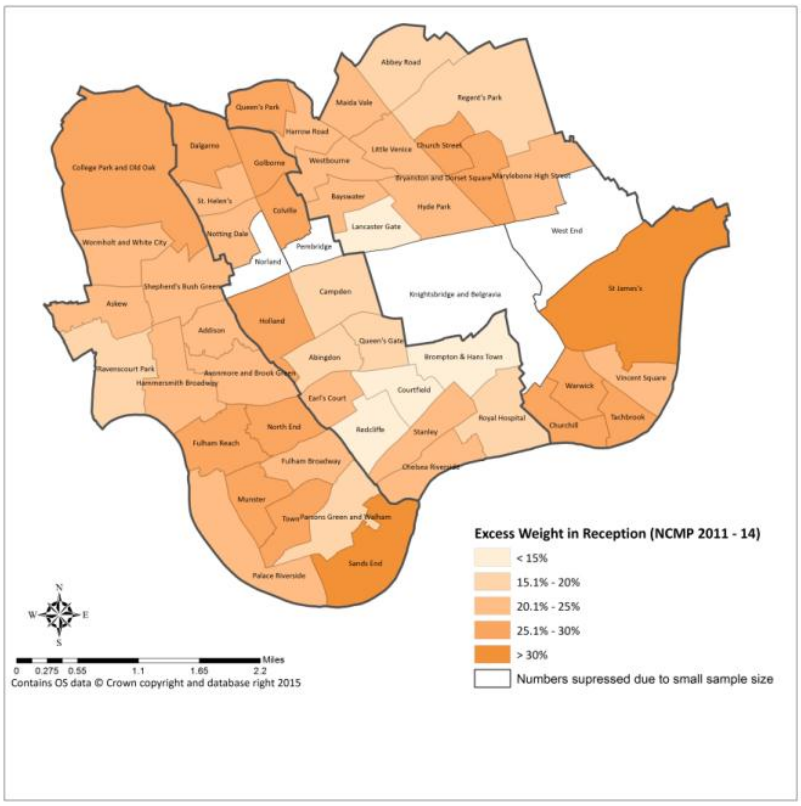


Figure 11: Overweight and obesity prevalence in Reception year (NCMP, 2011-2014)

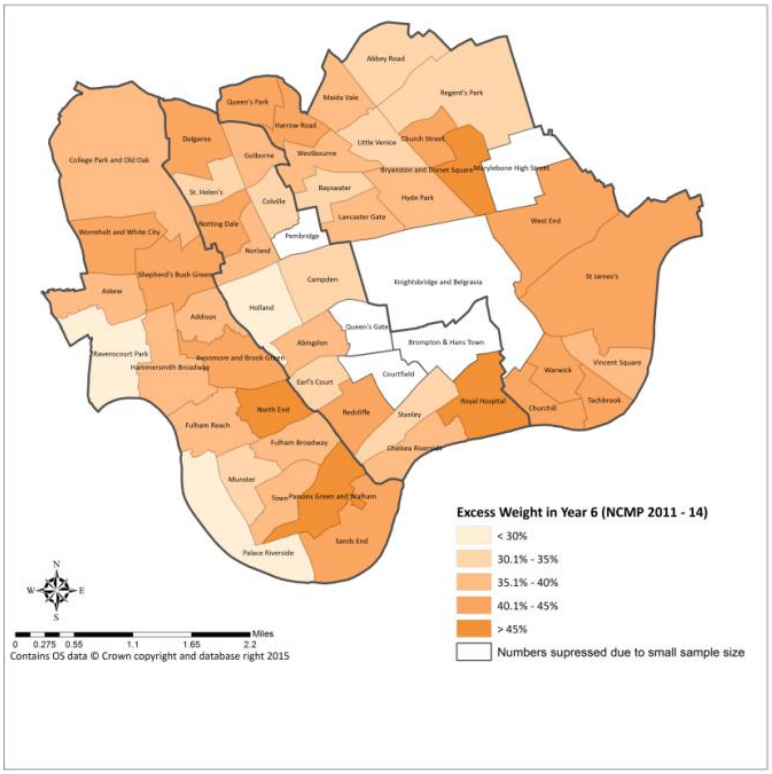


Figure 12: Overweight and obesity prevalence in Year 6 (NCMP, 2011-2014)

4.4 Ethnicity

Nationally, child obesity prevalence has been found to vary substantially between ethnic groups, with obesity prevalence generally lower in children of White British ethnicity (NOO, 2011). It has been observed that in Reception and Year 6, obesity prevalence is especially high for children of both sexes from Black African and Black Other ethnic groups, and boys from the Bangladeshi ethnic group.

This pattern is largely reflected across the three boroughs, with the exception of Year 6 children in Kensington and Chelsea, where obesity is most prevalent among Asian ethnic groups (Figure 13).

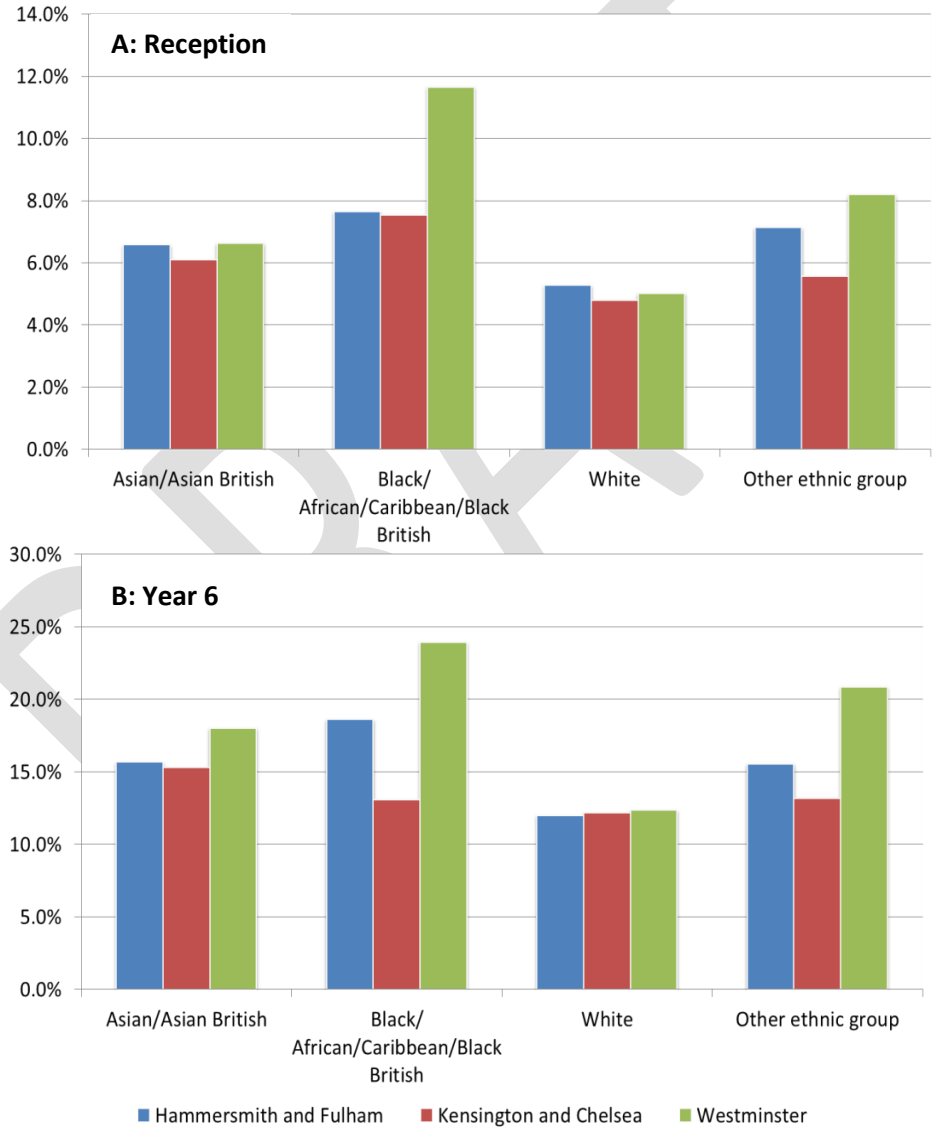


Figure 13: Obesity prevalence in Reception (A) and Year 6 (B) by ethnicity (NCMP, 2012/2013)

4.5 School population

The numbers of children's centres, school, and school populations are depicted in Figure 14 below.

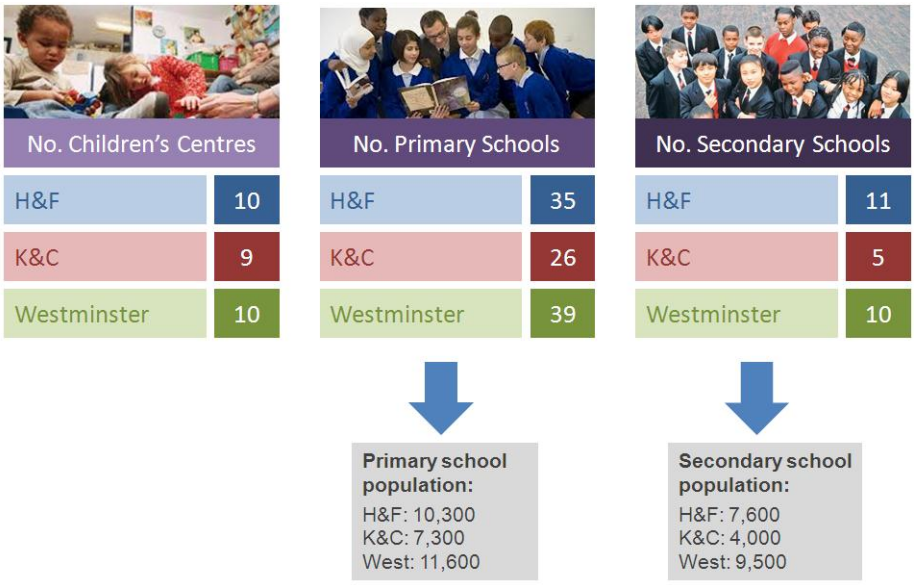


Figure 14: Number of school children in the three boroughs

4.6 Physical activity levels

Generally, children in the three boroughs have lower participation rates in high quality PE and school sport for at least two hours in a typical week compared with their peers in London and England. Hammersmith and Fulham has the lowest figures, with 70% of pupils participating in at least two hours of high quality PE and school sport with, compared to 75% of pupils in Westminster and 77% in Kensington and Chelsea (Figure 15).

