Open Agenda

Education and Children's Services Scrutiny Sub-Committee

Monday 11 April 2011
7.00 pm
Town Hall, Peckham Road, London SE5 8UB

Supplemental Agenda

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Agenda Item 8

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SCHOOL ADMISSIONS REVIEW

Report of the Education and Children's Services Scrutiny Sub-committee

April 2011

Southwark Council

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1. Introduction and background

1.1 The Education and Children's Services Scrutiny Sub-Committee decided to conduct a review on school admissions on 12 July 2010. The focus was on reviewing the clarity of information available alongside reviewing support networks to help parents negotiate the system.

1.2 The sub-committee chose this subject because of concerns about the complexity and about the ease with which parents and carers were able to negotiate the schools' admissions process. It was noted that even parents and carers with a lot of information could find the process stressful. It was particularly important to ensure that parents had the right information and support to make the best choices for their children and to minimize the difficulties involved.

1.3 The review's focus was a result of the sub-committee's interest in evidence which indicated that supporting parents had a major positive impact on their children's wellbeing and educational attainment. In the last administrative year the previous sub-committee had produced a report on the importance of parental involvement in children's education. This concluded that there should be an emphasis on enabling parents to have the skills, knowledge and confidence to help their children. Alongside this the sub-committee looked at a volunteer programme which demonstrated success in addressing child protection issues by using mentors to support parents. Members also held concerns that there was insufficient support for parents with children with disabilities.

1.4 This review is therefore part one of two reviews looking at parenting support. The second review will look at volunteer and peer support, with particular attention paid to support available for parents and carers of disabled children.

2. Context

2.1 School admissions are regulated through government legislation. The current School Admissions Code (the Code) came into force on 10 February 2010 and applies to admissions to all maintained schools. Academies are also required to adopt practices and arrangements that are in accordance with the Code and admissions law.

2.2 The Code sets out the regulations in place for management and implementation of school admission arrangements which includes:

i) Equity and fair access to school places and consultation
ii) Setting fair oversubscription criteria
iii) Coordination schemes for admission applications
iv) Referral of objections
v) Admissions forums
vi) Choice adviser service
vii) Support for parents and carers

2.3 Local authorities are responsible for coordinating and processing all primary, secondary and in-year admission applications to schools in their areas. Southwark processed 3725 primary and 4048 secondary applications for 2010/11 admissions and has received 292 in year applications from 1 September 2010 to date.

2.4 Parents and carers apply for places online or by completing a paper Common Application Form (CAF). Parents are able to apply for up to six schools of their preference; these must be listed in priority order. Many voluntary aided schools and some academies also require a supplementary information form to be completed which is used to rank all applicants in priority order against their published admissions criteria.

2.5 Local authorities have a duty to establish an Admissions Forum for their area with a membership that reflects the types of schools in the locality. The main focus of the Forum is to consider the fairness of admission arrangements in their local context. Southwark's Admissions Forum has the following ethos: *To consider and promote a fair and effective schools admission system which advances social equity and inclusion, serving the interests of local parents and children collectively.*

2.6 Local authorities are required to provide advice and assistance to all parents of children of all ages in their area to help them navigate the school admissions application process. This must be provided through an independent service that is focused on supporting the families who most need support. Southwark delivers this role through a School Preference Adviser (Choice Adviser), term time only as a member of the Parent Partnership Service which is also an independent service.

2.7 The School Preference Adviser supports parents through the process through: i) one to one and group meetings with parents at schools and community centres to explain admissions processes; ii) telephone and email requests; iii) explaining the admissions appeals process and accompanying parents to admission appeal hearings. Between September 2009 and July 2010, the following support was given to parents by the School Preference Adviser:

Number of group meetings held	Number of parents seen	Number of phone calls taken	Number of appeals attended
38	771	106	17

2.7 The election of a new coalition government in May 2010 means that arrangements for school admissions are in flux and subject to imminent policy and legislative changes. In addition the loss of central government grants and the requirement to make significant savings may affect current provision of admissions support.

2.8 The Government set out in the White Paper, 'The Importance of Teaching', that in early 2011 it would, 'consult on a simplified and less prescriptive School Admissions Code'. The aim is to publish a revised Code by July 2011.

2.9 The Education Bill 2011, currently before parliament, removes the requirement on English Local Authorities to establish an admissions forum.

2.10 The Area Based Grant (£49,425) supporting the Preference Advisers was 'protected' from the significant in year budget cuts for 2011-12; however, funding beyond the end of this financial year remains uncertain. Southwark's Admission Forum is due to consider support options for parents and carers post August 2011

3. Methodology

3.1 The methodology consisted of:

- Officer reports on School Admissions
- Sub-committee members sharing good practice
- Consultation with Parent Participation Forum (PPF)
- Southwark Governors Association (SGA) submission
- Consultation with the School Admissions Forum
- Questionnaire distributed to parents and carers making secondary school admissions (Data from this will be available in the beginning of May)

4. Findings and recommendations

Information for parents and carers

4.1 The council produces information for parents in two main ways - on the website and through two guides; one for starting primary and one for starting secondary school. These are printed as booklets.

4.2 Parents were positive about the information on the website. Most felt that the booklets were useful and the school information good. However there was feedback that the guide should be easier to navigate, as parents whose first language was not English found it difficult to use. It was felt that it might be helpful for there to be a short simple version for these parents and consideration should be given to translating a short, simplified guide. Parents with special needs wanted more information in the guide.