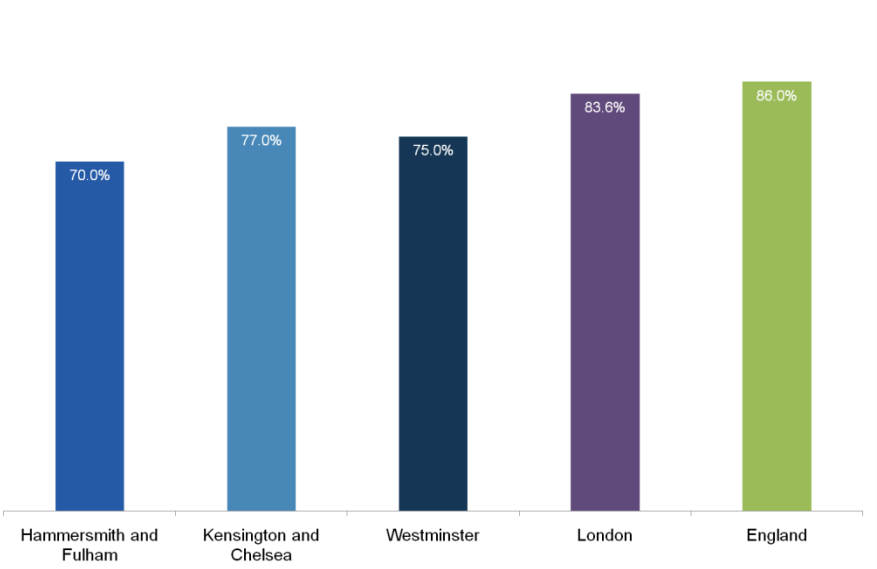


Figure 15: The percentage of state school children in Year 1-11 participating in at least two hours of high quality PE or school sport in a typical week (TNS Social Research, Annual Survey of School Sports Partnerships 2009/2010)

Nationally, whilst participation in school PE has increases, schools in deprived areas with a higher proportion of ethnic minority pupils, and pupils with special educational needs have the lowest level of participation in sports in and outside the school environment.

4.7 Access to healthy and affordable food

A number of studies have found that takeaway food outlets are often located in areas of higher socioeconomic deprivation, where obesity prevalence is generally higher (National Obesity Observatory). Evidence links the fast food environment and health, although a clear relationship between fast food restaurants and obesity rates is less obviously demonstrated (CIEH, 2014).

A series of mapping has been undertaken to further understand the food environment across Westminster and Kensington and Chelsea (Figures 16 and 17), with maps in development for Hammersmith and Fulham.

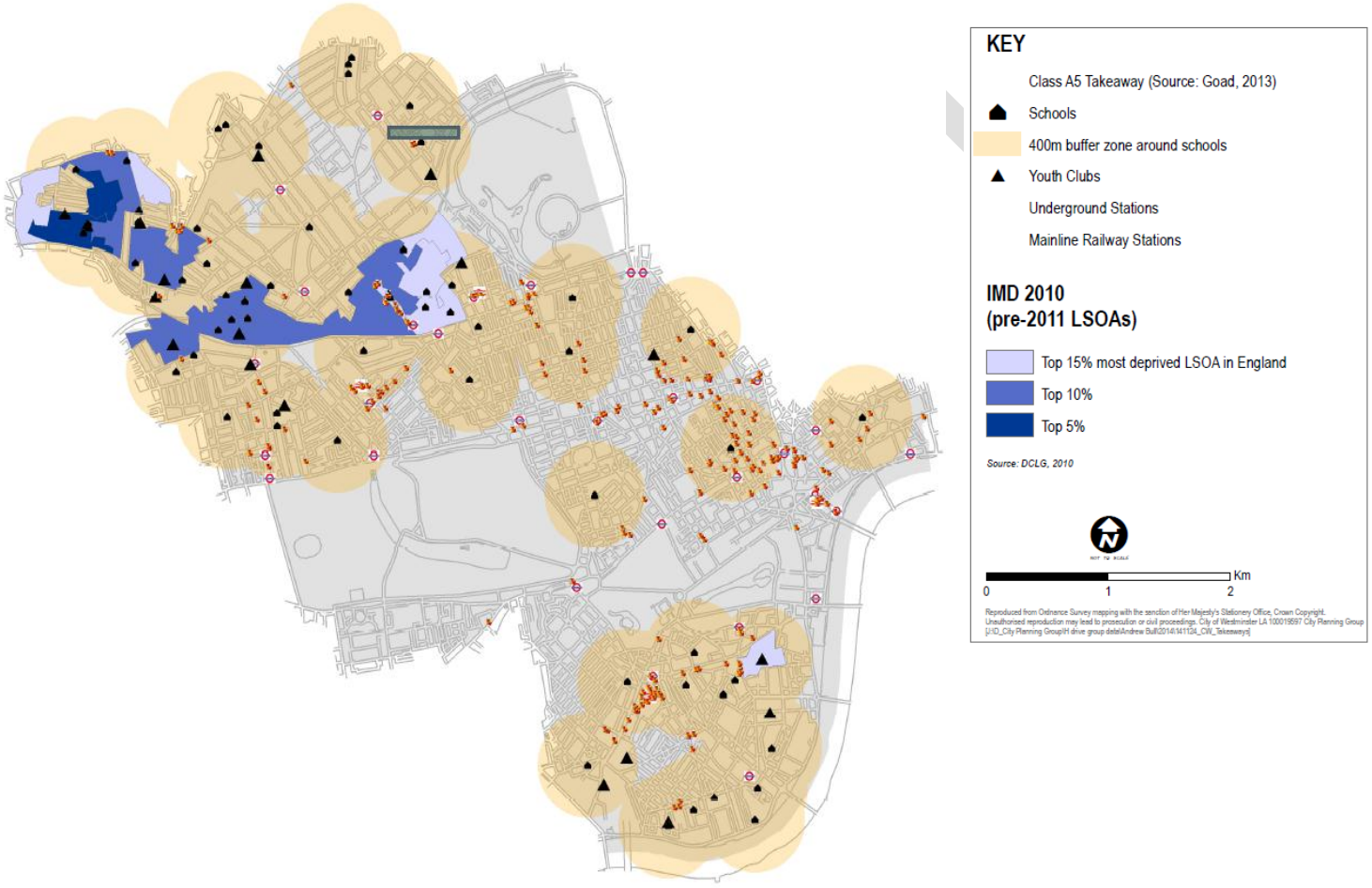


Figure 16: A5 Takeaway stores in Westminster mapped against school and youth clubs

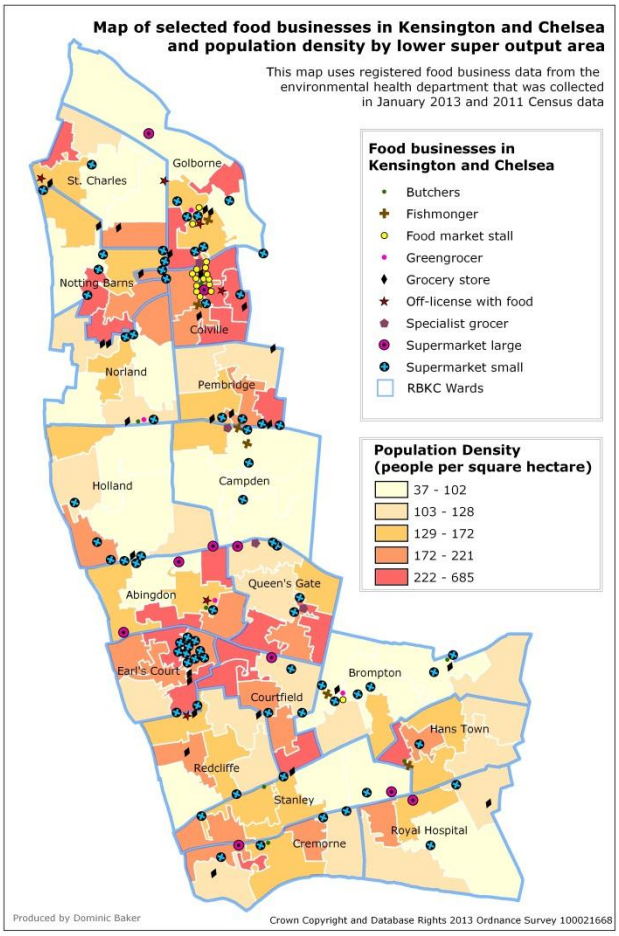


Figure 17: Map of selected food businesses in Kensington and Chelsea and population density by lower super output area

The Good Food for All report, developed by the Public Health Nutrition Team at Central London Community Healthcare (CLCH) sought to understand the social, personal and environmental issues that surround food choice for local communities in North Kensington (CLCH, 2013).