4.3 The parent participation forum wanted to give feedback on the guide and requested that next year's version come to them for comment.

Recommendations:

1. The guide should be made easier to navigate.

2. There should be more information in the guide on special needs.

3. Consideration should be given to producing a short simplified version and/or one in different languages to meet the needs of parents where English is not the first language.

4. Next year's draft guide should be brought back to the Parent Participation Forum for feedback.

Communication with parents and carers about the admissions process

4.4 Feedback from parents and officers was that the school preference advisor was very successful at reaching parents and carers to advise, support and assist them with the admissions process.

4.5 Parents, officers, teachers and governors all held the view that parents whose first language was not English, and who did not have good language skills, struggled the most in the admission process. Events at children's centres, school and nurseries were endorsed. It was suggested that these were expanded to all schools and centres and one be held at Tooley Street.

4.6 Outreach through links with predominantly BME communities and through specialised workers was endorsed.

4.7 Parents and carers recommended that children's centres and other providers used their databases to contact people and send reminders. These databases should be maintained and regularly updated.

4.8 Many parents are in contact with services through the use of nurseries, schools, children's centre and other providers. Some of these providers intensively targeted parents though advisory sessions, and speaking to parents as they picked up and dropped off their children. They ensured that all parents got a form and appropriate information and regularly reminded them. Kintore Way was held up as an example of good practice. This should be promoted.

4.9 Council officers already reach out to Private, Voluntary and Independent ["PVI"] early years managers. Parents and carers also noted that they use university nurseries and other early year provision so these providers should also be targeted.

4.10 It was pointed out that there are many parents and carers who might not be in regular in touch with services and these parents might be the ones that particularly struggle with the admissions process. Parents thought that health visitors 2½ year check would be a good time to alert parents to the nursery and primary admissions process. They also felt that more use should be made of databases that health and social services hold to do targeted mail outs.

4.11 The service already uses one stop shops and parents welcomed this and suggested that this is expanded so that information and training is also given to front line staff in libraries and community centres.

Recommendations:

5. Retain the school preference advisor for outreach and one to one support; particularly focus their work on the needs of parents whose first language is not English and parents of SEN children.

6. Hold open days at schools, Tooley Street and in the community; particularly focus these on the needs of parents whose first language is not English , and parents of SEN children.

7. Contact university nurseries as well as Private, Voluntary and Independent ["PVI"] early years managers.

8. Train workers and keep booklets on the admissions process at settings such as libraries , one stop shops and community centres.

9. Use networks and contact details more smartly to distribute information and send reminders (health visitors, children centres, nurseries). Ensure they have sufficient information and CAF forums.

10. Use face to face contact – health visitor 2 ½ year check ups with parents, parent mentors at the Parent Participation Forum, nursery school attendance.

Choosing a place and taking a test.

4.12 Parents found visiting lots of schools on the same day stressful. Disabled parents and children, for example wheelchair users, found access difficult to negotiate during these busy times.

4.13 Parents and children found the amount of tests for secondary schools very stressful and unnecessary. They wanted one common test for all the schools so that a child would only need to take one test.

Recommendations:

11. Introduce a common test for secondary school entry.

12. Draw up an open day schedule for parents of children with SEN.

Making an application by completing the CAF or using the online form

4.14 Parents gave very positive feedback on the CAF and online form, if they had a straightforward application; they liked the simplicity and the receipt received. A parent/carer with two children (not twins) noted a problem, as she received an offer for only one of the children. Other parents who made late applications had a few problems.

Recommendations:

13. Ensure that carers and parents with more than one child in the same academic year (who are not multiple births) can make a successful application.

Receiving an offer

4.15 Offer day is a very stressful time and it was suggested that more information and support is given at this time. Parents need more information on waiting lists, for example that their child's place in the queue can go up and down. Sometimes parents and carers hear nothing for some time and this can create anxiety. Parents would like more accessible real-time information on school availability, local waiting lists lengths and their child's place.

4.16 Currently parents are asked two or three times to accept a school place. Once via the online process, once by the school, and once by the local authority. They have to accept both the school and the local authority place and it is not clear what the purpose of the eform acceptance is. This is confusing.

Recommendations:

14. Simplify the process so that parents and carers do not have to accept and respond to both the local authority and school to successfully accept or decline a place. Disable the automatic eform acceptance unless it is functional.

15. Offer more support around offer day and including additional information explaining waiting lists and managing places.

Supporting parents

4.17 Offer time is a busy period for officers and a stressful time for parents. Officers would like to be able to meet parents at Tooley Street as this would

be much more efficient than booking slots in one stop shops etc. It would also mean that officers are more accessible to parents.

Recommendations:

16. Make meeting space available in Tooley Street for staff to take appointments with parents.

Local coordination and the admissions forum

4.18 The education bill currently before parliament will mean that having an admissions forum is a local choice. The admissions forum believe that this body enables a more coordinated and robust process across the local authority and advances social equity and inclusion.

Recommendations:

17. Retain the Admissions Forum.

5. Summary of recommendations

1. The guide should be made easier to navigate.
2. There should be more information in the guide on special needs.
3. Consideration should be given to producing a short simplified version and/or one in different languages to meet the needs of parents where English is not the first language.
4. Next year's draft guide should be brought back to the Parent Participation Forum for feedback.
5. Retain the school preference advisor for outreach and one to one support; particularly focus their work on the needs of parents whose first language is not English and parents of SEN children.
6. Hold open days at schools, Tooley Street and in the community; particularly focus these on the needs of parents whose first language is not English , and parents of SEN children.
7. Contact university nurseries as well as Private, Voluntary and Independent ["PVI"] early years managers.