Key highlights of the report include:

- A significant proportion of low income households spend less than £30 per week on food, with which they are unlikely to meet a nutritionally adequate diet,
- Half of survey respondents indicated that they do not have enough money to buy a range of foods each week
- Fruit and vegetable prices in markets and local greengrocers were often half that of the same product in a supermarket
- Inconsistent price labelling makes it difficult to ascertain the best value, for example comparing £1 bowls with unit pricing or cost per weight (used both in kilograms and pounds)
- Two areas identified with highest expense and lowest availability of the healthy food basket exercise were Dalgarno in St Charles and St James in Norland

5. National Response

5.1 Tackling overweight and obesity is a national government priority

The Government policy paper '*Healthy Lives, Healthy People: A call to action on obesity in England*' (2011) sets out the national approach for tackling obesity, building on the whole system approach described in the Government Office for Science's Foresight report '*Tackling Obesity: Future Choices*' (2007).

The Government's strategy clearly emphasises that preventing and treating childhood obesity requires a comprehensive approach and action at every level, from the individual and across all sectors which includes:

- A multi-level approach where preventing obesity and treating those already obese is happening at the same time
- A multi-stage approach where opportunities for intervention and support at key life stages, from before birth until early adulthood and then again at pregnancy, are exploited
- A multi-disciplinary and agency action approach where a range of stakeholders from different fields work together to address the obesogenic environment and support behaviour change, integrating strategies, policy development and redesigning services to improve health and wellbeing.

As part of the strategy, two national ambitions were set:

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

The three most recent amendments to legislation and policy which are directly relevant to childhood obesity are summarised below.

Health and Social Care Act 2012 (Chapter 7), March 2012

The Health and Social Care Act places local government at the core of the health and care service with statutory responsibility for commissioning services that improve the health and wellbeing of their local population. This includes addressing the wider determinants of health and wellbeing through a life-stages approach as the basis for the new public health service.

National Planning Framework, Department for Communities and Local Government, March 2012
The National Planning Policy Framework provides a framework within which local people and their accountable councils can produce their own distinctive local and neighbourhood plans, which reflect the needs and priorities of their communities. Local planning authorities should "work with public health leads and organisations to understand and take account of the health status and needs of the local population… including expected changes, and any information about relevant barriers to improving health and wellbeing".

Localism Act 2011 (Chapter 20), November 2011
The Localism Act contains a number of proposals to give local authorities new freedoms and flexibility to meet local people's needs. This includes a 'general power of competence' which will give local authorities more freedom to take action in the interests of their areas, reflecting the priorities of local people. It also includes provisions to make the planning system clearer, more democratic, and more effective. Neighbourhood planning will allow communities, both residents, employees and business, to come together through a local parish council or neighbourhood forum and say where they think new houses, businesses and shops should go – and what they should look like.

5.2 Accountability

The foundation for accountability arrangements for improving health in our local communities is the Public Health Outcomes Framework for England 2013-2016. This includes several indicators which are directly or indirectly related to childhood obesity:

- 2.6i: Proportion of children aged 4-5 years classified as overweight or obese
- 2.6ii: Proportion of children aged 10-11 years classified as overweight or obese
- 2.2i: Breastfeeding initiation
- 2.2ii: Breastfeeding prevalence
- 2.11: Diet
- 2.12: Excess weight in adults
- 1.16: Utilisation of green space for exercise/ health reasons

5.3 UK and International Guidance

In the UK, the National Institute for Health and Clinical Excellence (NICE) have produced public health guidance aimed at preventing and managing childhood obesity across a range of settings. Most recently, NICE published a quality standard which covers a range of approaches at a population level to prevent children and young people aged under 18 years from becoming overweight or obese (NICE, 2015). NICE quality standards consist of a prioritised set of specific, concise and measurable statements. They draw on existing guidance and are designed to support the measurement of improvement.

The quality statements for prevention of obesity in children in young people are:

- Children and young people, and their parents or carers, using vending machines in local authority and NHS venues can buy healthy food and drink options.
- Children and young people, and their parents or carers, see details of nutritional information on menus at local authority and NHS venues.
- Children and young people, and their parents or carers, see healthy food and drink choices displayed prominently in local authority and NHS venues.
- Children and young people, and their parents or carers, have access to a publicly available up-to-date list of local lifestyle weight management programmes.
- Children and young people identified as being overweight or obese, and their parents or carers as appropriate, are given information about local lifestyle weight management programmes.
- Family members or carers of children and young people are invited to attend lifestyle weight management programmes, regardless of their weight.
- Children and young people, and their parents or carers, can access data on attendance, outcomes and the views of participants and staff from lifestyle weight management programmes.
- (placeholder) Reducing sedentary behaviour. A placeholder is an area that has been identified as a priority but for which no guidance currently exists. There is an identified need for evidence based guidance on interventions to reduce sedentary behaviour in children and young people.

Tackling child obesity requires action across a number of areas and settings and it is generally acknowledged to be difficult to identify the specific components of prevention programmes that are most successful.

While recognising this limitation in the evidence base, the authors of a Cochrane review on interventions for preventing obesity in children (Waters et al., 2011) reported that the following could be promising policies and strategies:

- School curriculum that includes healthy eating, physical activity and body image
- Increased sessions for physical activity and the development of fundamental movement skills throughout the school week
- Improvements in nutritional quality of the food supply in schools
- Environments and cultural practices that support children to eat healthier foods and being active throughout each day
- Support for teachers and other staff to implement health promotion strategies and activities (eg professional development, capacity building activities)
- Parent support and home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen based activities

The review did find strong evidence to support the beneficial effects of child obesity prevention programmes on BMI, particularly for programmes targeted to children aged six to twelve years. However, the authors noted some other limitations of the evidence base and report that more robust research is required, including identifying any impact on health inequalities and the sustainability of interventions

Lessons from Australia

A benchmarking tool – the Obesity Action Award – was developed to compare obesity prevention policies implemented across states and territories within Australia (Martin et al., 2014). Based on a review of the evidence and consultation with experts the framework identified nine domains for potential government action on obesity prevention:

- whole-of-government approaches
- marketing restrictions
- access to affordable, healthy food
- school food and physical activity
- food in public facilities
- urban design and transport
- leisure and local environments
- health services
- social marketing

A scoring system for these domains was then developed for use by non-government stakeholders, resulting in a league table to identify the best and worst performers across Australia. The key factors for success for the best performing governments were:

(1) those with whole-of-government approaches and strategies;

(2) those who had extended common initiatives. For example, measures within schools, such as canteen guidelines and physical education are now considered a standard approach.

However these can be stepped up to have a greater impact, such as extending the focus on healthy eating and active play to early childhood centres;

(3) and those who demonstrated innovation and strong political will.

Social marketing campaigns were only considered effective if they were supporting other initiatives, not as a strategy in themselves

EPODE Model

The EPODE model (from the French Ensemble, Prevenons l'Obesite des Enfants/ Together Let's Prevent Childhood Obesity), is a coordinated, capacity-building approach aimed at reducing childhood obesity though a societal process in which local environments, childhood setting and family norms are directed and encouraged to facilitate the adoption of healthy lifestyles in children (Borys et al., 2012).

Central to the model are four critical factors which form the four pillars of the methodology:

1) **Political commitment:** Gaining formal political commitment at central and local levels from the leaders of the key organisations which influence national, federal or state polities as well as local policies, environments and childhood settings;
2) **Resources:** Securing sufficient resources to fund central support services and evaluation, as well as contributions from local organisations to fund local implementation:
3) **Support services:** Planning, coordination and providing the social marketing, communication and support services for community practitioners and leaders:
4) **Evidence:** Using evidence from a wide variety of sources to inform the delivery of EPODE and to evaluate process, impact and outcomes of the EPODE programme

The methodology was shaped over 5 years of pilot implementation in France in 10 towns, and is now being used in over 300 worldwide.

McKinsey Global Institute Review

In 2014, McKinsey published a paper which aimed to start a global discussion on the components of a successful societal response to overcome obesity. The main findings of the paper included:

- No single solution creates sufficient impact to reverse obesity: only a comprehensive, systemic programme of multiple interventions is likely to be effective
- Almost all of the interventions analysed were highly cost effective from the viewpoint of society
- Education and encouraging personal responsibility are necessary but not sufficient – restructuring the context that shapes physical activity and nutritional behaviour is a vital part of any obesity programme
- Capturing the full potential impact is likely to require commitment from government, employers, educators, retailers, restaurants and food and beverage manufacturers, and a combination of top-down corporate and government interventions and bottom-up community based ones

Community based interventions

Recently, there is emerging international evidence on the effectiveness of more complex, multifaceted community-based prevention initiatives (de Silva-Sanigorski et al., 2010; Economos et al., 2007; Taylor et al., 2007). These interventions have focussed on improving opportunities for healthy eating and participation in physical activity through building community capacity, promoting sociocultural and environmental change, and policy development.

A common theme from the studies is the importance of active and committed involvement from local stakeholders in the development, implementation and evaluation of the intervention (de Silva-Sanigorski et al., 2010; Economos et al., 2007). This partnership working is key to ensuring that the intervention (i.e. access to healthy foods and opportunities for physical activity) is embedded into the community and is sustainable long term.

5.4 UK Initiatives

The Government is leading a number of initiatives which have both direct and indirect links to tackling childhood obesity. These include:

- **The Change4Life social marketing campaign**: providing information to support families and individuals to make simple changes to their diet and activity levels
- **The Public Health Responsibility Deal**: working with the food and drink industry to voluntarily agree actions that support people to make healthier choices
- **The National Child Measurement Programme**: to inform local planning and commissioning
- **The Healthy Child Programme**: the main delivery mechanism for obesity prevention in early years and now provides greater emphasis on nutrition, breastfeeding and physical activity
- **Early Years Foundation Stage framework**: statutory requirements for all early years providers to ensure children in their care are provided with healthy, balanced and nutritious food
- **Standards for School Food**: Standards stipulating nutrients required for all school food including breakfast, lunch, vending machines and tuck shops
- **Healthy Start**: Vitamin and food voucher distribution initiative for pregnant women and women with children up to 5 years

In London, the Mayor has made childhood obesity the number one health priority. The report, *Tipping the Scales: childhood obesity in London (2011)* outlines the co-ordinated strategic approach to address this. The three key elements are:

- Setting strategic vision
- Directly supporting and funding city-wide interventions
- Promotion, evaluation and spreading good practice

6. Local strategies

6.1 Health and Wellbeing Board priorities

The interest and willingness to act effectively on the issue of childhood obesity has been communicated clearly by local politicians and leaders across the three boroughs. This has been achieved through commitments embedded into each borough's Health and Wellbeing Board's strategies to give every child the best start in life:

Westminster Health and Wellbeing Strategy

Royal Borough of Kensington & Chelsea Health and Wellbeing Strategy

Hammersmith and Fulham Health and Wellbeing Strategy

6.2 Tackling childhood obesity across the three boroughs programme

Tackling childhood obesity across the three boroughs (TCOT) is the overarching 5 year programme which aims to halt and reverse the rising trend in childhood obesity across the three boroughs. It comprises of three components (Figure 12):

1. Cross-agency child healthy weight care pathway and child obesity prevention and family healthy lifestyles services
2. A whole system approach to tackle childhood obesity in Westminster City Council working with internal and external partners to deliver an environment where making healthy choices are the easier choices
3. 'Go Golborne' – a community based project in the Golborne area of the Royal Borough of Kensington & Chelsea

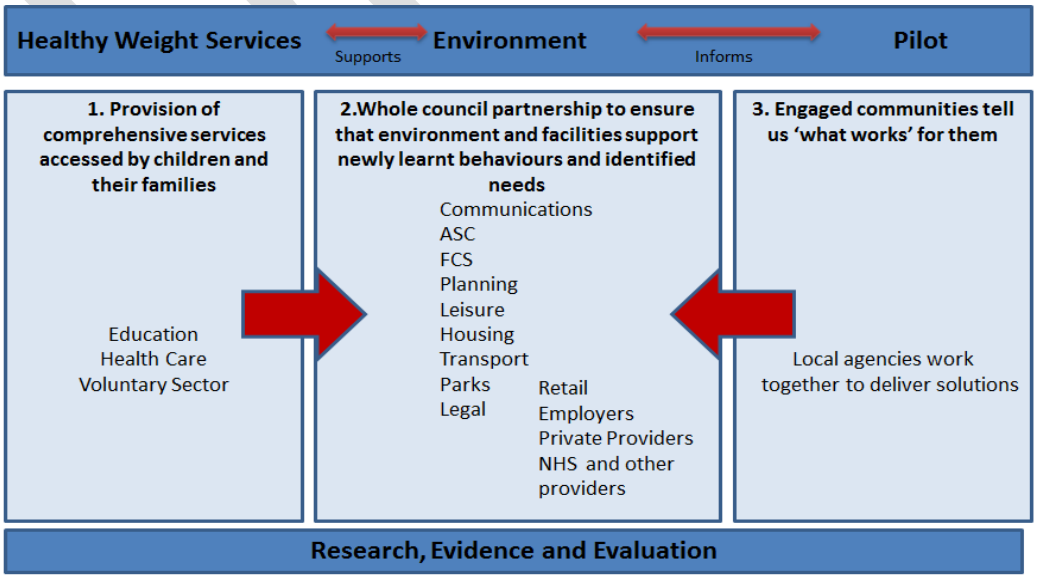


Figure 9: Tackling childhood obesity across the three boroughs programme

The following objectives for the programme have been identified:

- Children and families are more physically active in their daily lives
- Children and families develop a positive food culture within their families and communities
- Children and families are able, and supported, to make healthier choices where they live

These objectives will be delivered through action and increasing opportunities in the following areas:

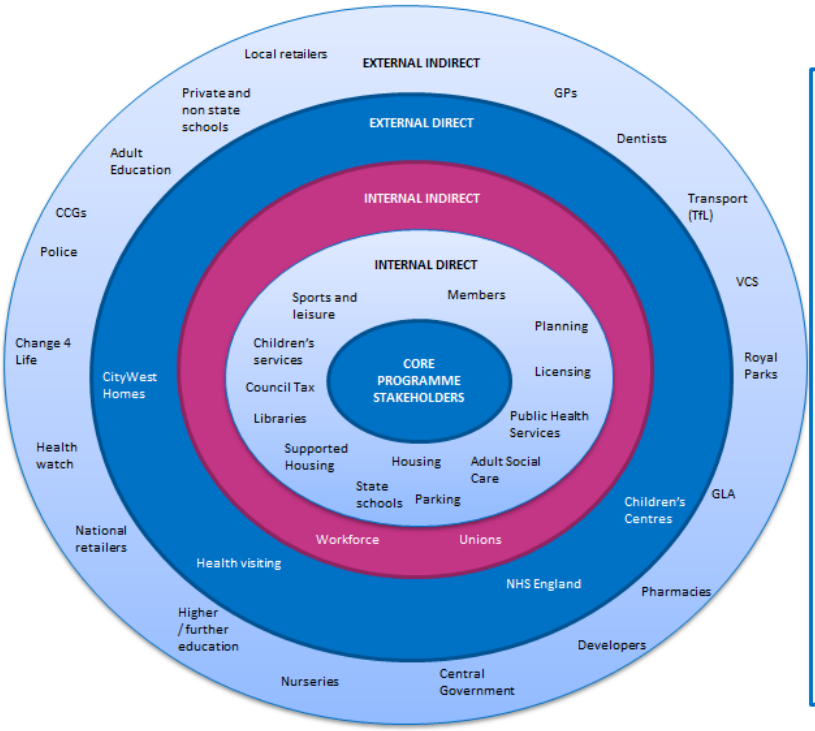
- **Supporting a healthy start in life** by supporting early years services to develop healthy lifestyle interventions
- **Healthier preschools and schools** by supporting a 'whole school' approach to healthy eating and physical activity
- **Strengthening partnership working and integration** across services and organisations to increase opportunities for children and their families to be active and eat healthily
- **Utilisation of system levers** to address the wider determinants of obesity and create local environments that better support healthy lifestyle choices
- **Providing consistent messages** to children and families about healthy lifestyles
- **Maximising the use of existing services and assets** within the community
- **Increasing the involvement of community members** in the design and delivery of healthy lifestyle initiatives
- **Monitoring, evaluation and increased research** to ensure we can evidence the difference our programme makes and contributing to the evidence base on 'what works' to tackle childhood obesity
- **Making health options** the easy option by addressing barriers to healthy lifestyles that children and families face in their day to day lives

The programme will follow these principles to halt and reverse the rising trend in childhood obesity across the three boroughs:

- Evidence based interventions
- Engagement, collaboration and co-production (internally to LAs and with external stakeholders) recognising children and young people as agents for change, building on existing assets and achievements
- Identifying and utilising opportunities, systems/levers and mechanisms available in house and through partners to counteract the adverse obesogenic environment (including marketing and advertising where appropriate)
- Taking action to reduce inequalities
- Ensuring the sustainability of redesigned services and interventions

There are 4 elements that are fundamental to the success of the programme:

- Visible and vocal **political leadership**
- A **vision** shared by all parties
- **Commitment** from senior leaders and influential figures, with regular **engagement**
- **Priorities** which are clear, shared and ambitious that stimulate **debate**



Core programme Stakeholders:

- Residents and Communities
- Programme Sponsor
- Tri-borough Executive Director of Adult Social Care Services
- Director of Public Health
- Public Health Integration Transformation Board
- Workstream leads
- Chief of Staff
- WCC Cabinet Member for Adults and Public
- WCC Deputy Cabinet Member for Adults and Public Health
- K&C WCC Cabinet Member for Adults and Public Health
- H&F WCC Cabinet Member for Adults and Public Health
- Tri-borough Executive Director of Children's Services
- Public Health Family and Children Services commissioner
- EMT
- JMT

Figure 10: Stakeholders for the tackling childhood obesity across the three boroughs programme

Key to informing the development of the programme, particularly component 1, was the review of existing service provision for child obesity prevention and healthy family weight services, published in April 2014.

In November 2015, the TCOT programme was accepted as member of the EPODE International Network, which is the first UK Council intervention to join the network.

The following section described the progress made in the first year for each component of the programme.

Component 1 – Commissioned Services

Two lots of services have been commissioned for three years across all three boroughs.

Lot 1: *Policy and Workforce Development* aims to improve settings and environments to ensure healthier choices are the easy choices for children and families in relation to physical activity and healthy eating (including those related to oral health) e.g. schools, nurseries, parks, leisure centres. Professional development and support for staff that have contact with children and their families is offered to raise the issue of healthy weight e.g. brief interventions, therefore 'making every contact count.'