8. Train workers and keep booklets on the admissions process at settings such as libraries , one stop shops and community centres.

9. Use networks and contact details more smartly to distribute information and send reminders (health visitors, children centres, nurseries). Ensure they have sufficient information and CAF forums.

10. Use face to face contact – health visitor 2 ½ year check ups with parents, parent mentors at the Parent Participation Forum, nursery school attendance.

11. Introduce a common test for secondary school entry.

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15. Offer more support around offer day and including additional information explaining waiting lists and managing places.

16. Make meeting space available in Tooley Street for staff to take appointments with parents.

17. Retain the Admissions Forum.

Appendices

1. Consultation with Parent Participation Forum (PPF)

2. Southwark Governors Association (SGA) submission

3. Consultation with the School Admissions Forum

Members of Children's Services and Education Scrutiny Sub-Committee who contributed to this review:

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References

School Admissions Codes and Regulations:
http://www.education.gov.uk/schools/adminandfinance/schooladmissions/a00195/school-admissions-codes-and-regulations

Education Bill 2011
A Summary of the Government Bill, Ref. Bill 137, February 2011 Document Summary Service

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Research Note November 2008

ideas with impact

Weighing in

Dealing with the challenge of obesity

The challenge

In the UK, the prevalence of obesity has trebled since the 1980s.[1,2] Almost a quarter of adults in the UK were estimated to be obese in 2006. And an incredible two thirds of adults (31 million people) and one-third of children (3 million) are now overweight.[3] By 2050 the Government believes that, without action, that will rise to nine in ten adults (59 million) and two-thirds of children will be overweight.[4,5]

The UK's heavy burden is placing a huge strain on public services and the economy. The direct cost of obesity to the NHS reached £4.2 billion last year: nearly 5% of the total NHS budget. The cost to the wider economy (including lost work time) is nearly £16 billion; these annual costs are expected to reach £50 billion by 2050.[6]

Excess body fat also has a significant health cost.[7] But most obese people do not receive any form of support before they develop a serious condition, because the NHS doesn't have the resources for such a large section of population.[8] This is unsurprising: UK investment in public health is only two-thirds of the OECD average and less than two years ago there was 20-fold regional variation in expenditure on health improvement.[9,10]

What is being done

In 2004, the Government paper 'Choosing Health' acted as a starting point for a "national renewal of practical and acceptable action to make a difference to the health of people in England". In October 2007 the government published a new long-term plan to reverse the rising tide of obesity and overweight in the population. As part of this plan, a new Public Service Agreement (PSA) to promote better health and well being for all was established. The PSA targets children and aims to reduce the number of obese and overweight children to 2000 levels by 2020.[11]

A toolkit helping commissioners respond to obesity problems in their area was published in October 2008. It reaffirmed the government's ambition to be "the first major country to reverse the rising tide of obesity".[12] But government guidance offers little direction on what schemes work and why.

What works

Weighing In identifies ten effective interventions that cover both healthy eating and physical activity. These schemes are all relatively recent efforts to deliver low cost interventions and increase the capacity of obesity services. The case studies are broadly divided into four categories: community schemes, active travel initiatives, health in the workplace, and lifestyle incentives. The research team has focused on examples that use new or innovative ideas; encourage individuals to take responsibility; demonstrate partnership working with stakeholders; have had a demonstrable impact; are replicable in other areas.

What needs to change

It is striking that there is very little evidence of long term impact and cost effectiveness. Systematic reviews of the effectiveness of interventions reveal few scientifically conducted trials that have shown a direct effect on Body Mass Index (BMI) or obesity prevalence, and there is a lack of cost effectiveness evidence in the literature.[13] This does not necessarily mean that there are no effective interventions, but they are in the early stages of development meaning that the evidence to justify increased investment by the NHS, in accordance with the current assessment system, is limited.

The research team make four sets of recommendations:

1. Set up bodies to evaluate schemes and provide guidance
2. Stop public health funds being raided and empower communities to tackle obesity
3. Provide appropriate financial incentives for employers
4. Encourage early intervention