Current work:

The contract was awarded to 'MyTime Active' and commenced on 1st August 2015. The provider is contracted to deliver the following services:

Work Force Training: Supports front line staff to better identify those who are, or are at risk, of becoming overweight or obese and to enable them to provide effective first line advice and appropriate signposting.

Whole School Approach and Curriculum Support: Schools and Early Years settings will be provided with support to achieve Bronze, Silver and Gold Healthy Schools and Early Years Awards. This includes guidance and training on cooking in the curriculum, and nutrition education for Key Stage 1 to Key Stage 3

Healthier Catering Commitment: Support environmental health teams to work with local food businesses to increase those achieving the Healthier Catering Commitment award and sustain improvements in healthy catering practice.

Lot 2: *Obesity Prevention and Lifestyle and Weight Management Services* provide a range of services for families with children for cohorts aged 0-4 years; 5-12 years; and teenagers. There will also be services for targeted schools where there is delivery of practical, fun, healthy eating sessions for a term for years 1 and 4 and extra physical activity for a year each year for 3 years.

Current work:

The contract was awarded to 'MyTime Active' and commenced on 1st August 2015. The provider is contracted to deliver the following services:

- **MEND Mums:** A six week postnatal weight management programme for new mums
- **MEND 2-4:** A six week healthy lifestyle programme for children aged 2-4 years and their parents and carers
- **One to ones:** Tailored advice from a dietician for parents with children aged up to 4 years for whom a group programme is not suitable, or have additional needs
- **MEND 5-7 and MEND 7-13:** Ten week programme for children who are above a healthy weight and their parents and carers
- **MEND Teens**: Developed in collaboration with 13-18 year olds across the three boroughs who are above a healthy weight
- **MEND in schools:** Targeted work with schools identified as having high levels of overweight and obesity to deliver a multicomponent whole schools obesity prevention programme.

Family Healthy Weight care Pathway and Toolkit

A range of stakeholders, from Public Health, Children's Services, Clinical Commissioning Groups (CCGs), Acute Healthcare, Community Health Services, Obesity Prevention and Weight Management Services, and Healthwatch have worked together to produce a holistic, evidence based, and system wide care pathway. The objective of the pathway is to ensure that those who work with children know their role in the prevention and treatment of childhood obesity and can appropriately promote and refer on to services.

The pathways and toolkit can be found here: http://www.lbhf.gov.uk/familyhealthyweightcare

Component 2 – Whole Council Partnership

In order to see a demonstrable and sustained reduction in childhood obesity, the services provided through Component 1 need to be accompanied by an integrated approach which uses the full levers available to councils and their partners to address the many environmental factors contributing to childhood obesity over the longer-term.

The approach for Component 2 is to identify opportunities within the council, and then across external networks, to work with partners to make positive changes to the wider environment within the borough. The aim is to engage children and young people and their families and communities, colleagues in e.g. sport and leisure, planning and housing, children and family services, as well as partners across the local geography and economy including the NHS, education, academia, catering and retail to secure collaboration, co-design and longstanding commitment to action.

The key aims of this component are to work with every council department to consolidate and strengthen activities that contribute to the prevention of childhood obesity by:

- understanding work already underway across the council contributing to preventing childhood obesity;
- identifying actions to be included departmental business plans to deliver the corporate strategy;
- understanding the areas where the council currently has limited control or opportunity to influence; and
- identifying opportunity areas for further development

This approach will be developed in Westminster initially, before being taken forward in the other two boroughs.

Current work in Westminster:

Initial engagement with Executive Directors identified areas where opportunities may exist to strengthen prevention of childhood obesity. Initial cross service workshops developed the first tranche of action plans signed off by members and officers. These cover:

- Food growing and education: Pilot food growing projects in two schools and a housing estate in a regeneration area
- Increasing physical activity: Working with priority schools to engage with the school sports development team membership offer and services
- Healthier Catering commitment: Working with 20 fast food providers to improve the nutritional content and quality of their food offer

Work is underway to develop action plans covering

- Planning
- Food and poverty: Mapping fast food and convenience stores; developing a social supermarket model; applying for capital funding to host a social supermarket
- Cook and Eat programmes – mapping current provision and assets
- Increased availability of drinking water
- Procurement
- Housing and Social Landlords

Planning is also underway to design our engagement approach with food businesses. The aim is to:

- Increase access to healthy and affordable food
- Engaging residents and organisations to support sustainable food retail change in their community
- Influencing supply and demand to facilitate the purchase and promotion of healthy food

Component 3: Whole place intervention pilot

The third component of the programme is a pilot project that has been developed to tackle childhood obesity within one community called 'Go Golborne'. This is based on evidence that initiatives to tackle obesity are most effective when they are designed at a local level, so they respond to the unique demographic, economic and cultural characteristics of individual communities.

Golborne, in North Kensington, was chosen for this pilot as it is densely populated and has relatively high levels of both childhood obesity and deprivation. The pilot offers the opportunity to try relevant multi-agency interventions on a smaller scale to identify what works (and what does not) before replicating in other areas across the three boroughs.

Through the development of a network of local organisations, existing work to promote healthy lifestyles will be consolidated, as well as identifying opportunities to extend and implement new initiatives. Every six months, activities will focus on a different headline theme linked to a specific behaviour change goal. The six themes are:

- Five a day: Promoting fruit and vegetable consumption
- Snack check: promoting healthy snacking habits
- Sugar sways: reducing sugar consumption
- Active travel: promoting walking and cycling
- Active play: promoting play and physical activity
- Screen time: reducing sedentary time watching TV/ playing with tablets and other devices

Current work:

Go Golborne launched in May 2015 with numerous events in different settings including schools, community centres, play services, parks, the library and local market. A range of resources were disseminated to children and parents to introduce them to Go Golborne, including a guide to local services and activities that can support healthy lifestyles.

Prior to this, extensive engagement with local organisations was carried out to establish a network which aims to help promote consistent lifestyle messages to children and families and create new ways to implement them.

A website has been created including information for parents and a 'partner zone' where local partners can access information about forthcoming activities, resources, and opportunities to get involved in Go Golborne www.rbkc.gov.uk/gogolborne.

A wide range of local partners have attended a series of workshops to help shape project plans and identify priorities for action, including plans for the 5 A DAY campaign due to launch across the community on 23rd November 2015.

Training sessions on key nutrition and physical activity messages was delivered to staff and volunteers in partner organisations in June/July 2015 and will be available on a rolling basis.

Links have been developed with key departments across RBKC to explore opportunities for partnership work and align activities to help meet the objectives of Go Golborne (i.e. food growing and healthy catering projects, planning consultations, park refurbishments etc).

The school nursing service has been commissioned to deliver an extended National Child Measurement Programme (NCMP) in local schools and link children who are above or below a healthy weight with family healthy lifestyle services provided by Mytime Active.

The University of Kent has been commissioned to conduct a process and outcome evaluation of Go Golborne to capture learning from the project and high quality evidence of its impact on the health of local children. Baseline data is currently being captured via local schools.

6.3 Local Authority departments

The following tables aim to provide an overview of work currently being delivered by Local Authority teams that contribute to tackling childhood obesity.

PLANNING			
	Hammersmith & Fulham	**Kensington and Chelsea**	**Westminster**
Strategy & Focus	The Core Strategy (2011) Recognises the importance of the promotion of healthy lifestyles to address health inequalities The strategy aims to improve cycling and walking by working with partners to improve the opportunities for cycling and walking	Planning policies protect existing and encourage new health and sports facilities Policies ensure neighbourhoods benefit from shopping facilities and community facilities within a walkable distance	Westminster's City Plan: Strategic Policies (2013) Plan revision: - Focus on pedestrians - Policies of food and drink Development of the following strategies: - Walking and cycling - Open space - Biodiversity
Hot food Takeaways	Planning policies restrict A3-A5 uses to a specified percentage of frontages in shopping areas (DM C2, C4 & C5 in Development Management Local Plan). A5 uses also restricted within 400m of a school or other places that children are likely to congregate (SPD Amenity 1).	Planning policies ensure a balance of use within and outside centres (including A5 use). No specific policies to restrict the proximity of takeaways to schools	Planning policies ensure a balance of use within and outside centres (including A5 use). No specific policies to restrict the proximity of takeaways to schools
Open Space	In particular, the strategy notes that many of the schools in H&F are built on sites with limited outdoor space and therefore it is important to improve access to and provision of sports facilities to improve health and reduce child obesity levels.		The plan includes commitments to protecting and enhancing open spaces, including addressing active play space deficiency, as well as protecting existing and encouraging new facilities including playgrounds, leisure centres, and sports facilities.

TRANSPORT			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Strategies	Air Quality Action Plan to be rolled out April 2016 Cycling Strategy in place Walking Strategy in place	Air Quality and Climate Change Action Plan (2016 – 2021) (specific objectives to encourage walking and cycling) Council Travel Plan to be updated April 2016	Air Quality Action Plan (2013-2018) Cycling Strategy in place Walking Strategy currently being refreshed Sustainable modes of travel strategy in place
Travel Plans	School travel plans Support offered to developers to incorporate active travel into new developments	School travel plans Small grants (up to £500 per school) available to implement tailored projects based on school needs	School travel plans
Pupil-led projects	Junior Travel Ambassadors (Primary Schools) and Youth Travel Ambassadors (Secondary Schools)	Junior Travel Ambassadors (Primary Schools) and Youth Travel Ambassadors (Secondary Schools)	Junior Travel Ambassadors (Primary Schools) and Youth Travel Ambassadors (Secondary Schools)
Cycling	Bike maintenance sessions (free) Lorry danger awareness sessions (free), including training for HGV operators Refurbished bikes and discounts from Bikeworks for LBHF employees Bike It (sustrans-funded) scheme encourages residents to cycle Barclays Cycle Hire scheme: 1,700 bikes and 60 docking stations Free cycle training to pupils in Year 5 & 6 (Bikeability). Free or subsidised cycle training for those living, working or studying in H&F.	Free cycle training for those who work, study or live in RBKC: Bikeability Level 1 & Level 2 All Ability Cycling for those with disabilities Recycle the way you travel – provision of free second hand bikes for people on low incomes Lorry driver training: Safer Urban Driving Cycling campaign: Bikeminded website & events Bike maintenance sessions (free) Workplace Travel Network supports companies to promote sustainable travel choices to and from work	Free cycle training for those who work, study or live in Westminster Subsidised bike maintenance courses Lorry danger awareness sessions (free) Free city cycling courses Business Engagement programme: developing a web based toolkit and direct engagement aimed at bike use for employees Incentive based app being developed to encourage employees to move 3x10mins per day

Walking		Promotion of walk on weekdays and walk to school campaigns The 'naked street' on Exhibition Road encourages walking and discourages car driving	Westminster Wiser Walking Scheme: Child pedestrian training scheme offered to Year 2 & 3 pupils at all Westminster primary schools
SPORT AND LEISURE			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Strategy & Focus	CSPAN Physical Activity Strategy 2011-2016 Focus on 'those who are not participating in enough physical activity, in particular 16–24 year olds, BME groups, women and girls, and disabled people'	A sports and physical activity policy for Kensington and Chelsea 2010 to 2016 Focus on areas and groups where health is poor and participation levels are low. Additionally, focus on physical activity through the life course	Active Westminster Physical Activity Strategy 2015-2020 currently in development Active Communities approach embedded within this: asset mapping/ identifying needs/ prioritising services better
Leisure Facilities & Memberships	Leisure Provider: GLL Concessionary memberships available for eligible residents	Leisure Provider: GLL Concessionary memberships available for eligible residents (including a Family Pass for up to 2 children for those in receipt of Income Support; or Job Seekers Allowance)	Leisure Provider: GLL Re-let of contract –each facility required to provide 10hrs of Active Communities delivery per week Concession cards for 0-19 year olds (Active Westminster Passport) Free swimming for 0-19 year olds and over 60s
Sports Development Team	Sport England Project: Family activity sessions within children's centres. Work with a lead school on promoting Change4Life clubs in Primary Schools: promote physical activity to pupils 'Get Going' summer activity programme to encourage young people and adults to access local green spaces Offer support to third sector to access funding and developing activity programmes	Work with schools to encourage active lifestyles.	Westminster Mile Westminster Active Awards Primary School membership offer Neighbourhood Sports Clubs

CHILDREN'S SERVICES			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Children's Centres	Contracts have clear outcomes for 'healthy children under 5', including healthy eating, promotion of breast feeding and weaning advice. Additionally, only healthy snacks are available for children during sessions		
Early Years	Nurseries and childminders who are rated less than 'good' receive support from the councils including meeting the 'healthy lifestyle' criteria.		
School Meals	Maintaining school meals support service and monitoring take up of school meals.		

ENVIRONMENTAL HEALTH			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Strategies	Air Quality Action Plans highlighted previously in transport section		
Healthier Catering Commitment	The Healthier Catering Commitment (HCC) is a voluntary award scheme which encourages food businesses to demonstrate a commitment to offer healthier options		
	To date, 25 premises have achieved HCC award	To date, 59 businesses have achieved HCC award	To date, 21 businesses have achieved HCC award
Food Businesses	EH work with all food businesses to reinforce good principles on preparing healthy food and healthier food preparation processes		
Other	Fuel poverty service across two boroughs: advice and support on budgeting for food and fuel		

PARKS AND OPEN SPACES			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Strategy	Parks and Open Spaces Strategy (2008-2018)	Park strategy outlines investments into parks, including outdoor gyms	Open Spaces and Biodiversity Plan being refreshed
Access to Open Space	Considerable work has been undertaken to improve parks	Capital improvements being made to encourage greater use by under-represented groups	All major parks awarded Green Flag Status (healthy, safe and secure)
Other	Parks police patrol the parks to increase safety and use	Healthy Parks projects. Capital investments in parks to increase use such as installing distance markers Community kitchen gardens: Over 60 food growing gardens installed with over 1000 residents and community groups involved in growing fruit and vegetables	Parkmakers develop accessible activities in parks and open spaces, delivered by appropriately qualified coaches, personal trainers, park staff and volunteers

PUBLIC HEALTH			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Health Visiting	Commissioning responsibility for the three borough Health Visiting service transferred from NHS England to Local Authority on 1st October 2015. The service works across a number of stakeholders, organisations and settings to lead the delivery of the Healthy Child Programme (0-5); a prevention and early intervention public health programme. Advice and support provided on breastfeeding and weaning, weighing and measuring.		
Healthy Schools &Healthy Early Years Partnership	The Healthy Schools Partnership provides advice and guidance to early years settings and schools on how to take a whole setting approach to health and wellbeing		
	Schools have achieved the following Healthy Schools London awards: • 16 achieved Bronze • 5 achieved Silver • 1 achieved Gold	Schools have achieved the following Healthy Schools London awards: • 11 achieved Bronze • 5 achieved Silver • 0 achieved Gold	Schools have achieved the following Healthy Schools London awards: • 11 achieved Bronze • 5 achieved Silver • 1 achieved Gold
School Nursing	Delivers the National Child Measurement Programme. Conducting an extended NCMP programme in RBKC as part of the evaluation of the 'Go Golborne' project.		

Oral Health Promotion	Oral Health Promotion Team deliver evidence based oral health advice and implement oral health improvement programmes at schools, children's centres and community centres. The team work with children and families and vulnerable adults who require education to improve their oral health		
Workplaces	Tri-borough Workforce Wellbeing Strategy (2015-2018) and Workforce Wellbeing Group Work with businesses to raise awareness of workforce wellbeing and support offered to sign up to the London Healthy Workplace Charter		
	Council not currently engaged to sign up with the London Healthy Workplace Charter, however have carried out a partial gap analysis	Council not currently engaged to sign up with the London Healthy Workplace Charter, however have carried out a partial gap analysis	Council preparing to submit evidence to GLA to achieve commitment level of London Healthy Workplace Charter

LIBRARY SERVICES			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Health Info Project	The Health Information Project has worked in partnership with a number of professionals and organisations to promote key messages, including Dieticians, MyTime Active and are working closely with the Go Golborne Pilot		

6.4 External Partners

Health Services

Two paediatric dietetics services are offered by Chelsea and Westminster Hospital, and Central London Community Healthcare NHS Trust (CLCH) which offer specialist advice and care for children.

Further information is detailed in the Family Healthy Weight care Pathway Toolkit, which can be found here: http://www.lbhf.gov.uk/familyhealthyweightcare

Additionally, Chelsea and Westminster Hospital, CLCH and Imperial College Healthcare NHS Trust have all been accredited with Level 3 UNICEF UK Baby Friendly Initiative; ensuring good quality support is available across the community for all mothers and babies aiming to improve breastfeeding prevalence and very early child development.

Furthermore, West London Clinical Commissioning Group (WLCCG) support Child Health GP Practice Hubs which provide an environment in which health and social care professionals can work together in multi-disciplinary teams to provide integrated care for children most in need.

Voluntary Sector

The three boroughs benefit from an active and vibrant voluntary sector which delivers a range of programmes and activities that support healthy lifestyle messages. For example, healthy cooking classes, parenting classes which cover healthy eating, physical activity sessions for under-represented groups and opportunities for children to play in safe open environments. Other initiatives include the 'Snack Right' project, promoting healthy after school snacks.

The three boroughs are also home to a number of football teams who deliver outreach programmes to inspire young people to participate in physical activity; these include Chelsea Football Club and Queens Park Rangers.

7. Recommendations

1. Every department/organisation has a role to play in creating and / or supporting increasingly healthier environments to make healthy choices easy choices. Be creative within roles/responsibilities.
2. Utilise every engagement with partners to achieve shared understanding of the need to address this complex problem collectively and to identify opportunities, for example:
    a. Systematically use contracting as a delivery mechanism for healthy lifestyles.
    b. Find ways to encourage food businesses with poor hygiene ratings to improve and join in the Healthy Catering Commitment.
3. Focus on early years. Exploit all possible opportunities to encourage children and families to be more active.
4. Develop clear and consistent messages that are readily understood by all audiences. Use the optimal communication channels for each audience. Communicate constantly and consistently.
5. Contribute to, and keep abreast of, national and regional developments.
6. Act on, and increase the evidence base.

8. References

Borys, J., Le Bodo, Y., Jebb, S., Seidell, J., Summerbell, C., Richard, D., De Henauw, S., Moreno, L., Romon, M., Visscher, T., Raffin, S., Swinburn, B. (2012). EPODE approach for childhood obesity prevention: methods, progress and international development. *Obesity Reviews, 13*, 299-315

Butland, B., Jebb, S., Kopelman, P., McPherson, K., Thomas, S., Mardell, J., . . . Government of Science. (2007). Foresight. Tackling Obesities: Future Choices – Project report (2nd ed.). United Kingdom: Department of Innovation, Universities and Skills.