Scheme Name	Target Group	Focus	Methods	Scale	Funding & Costs	Impact
MEND (Mind Exercise Nutrition... Do It!)	Children (7-13 years old)	Exercise Diet Behaviour Change	Education	Biggest non-clinical obesity intervention in the world - 300 schemes all over the UK, and exported to Australia and Denmark	The Big Lottery Fund and Sainsbury's. £200-450 per household	Proven to drive improvements in key health outcomes at 12 months such as BMI, waist circumference, increased participation in and uptake of physical activity and reduced sedentary behaviour, as well as improved self-esteem. A trial demonstrated that participants in the programme achieved a waist circumference of 4.3cm less than the control group and had a 1.9 kg/m2 lower BMI after 6 months. It also found that positive benefits were sustained, although reduced, after 12 months.
LEAP (Local Exercise Action Pilots)	All	Exercise	Education Exercise Classes Motivational Interviewing	10,433 participants across ten sites in England	The DoH, the Countryside agency and Sport England. £50 - £3,400 per participant	Average increase in physical activity equivalent to around 75 minutes of brisk walking a week. 80% of LEAP participants who were sedentary at the start of the project and 63% of those who were lightly active moved up at least one physical activity category.
Well@Work	Adults (20-65 years old)	Exercise	Advice Incentives	Well@Work reached up to 10,000 employees in 32 workplaces across England in the two year trial (2005-2007). Well-being pilots for 4,000 NHS staff were launched in 10 NHS Trusts across England in 2008.	British Heart Foundation and Active England. £150 per participant	Proven to help improve employees' health and bring benefits through fewer absences and an engaged workforce. Specific outcomes: • Those taking part in the pedometer challenges increased their weekly step counts by a third; • People taking part in active travel schemes spent an extra 24 minutes walking or cycling to and from work (on average); • Use of the workplace stairs increased by 28% following initiatives such as posters • Participants upped their intake of fruit and vegetables, with an additional 11 percent who began meeting their five plus a day requirements; • Employers also reported a boost in staff morale.
Bike It	Children	Active travel	Education	In four years of operation Bike It has rapidly expanded to 32 staff addressing almost 400 schools in England and Wales, and around 70,000 children will benefit from Bike It during the 2008 - 9 academic year.	The Bike Hub, the Big Lottery fund, DfT and DoH. £6000 per school	A survey of 50 Bike It schools in summer 2007 showed that everyday cycling had more than trebled from 3% to 10% of journeys; weekly cycling had increased from 10% to 27%, and 25% of pupils had started cycling for the first time. Bike It is working with over 30 schools across a range of London Boroughs. The number of pupils cycling every day has trebled from 3% to 9% of school journeys. The number of pupils who never cycle fell from 81% to 68%.

Travel Smart	All	Active travel	Individualised Travel Marketing	315,000 households have been targeted in 21 pilot projects, with 3 current projects targeting 25,000 households oven 3 years.	Active England Projected costs of £25 per household	Projects have achieved relative reductions in car driver trips of 6% to 14%, with increases of 5% to 45% in walking and 14% to 75% in cycling. Recent evaluations have shown increases in active travel of 7 to 28 minutes each week and the shift from car travel to walking, cycling and public transport resulted in a 15% increase in average daily exposure to physically active forms of travel.
The National Cycle Network	All	Active travel	Infrastructure	At the end of 2007, 12,000 miles of routes and local links had been established, with roughly one-third traffic-free and two thirds minor rural roads and traffic-calmed urban streets.	DfT Costs approaching £1per capita per annum	78% of users self-report increased physical activity levels as a result of their local routes, 42% claim to be walking or cycling more than a year previously, and a third plan to walk or cycle more in future. Sustrans monitoring indicates that this usage level represents a saving of 70 million trips by car per annum, significantly boosting active travel and saving an estimated 329,000 tonnes of CO2.
COCO (Care of Childhood Obesity Clinic)	Children	Exercise, Diet, Pharmacotherapy, and Bariatric Surgery	Techniques delivered by doctors, dieticians, and health and exercise specialists	140-150 children per year	NHS	83% success rate according to measures developed to determine progress against expected falls in BMI (set against 26% drop-out rate).
Tackling Obesity with HENRY	Pre-school children	Diet	Training for Sure Start Nursery Practitioners	672 practitioners to date	Child Growth Foundation, Royal College of Paediatrics and Child Health, DCSF and DH £575 k in Government funding	High approval ratings for the training programme and positive early feedback from parents.
WATCH IT!	Children (8-16 year olds)	Exercise Diet	Education Motivational Interviewing	20 staff members, operating out of 12 clinics across Leeds	Neighbourhood Renewal funding, Leeds Primary Care research Consortium and Leeds PCT £457 - £2460 per child (2005 figures)	Most individuals showed significantly decreased BMI at six months and reported improved nutrition, decreased self-harm and increased self-confidence. Qualitative research indicated significant appreciation of the service, with particular benefits coming from the development of friendships with children experiencing similar problems.
Vitality	All	Exercise	Incentives	Globally, 1.5 million people are enrolled in the Vitality programme. In the UK 254 gyms are participating, covering upto 39,000 people and generating over 250,000 gym visits a month.	PruHealth Members who go to the gym incur healthcare costs which are on average 38% less than those who don't.	The number of PruHealth gym members increased by 63% (excluding new members joining specifically because of the offer). The average number of gym visits per week almost doubled, and the proportion of people going more than twice a week more than tripled to 49%. A recent study of the South Africa programme showed that highly engaged members experience significantly lower costs per patient, shorter stays in hospital and fewer admissions.

Conclusions and Recommendations

It is striking that given the prevalence of weight problems, there is very little evidence of long term impact and health economic analysis. Most of the schemes are relatively new; Randomised Controlled Trials are only now getting underway in many cases. But the lack of data is also due to the difficulty estimating how interventions translate into future health outcomes, which in turn depends on sustained behaviour change.

The research team make six sets of recommendations designed to help local policy makers share best practice, give practitioners the freedom to innovate, encourage governments to set appropriate financial incentives and to put the legislative framework in place, and provide appropriate clinical guidance.

1. Set up bodies to evaluate schemes and provide guidance

a. The National Obesity Observatory should coordinate a programme of trials to develop comparable information on methods that achieve the most cost effective interventions available in different population groups. Emphasis should be placed on the continued collection of data from participants in order to study the long term impact of interventions.

b. Obesity hubs should be formed in each Strategic Health Authority (SHA) area, in order to coordinate research efforts in local Primary Care Trusts (PCTs) and share best practice within the local area and through submissions to the National Obesity Observatory.

c. There is no comprehensive clinical guidance for dealing with obesity. The National Institute for Clinical Excellence (NICE) should develop a best practice pathway, to ensure every obese person has access to appropriate interventions.

d. NICE should review community initiatives as Randomised Controlled Trial data becomes available, taking short-term quality of life gains into account, to enable NHS funding for evidence based interventions.