Chartered Institute of Environmental Health (2014) Takeaways Toolkit file:///Q:/Takeaways_Toolkit.pdf

Davies, S. C. (2013). Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays. London: Department of Health.

De Niet, J. E., & Naiman, D. I. (2011). Psychosocial aspects of childhood obesity. *Minerva Pediatr, 63*(6), 491-505.

de Silva-Sanigorski, A. M., Bell, A. C., Kremer, P., Nichols, M., Crellin, M., Smith, M., . . . Swinburn, B. A. (2010). Reducing obesity in early childhood: results from Romp & Chomp, an Australian community-wide intervention program. *Am J Clin Nutr, 91*(4), 831-840. doi: 10.3945/ajcn.2009.28826

Doak, C. M., Visscher, T. L., Renders, C. M., & Seidell, J. C. (2006). The prevention of overweight and obesity in children and adolescents: a review of interventions and programmes. *Obes Rev, 7*(1), 111-136. doi: 10.1111/j.1467-789X.2006.00234.x

Dobbs, R., Sawers C., Thompson, F., Manyika, J., Woetzel, J., Child, P., McKenna, S., Spatharou, A. (2014) Overcoming obesity: An initial economic analysis. McKinsey Global Institute

Economos, C. D., Hyatt, R. R., Goldberg, J. P., Must, A., Naumova, E. N., Collins, J. J., & Nelson, M. E. (2007). A community intervention reduces BMI z-score in children: Shape Up Somerville first year results. *Obesity (Silver Spring), 15*(5), 1325-1336. doi: 10.1038/oby.2007.155

Greater London Authority (GLA) Intelligence Unit (2011) Childhood Obesity in London

Gatineau, M. & Mathrani, S. (2011) Obesity and Ethnicity. Oxford: National Obesity Observatory

House of Commons Health Select Committee. (2004). Obesity: third report of session 2003/04. London: The Stationery Office.

King, L., Gill, T., Allender, S., & Swinburn, B. (2011). Best practice principles for community-based obesity prevention: development, content and application. *Obes Rev, 12*(5), 329-338. doi: 10.1111/j.1467-789X.2010.00798.x

Kumanyika, S. K., Rigby, N., Lobstein, T., Jackson Leach, R., & James, W. P. T. (2010). Obesity: Global Pandemic *Clinical Obesity in Adults and Children* (pp. 423-439): Wiley-Blackwell.

Martin, J., Peeters, A., Honisett, S., Mavoa, H., Swinburn, B., & de Silva-Sanigorski, A. (2014). Benchmarking government action for obesity prevention—An innovative advocacy strategy. *Obesity Research & Clinical Practice, 8*(4), e388-e398. doi: http://dx.doi.org/10.1016/j.orcp.2013.07.001

McAuley, K. A., Taylor, R. W., Farmer, V. L., Hansen, P., Williams, S. M., Booker, C. S., & Mann, J. I. (2010). Economic evaluation of a community-based obesity prevention program in children: the APPLE project. *Obesity (Silver Spring), 18*(1), 131-136. doi: 10.1038/oby.2009.148

McCormick, B., & Stone, I. (2007). Economic costs of obesity and the case for government intervention. *Obes Rev, 8 Suppl 1*, 161-164. doi: 10.1111/j.1467-789X.2007.00337.x

Morris, S. (2006). Body mass index and occupational attainment. *J Health Econ, 25*(2), 347-364. doi: 10.1016/j.jhealeco.2005.09.005

National Obesity Observatory, Obesity and the Food Environment: Fast Food outlets http://www.noo.org.uk/uploads/doc/vid_15683_FastFoodOutletMap2.pdf

NICE. (2013). Managing overweight and obesity among children and young people: lifestyle weight management services. Public health guidance 47: NICE.

NICE. (2015). Obesity: prevention and lifestyle weight management in children and young people. NICE quality standard 94.: NICE.

Olshansky, S. J., Passaro, D. J., Hershow, R. C., Layden, J., Carnes, B. A., Brody, J., . . . Ludwig, D. S. (2005). A potential decline in life expectancy in the United States in the 21st century. *N Engl J Med, 352*(11), 1138-1145. doi: 10.1056/NEJMsr043743

Oude Luttikhuis, H., Baur, L., Jansen, H., Shrewsbury, V. A., O'Malley, C., Stolk, R. P., & Summerbell, C. D. (2009). Interventions for treating obesity in children. *Cochrane Database Syst Rev*(1), Cd001872. doi: 10.1002/14651858.CD001872.pub2

Sanigorski, A. M., Bell, A. C., Kremer, P. J., Cuttler, R., & Swinburn, B. A. (2008). Reducing unhealthy weight gain in children through community capacity-building: results of a quasi-experimental intervention program, Be Active Eat Well. *Int J Obes (Lond), 32*(7), 1060-1067. doi: 10.1038/ijo.2008.79

Simmonds, M., Burch, J., Llewellyn, A., Griffith, C., Yang, H., Owen, C., Duffy, S., Woolacott, N. (2015) The uses of measures of obesity in childhood for predicting obesity and the development of obesity-related disease in adulthood: a systematic review and meta-analysis. Health Tech Assess, 19(43) http://dx.doi.org/10.3310/hta19430

Strelits, J. (2013). Chief Medical Officer's annual report 2012: Our children deserve better: Prevention pays. London: Department of Health

Summerbell, C. D., Waters, E., Edmunds, L. D., Kelly, S., Brown, T., & Campbell, K. J. (2005). Interventions for preventing obesity in children. *Cochrane Database Syst Rev*(3), Cd001871. doi: 10.1002/14651858.CD001871.pub2

Swinburn, B., Sacks, G., Hall, K., McPherson, K., Finegood,D., Moodie, M., Gortmaker. (2011) The global obesity pandemic: shaped by global drivers and local environments. *Lancet* 378, 804-14

Taylor, R. W., McAuley, K. A., Barbezat, W., Strong, A., Williams, S. M., & Mann, J. I. (2007). APPLE Project: 2-y findings of a community-based obesity prevention program in primary school age children. *Am J Clin Nutr, 86*(3), 735-742.

Waters, E., de Silva-Sanigorski, A., Burford Belinda, J., Brown, T., Campbell Karen, J., Gao, Y., . . . Summerbell Carolyn, D. (2011). Interventions for preventing obesity in children. *Cochrane Database of Systematic Reviews,* (12). http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001871.pub3/abstract

9. Appendices

Appendix A: National Child Measurement Programme (NCMP) Participation Rates

The NCMP participation rate is calculated as a proportion of the number of students who are measured during the programme over the number of students who are eligible for measurement. Participation in the programme is not compulsory, but non-participation is on an opt-out basis only.