2. Stop public health funds being raided and empower communities to tackle obesity

a. Where Local authorities are demonstrating an ability to tackle obesity, they should be given the freedom to bid for central funds in-line with the recommendations of the 2007 Sustainable Communities Act.

b. Other funding options might include reallocating a proportion of Department of Health (DoH) and Department for Children, Schools and Families (DCSF) funding as a ring-fenced payment for local government to tackle obesity. This has been recommended by the Association of Directors of Public Health because Public Health Budgets are commonly raided to deal with other priorities.[14]

c. The NHS recorded a surplus of £1.7 billion last year and will save an estimated £1.75 billion this year.[15] Currently PCTs are expected to hand back surpluses to the DoH. The government should allow PCTs to retain a portion of surpluses subject to development and investment in long-term schemes aimed at improving the health of the local population.

3. Provide appropriate financial incentives for employers

It is in the interests of employers to have a healthy workforce, and in the interests of society to combat the sedentary lifestyle of most working age adults. As Dame Carol Black said in her review of the health of Britain's working age population, Working for a Healthier Tomorrow, "Good health is good business".[16]

a. Private gyms have to charge VAT on membership at 17.5 percent. Gyms run by leisure centres have historically enjoyed a partial exemption. If businesses use external gyms they do not receive the same tax incentives as companies which provide gyms 'on site'. Tax breaks should be provided for all gyms engaged with obesity schemes.
b. People who have been on acute courses should be passed onto on-going schemes

4. Encourage early intervention

a. The Government's Sure Start Nurseries provide an ideal platform for intervention, but efforts should be made to reach all parents, such as through information provided by midwives or via NHS Direct.

Individual case studies

MEND

Description
MEND (Mind Exercise Nutrition... Do it!) is a social enterprise that was started in 2004. The organisation was developed by experts in child health at Great Ormond Street Hospital and University College of London. MEND offers free healthy living programmes to families across England and Wales.

MEND is aimed at 7-13 year olds who are overweight. The programme focuses on behaviour change (Mind), physical activity (Exercise) and a good diet (Nutrition), with an emphasis on personal responsibility (Do it). There is also a Mini-MEND Programme for 2-4 year olds. Programmes for 5-7 year olds and expectant mothers as well as educational resources for use in primary schools are currently being developed.[17] The scheme is designed to provide clinically effective interventions outside of a clinical setting, reducing costs and increasing the level of contact and support by up-skilling community care workers. The Government's *Healthy Weight, Healthy Lives* programme is expected to increase demand and funding for obesity schemes, and the MEND programme expects to be a major beneficiary.

Scale
MEND is now probably the biggest non-clinical obesity intervention in the world, with around 300 schemes running all over the UK, and exported to countries such as Australia and Denmark.[18] Over 5,000 children and families have already attended a MEND course.[19]

Outcomes
The MEND Programme has been proven to drive improvements in key health outcomes after a year, including reduced Body Mass Index (BMI), waist circumference, increased participation in and uptake of physical activity. Participants show substantial improvements in self-esteem.[18] A scientific trial conducted on over 100 obese children demonstrated that participants in the 9-week programme achieved a waist circumference of 4.3cm less than the control group and had a 1.9 kg/m^2 lower BMI after 6 months. These benefits were sustained after 12 months.[20] Unfortunately, as the project grows in size, there has been an increase in the number of drop outs from the programme.

Cost
MEND was initially funded with a £9 million grant from the Big Lottery Fund, and £3 million partnership from Sainsbury's. It now holds contracts with Local Authorities and Primary Care Trusts worth an estimated £3 million. MEND provide training, equipment and support, as well as essential monitoring and evaluation, while staff costs, site fees and the managerial overhead are paid from the local public health budget. Typical MEND costs range from between £200 - £450 per family.

Analysis
The MEND programme has been effective partly because it includes 2 years of ongoing support. Data collection of waist circumference and BMI must be collected during this period. But even this data cannot tell us the impact on future health outcomes - hence the lack of clear 'cost-benefit' data. The crucial question is to what extent, and in how many people, does this short-term intervention have a lasting impact on behaviour?

The National Obesity Observatory should coordinate a programme of trials to develop comparable information on methods that achieve the most cost effective interventions available in different population groups.

Health risks

Being overweight increases the risk of coronary heart disease, stroke, type 2 diabetes, high blood pressure, metabolic syndrome, osteoarthritis and cancer. For example, obese women aged 35 are four times more likely to have type 2 diabetes than women of normal weight. In 2006, over a million prescriptions were dispensed for the treatment of obesity, more than eight times the number prescribed in 1999.

WATCH IT!

Description

The *Watch It* programme has been running since January 2004 and targets 8-16 year olds from disadvantaged communities in Leeds. Clinics are located in sports or community centres and the programme is staffed by part time health trainers, who receive training, materials, ongoing support from team leaders and professionals.[21] The programme is divided into three stages: Bronze, Silver and Gold awards over a 12 month period, and includes individual counseling, Healthy Education Lifestyle Plan (HELP) tuition and group activity sessions. The programme has received a number of awards.[22]

172 children have participated to date, all of whom were classified as being extremely obese, and including many with mental health problems, making them the most challenging cases to deal with.[23]

Scale

The project is relatively small with 20 staff members operating out of 12 clinics across Leeds. Plans are being developed for national rollout. It capitalises and extends community resources and facilities, while placing little pressure on existing NHS services and has been adopted at low cost in Birmingham and Harringey PCTs, without extensive employment of professionals.

Outcomes

A process evaluation of the projects reported improved nutrition, decreased self-harm and increased self-confidence.[24] Qualitative research indicated significant appreciation of the service, with particular benefits coming from the development of friendships with children experiencing similar problems.[25] An evaluation by Leeds Metropolitan University highlighted WATCH IT's impact:

- In those children who achieved the silver award (6 months participation) there was a steady but significant reduction in obesity;
- The quality of life scores have improved to the normal range;[26]
- Attendance was excellent, with an average 3.3 hours physical activity per month and only 7.5% failing to attend.

Cost

The service was set up with resources using Neighbourhood Renewal funding, followed by the support of the Leeds Primary Care Research Consortium, and mainstream funding from Leeds PCT.

Figures from 2005 suggest the cost per child range from £457 to £2450 per participant for the complete programme and ongoing monitoring, with total deliver costs between £65-100,000. The variation depends on venue costs and attendance levels.[27]

Analysis

The success of *Watch It* is grounded in recruitment of trainers with strong people skills coupled with a well designed training programme.[28] Both of these factors contribute to the high attendance. Costs are kept down through partnerships with local providers, who provide facilities and professional support at minimal expense. But the research team have concerns regarding how this project could be scaled up effectively, without the development of a central management structure or local support networks.

Obesity hubs should be formed in each SHA area, in order to coordinate research efforts in local PCTs and share best practice within the local area and through submissions to the National Obesity Observatory.

Tackling Obesity with HENRY

Description
HENRY is the only initiative in the UK that focuses on babies, toddlers and preschool children. The emphasis lies in enhancing the skills of health and community practitioners so they are more effective in preventing and reversing obesity when working with young parents in disadvantaged communities. HENRY provides a core training course for practitioners, enabling them to deliver an 8-week programme for parents and carers. There is also an e-learning course and a toolkit with resources such as reading materials, portion guides, food and activity diaries and a DVD illustrating babies' hunger and fullness cues.

Scale
HENRY has been successfully piloted with 15 Sure Start Centre teams (137 health visitors, nursery nurses and others). The e-learning course was piloted in 115 Children's Centres involving 535 practitioners.[5]
Interest in HENRY training has come from 23 PCTs and SHAs in the UK, and another 35 Sure Start Centres are scheduled for participation in the next year.

Outcomes
Evaluation showed that 99% of professionals found the training useful and that their confidence scores for working in this area increased by 75%. Follow up by an independent researcher 6 months later showed that 13 of the 15 Sure Start managers reported ongoing changes attributed to HENRY.

98% of participants reported that they would recommend the e-learning course to colleagues and 94% that it had enhanced their knowledge and skills when working with families. Attendance at the parenting groups has been high and feedback indicates that parents are instituting positive changes.

Cost
HENRY was set up with a grant from the Child Growth Foundation. The pilot and evaluation in Sure Start Children's Centres were supported by grants to the Royal College of Paediatrics and Child Health from the Department of Health (£375,000) and the Department for Children Schools and Families (£200,000).

Analysis
This programme's focus on very young children should be welcomed, because interventions are required to prevent obesity before it becomes a problem. Recent figures from the National Growth Monitoring Programme confirm this – by the time children start school 1 in 4 are overweight and 1 in 10 are obese.[29] A systematic review in the BMJ provided evidence that obesity has its roots at an earlier age than previously thought; rapid weight gain in the first weeks of life increases risk. Overweight toddlers are 5 times more likely to develop obesity in later childhood.[30]
The Government's Sure Start Nurseries provide an ideal platform for intervention, but efforts should be made to reach all parents, such as through information provided by midwives or via NHS Direct.

LEAP

Description
LEAP (Local Exercise Action Pilots) programmes were commissioned in 2004, and ran until 2006, to test the best ways of encouraging people to be more active. The pilots focus on those who do little exercise and those at risk from health problems. The LEAP pilots involved a wide range of activities reaching various target groups, from activity camps for children to community walking programmes for elderly people recovering from strokes.[31]

The methods included targeted exercise 'referrals' from NHS professionals, peer mentoring sessions, exercise classes and outdoor activities, health campaigns and directories, interviews by trained advisers, and training & support for community leaders and coordinators.

Scale
One LEAP site was located in each of the nine English regions, with the exception of the South West region which had two pilots. This figure excludes a wider audience who may have been exposed to a LEAP physical activity campaign or awareness raising intervention.

Outcomes
A total of 10,433 participants were recorded as attending LEAP interventions. 80% of LEAP participants were sedentary at the start of the project. A comparison of 1051 participants showed an average increase in physical activity equivalent to around 75 minutes of additional brisk walking per week. Nearly two-thirds (63%) of those who were lightly active undertook more physical activity.[32,33]

Cost
LEAP cost £2.6 million with funding coming from the Department of Health, the Countryside Agency and Sport England. The cost per participant of LEAP interventions ranged from £50 to £3,400 and the cost per participant who improved their physical activity category ranged from £260 to £2,790.