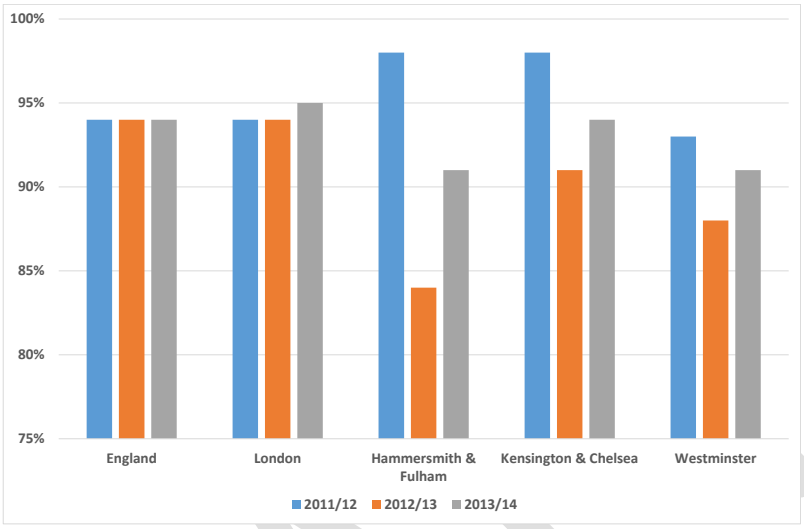


Figure A: Trends in NCMP participation rates: Reception Year

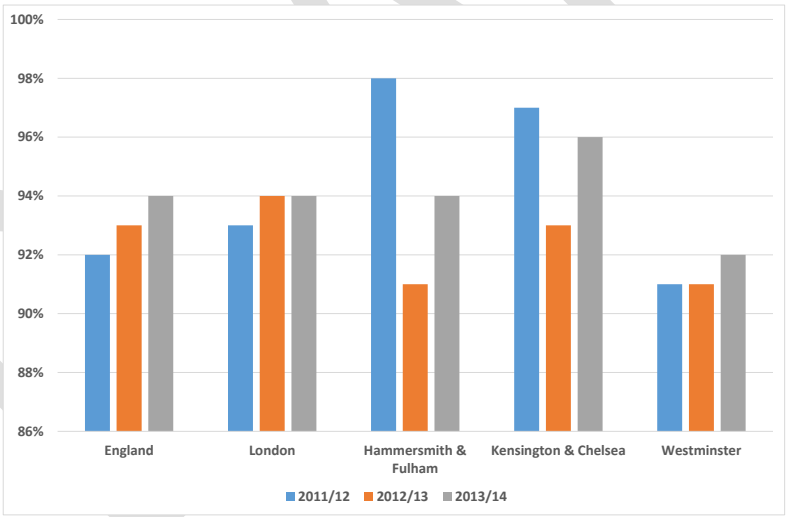
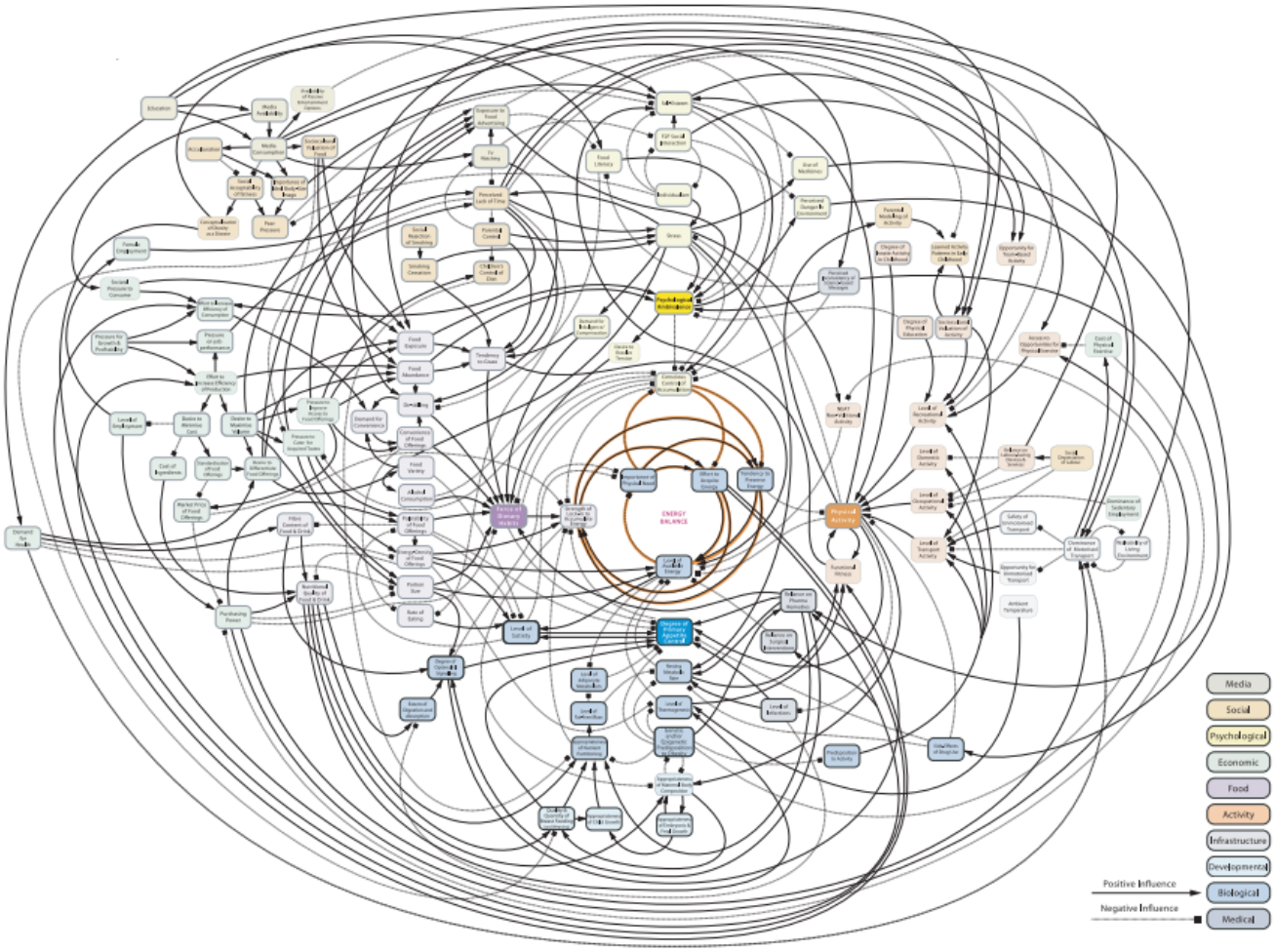


Figure B: Trends in NCMP participation rates: Year 6

As demonstrated in Figures A and B, overall London and England have 95% and 91% participation rates for Reception year and Year 6 respectively. Over the past three years, the three boroughs have had good participation rates for NCMP and therefore represent an accurate prevalence of obesity among state school children.

Appendix B: Obesity Systems Map



Appendix C: Evidence based opportunities for Local Authorities to support the development of the environment

Transport and Active Travel

Prioritising walking and cycling

- NICE recommends that pedestrians, cyclists and users of other modes of transport involving physical activity be given priority in the development of streets and roads. This may include:
  - Widening foot paths
  - Introducing cycling lanes
  - Reducing motor traffic by narrowing roads, introducing lower speed limits and creating calm routes to schools and designating streets as home zones
- Foot paths and bike lanes should be networked with paths and routes to destinations aiming at continuity and usability of routes by:
  - Ensuring sidewalk construction or improvements consider pedestrian needs
  - Increasing the ease and safety of crossing streets
  - Improving signage and markings at crosswalks and school zones
  - Implementing zoning standards that support mixed land use
- Introduce 20mph default speed limits to ensure traffic calming and improve perceptions of safety
- Association of Directors of Public Health (Take action on active travel) recommends the allocation of 10% of transport budgets to active travel
- Promote awareness amongst motorists of the needs of both cyclists and pedestrians
- All policies and design should be evaluated in accordance to their ability to also meet the needs of children with special needs

Shifting travel mode

- Social marketing campaigns can shift perceptions of car use and demonstrate the benefits of active travel. Campaigns should consider the age and locality of the audience and make use of prominent trends, for example increased awareness of environmental issues, especially amongst children
- Campaigns should also address parental concerns in relation to safety, convenience and social norms
- Using Active Travel Routes that link destinations to make walking quicker and more convenient than car travel (Everyday Activity Destinations by Sports England)

Tackling fear

- Promote schemes such as “walking bus” schemes and other “walk to school” together with initiatives to address safety (including traffic calming, improvements of lighting and addressing bullying)
- Involve the public, including parents and schools in developing neighborhood walking and cycling schemes
- Encourage children’s autonomy and confidence in active travel through schemes like Bikeability which teach children skills to navigate different road conditions.

Parks and Public Open Spaces (POS)

- **Environmental Quality of the Park:** Improve aesthetic factors of the park such as the number and placement of trees (shady trees along walking paths), presence of water features (lakes and ponds), birdlife, park maintenance (irrigated lawns), park size (which in itself provides opportunities for various activities), park contours (slopes).
- **Enabling visual cues**: Use signs and banners in parks and POS that are encouraging of physical activity. For example assess proposals for signs restricting physical activity in public spaces and facilities (such as those banning ball games) to judge the effect on physical activity levels.
- **Availability of amenities:** Consider the presence and placement of walking paths, children's play facilities, outdoor gyms and sports facilities, specifically age appropriate facilities. Also consider location of toilets, food retail amenities and shelters.
- **Perceived safety**: Ensure parks and open spaces are maintained to a high standard to ensure they are safe, attractive and welcoming to everyone. Consider lighting, visibility of surrounding houses or roads, types of surrounding roads (quiet roads) and presence of crossings. Whether dogs are allowed (leashed or unleashed) can also affect receptions of child safety. Ensure the cleanness of the park including the presence of graffiti.
- **Expanding use of available open spaces:** increae the use of vacant spaces in inner city areas to create mini-parks or pocket parks. In park poor neighborhoods, encourage recreational programmers in school playgrounds and other existing areas.
- **Involve local communities and experts:** Involvement at all stages of the development can help ensure that the potential for physical activity is maximized. Engaging with community can itself increase park usage.
- **Planning of new developments**: Work with local communities to help develop strategic parks and open spaces within neighbourhood plans – particularly for lower socio-economic groups this could help prioritise green spaces.
- **Involving other sectors:** Work collaboratively with third sector and private sector to build partnerships, specifically in relation to funding opportunities.

Built Environment

- Health and well-being should be prioritised and integrated into planning processes
- Consult children and families through-out the planning, design and delivery processes, ensuring that people in different socioeconomic and minority groups are involved and that the needs of disabled community members are considered

Streets, squares and other urban spaces

- Design street space to support active travel (widening foot paths, restricting motor vehicle access and parking)
- Introduce traffic-calming schemes to safe routes to school and facilities
- Balance the needs of pedestrians, cyclists, local businesses and institutions to create healthy streetscapes that are attractive and safe
- Squares and open spaces should be flexibly designed to support community, cultural and sporting events

Parks and Open Spaces

- Design open spaces that are connected to paths, public transportation and existing amenities
- Parks and open spaces should complement cultural preferences of the local community and accommodate different of age groups including parents
- Provide street lights and outdoors play areas to encourage physical activity in the evenings
- Actively promote public parks and facilities, including non-traditional spaces such as car parks, unused green spaces in housing estates and the use of school playgrounds after hours

Buildings and Housing

- Ensure public buildings and spaces are designed to encourage people to be more physically active (positioning and signing of stairs, entrances and walkways)
- Design courtyards, gardens, terraces and roofs that can serve as outdoors spaces for children to play
- Housing design should ensure adequate space for families to eat meals together and for children to engage in active play
- Integrate cycle storage into design of new homes

Schools and Child care facilities

- Use ground markings and colour-coordinated zones to encourage more vigorous activity for children in school playgrounds
- Design new school physical activity facilities to potentially allow for public use outside school hours
- Nurseries and other childcare facilities should aim to minimize sedentary activities. Indoor and outdoor facilities should provide sufficient space for active play
- Design of school should incorporate building layout, recreational spaces and catering facilities that promote physical activity, healthy eating and safe enjoyable environment to encourage healthy behavior