The cost per Quality Adjusted Life Year (QALY) gained, ranged from £50 to £510, compared to the NICE (National Institute for Clinical Excellence) funding threshold of £30,000 per QALY gained.

The savings for the NHS per participant ranged from £770 to £4,900 and for all interventions exceeded the current cost per participant, clearly demonstrating that schemes to improve public health are cost effective, and are worthy of a far greater proportion of NHS spending.[34]

Analysis
The LEAP evaluation confirmed that the way that interventions are planned, delivered and managed can make a significant difference to their overall effectiveness.

Key design characteristics include undertaking prior outreach work in the target population, linking the scheme into existing local strategies and programmes, putting in place simple referral protocols, and tailoring the programme to meet the needs of target groups.

This requires local research, which can then form the basis of a training programme for local staff and volunteers. The LEAP evaluation also found that offering people a choice of interventions based in familiar locations, and developing exit routes into alternative activity options, improves uptake and the sustainability of behaviour change. The best way to achieve this is by developing partnerships with a range of organisations from the health, physical activity and sports sectors, which can provide resources, advice and sustainable exit routes for participants.[35] The recommendations about the National Obesity Observatory and SHA obesity hubs would help encourage collaboration between organisations and disseminate best practice.

COCO (Care of Childhood Obesity Clinic)

Description
COCO, part of the Bristol Royal Hospital for Children (BCH), was the first hospital-based, childhood obesity clinic in the UK founded in the late 1990s. The clinic consists of dedicated doctors, dieticians, and health and exercise specialists working to develop successful techniques to help obese and morbidly obese children lose weight.[36]
Methods include a scale of interventions starting with a basic lifestyle change programme. This moves onto an intense dietary programme and calorie restriction after 6 months depending on a patients progress. In extreme circumstances pharmacotherapy, such as the NICE recommended drug Orlistat, and bariatric surgery are both used.[18]
NICE guidance for drug therapies and obesity surgery recommends attendance at a specialised clinic prior to these last resorts, which can be a barrier to life-saving treatments given the shortage of capacity and the scale of the problem.[37]

Scale
COCO caters for 140-150 children per year, which is a fraction of the eligible children in the region.[18] Scaling up this intervention would require either a substantial increase in funding commitment or using a small number of specialist research centres to develop best practice, and to train professionals to deliver interventions in the community. There are few clinics offering effective treatment for childhood obesity.

Outcomes
COCO received the BUPA Foundation Clinical Excellence award in 2006 in recognition for their innovative research in a greatly under-resourced area of medicine. It had previously received the Best Practice Award from the Association for the Study of Obesity in 2005. The clinic reports a success rate of 83% according to measures developed to determine progress against expected falls in BMI. However, 1 in 4 participants drop out of the programme

Cost
COCO is currently working with the South West Primary Care Research Network, funded by the Research for Patient Benefit Programme, to pilot the transfer of clinic interventions to a primary care setting, with results expected in April 2010. This could contribute to the challenge of developing a best practice obesity pathway, to ensure adequate and sustainable NHS provision to help redress weight problems before they become life threatening. This will determine the cost effectiveness and efficacy of moving medical interventions into community settings, to enable delivery on a wider scale.

Analysis
Specialist obesity clinics play an important role in developing methods for reducing obesity. For example, COCO recently ran the Mandometer trial, which has demonstrated the promise of an innovative technique that aims to retrain children to adjust their eating rate, which in turn reduces the calories they consume in a single sitting. Specialist clinics also provide for those most in need; more NHS funded childhood obesity clinics would be a rational response to escalating levels of childhood obesity. The dropout rate suggests that access is an issue. A medical environment may be an unattractive option for many.[38] But obesity specialists can play an important role in developing, monitoring and supporting community obesity interventions.[39]

There is no comprehensive clinical guidance for dealing with obesity. The National Institute for Clinical Excellence (NICE) should develop a best practice pathway, to ensure every obese person has access to appropriate interventions.

Well@Work

Description
The Well@Work programme consisted of nine regional projects which were designed to provide an evidence-base for the efficacy of a range of work based health programmes. The programmes – which ranged from education programmes to the use of incentives ran from Autumn 2005 until 2007. In June 2008, a further pilot for 4,000 NHS staff was launched in 10 NHS Trusts across England. NHS staff are being offered confidential, online health assessments linked to personalised health advice and lifestyle management programmes.

Scale
Each Well @ Work project was delivered by a regional partnership or collaboration. Members of these partnerships include representatives from Primary Care Trusts (PCTs), local government, the voluntary sector and small and large businesses. The worksites where the interventions took place varied from region to region and included offices, factories, local council departments, GP surgeries, a prison and a hospital. Well@Work reached up to 10,000 employees in 32 workplaces across England over two years.[40]

Outcomes
These programmes have been proven to help improve employees' health and bring benefits through fewer absences and an engaged workforce.[41] Employers also reported a boost in staff morale and an improvement in communications and interactions between employees and managers in the workplace.[40]
• Those taking part in the pedometer challenges - where each employee was given a pedometer - increased their weekly step counts by a third
• People taking part in active travel schemes, which encouraged employees to walk or cycle to work, increased their daily exercise by an average of 24 minutes
• Use of the workplace stairs increased by 28% following initiatives such as posters encouraging staff to take the stairs and redecoration of stairwells

Cost
Well@Work was a joint programme led by the British Heart Foundation with funding from Active England (Sport England and Big Lottery Fund's joint awards programme) and the Department of Health, costing a total of £1.5m, or approximately £150 per participant. Resource commitments by PCTs included Technical Support Officer staff and provision of training for workplace champions, as well as coordinating the partnerships and research efforts.

Analysis
The principle problem with government funded pilots is that the funding is intermittent. The pilots demonstrated that a coordinated partnership approach is required. And this means public health officials in PCTs and local authorities are most effective if they receive advice incorporating ongoing research efforts to ascertain and disseminate the most effective interventions.

Where local authorities are demonstrating an ability to tackle obesity, they should be given the freedom to bid for central funds in-line with recommendations of the 2007 Sustainable Communities Act. Other funding options might include reallocating a proportion of DoH and DCSF funding as a ring-fenced payment for local government to tackle obesity. PCT surplus could also be used to fund innovative schemes.

Vitality

Description

For long term funders of healthcare, it makes economic sense to fund immediate lifestyle changes in return for the future health benefits.[42]

Alongside traditional health insurance cover, PruHealth offers its 190,000 customers an incentivised wellness programme called Vitality in order to help them to lead a healthy life. The Vitality scheme awards members points for looking after their health, for example by going to the gym, having a health screen or eating healthily. The value of these incentives can amount to hundreds of pounds, including reduced health insurance premiums and access to a range of travel and entertainment rewards. For example, members going to the gym more than twice a week could get their gym membership for free.

Scale

The usage based gym model was rolled out in 254 gyms across the country and covered up to 39,000 people, generating over 250,000 gym visits a month. The implementation relied on a combination of the gym swipe-card turnstile systems and the PruHealth billing system in order to calculate each member's monthly membership fee.

Outcomes

Excluding new members who joined as a result of the offer, the number of PruHealth gym members increased by 63% as a result of the incentives package. All of these new members were people who previously had access to a heavily subsidised gym deal but were not taking advantage of it. It also had a major impact on the frequency of gym usage. Overall, the average number of visits per week almost doubled, and the proportion of people going more than twice a week more than tripled to 49%. This effect was still evident one year after the introduction of the new model.

Costs

The net effect of this shift on the cost of healthcare is significant. Members who go to the gym incur healthcare costs which are on average 38% less than those who don't, after allowing for other factors such as age, gender, and location. Currently over 1.5 million people are enrolled in the Vitality programme across the three countries in which it operates (the UK, the USA and South Africa). A recent study covering 900,000 people from the South African programme, conducted in conjunction with the University of the Witwatersrand, the University of Cape Town and Harvard Medical School, found that highly engaged members of the Vitality programme experience significantly lower costs per patient, shorter stays in hospital and fewer admissions compared with all other groups. The difference in cost of treatment per beneficiary of the highly engaged group was over 7% lower for cardiovascular disease, over 15% lower for cancers and over 21% lower for endocrine and metabolic disease.

Analysis

When community, school, workplace or marketing schemes are deployed to secure healthier lifestyles, they have, at best, demonstrated a short term impact. But this will benefit only translate into improved long term outcomes if behavior change is sustained; an 'exit route' into ongoing exercise options is essential. Incentives such as free gym membership or free swimming are likely to maximise the number of participants who remain active.

Sustainable exit routes from community interventions into ongoing exercise schemes should be devised in partnership with insurers, including incentives such as free gym membership or free swimming, subject to frequent usage. Private gyms have to charge VAT on membership at 17.5 percent. Gyms run by leisure centres have historically enjoyed a partial exemption. If businesses use external gyms they do not receive the same tax incentives as companies which provide gyms 'on site'. Tax breaks should be provided for all gyms engaged with obesity schemes.

Bike It

Description

Children need to do roughly twice as much physical activity as adults to stay healthy, and cycling to school offers one way to ensure that exercise is part of a child's daily routine. Bike It was developed 4 years ago by Sustrans to work in partnership with schools to increase levels of cycling to school and establish a pro-cycling culture.[43] The Bike It programme includes assemblies and classroom presentations, assistance with school travel plans, securing the installation of cycle storage and cycle training, after school cycle skills sessions, and a series of family-friendly school travel events and rides.

Scale

The *Bike It* team has doubled in size each year since its foundation. 32 staff are currently working in almost 400 schools in England and Wales, and around 70,000 children will benefit from Bike It during the 2008/9 academic year. A number of PCTs have committed to fund *Bike It* officers this year, and the aim is to put at least one officer into each PCT local area within the next two years.

New funding from Cycling England will establish a further 10 cycle demonstration towns, each supported by a Bike It officer. The next goal is to establish a network of around 70 to 80 staff across England and Wales, enabling every local authority to join the project. *Bike It* is also working with over 30 schools across a range of London Boroughs.

Outcomes

In 2007 Sustrans surveyed 11,000 children, and found that while nearly half of pupils would like to cycle to school, only 3% were doing so. A survey of 50 Bike It schools in summer 2007 showed that everyday cycling had more than trebled and a quarter of pupils had started cycling for the first time. Teachers say Bike It has transformed their schools: children are energised, excited and ready to learn.

Despite lower levels of bike ownership amongst children and greater safety concerns amongst parents, results in the London schemes have echoed trends seen in the rest of the country. The number of pupils cycling to school every day has trebled from 3% to 9% of school journeys.

Costs

Bike It is funded by the bicycle industry through its "Bike Hub" fund. In 2007 Sustrans successfully led a consortium of similar organisations to receive funding from the Big Lottery Fund for active travel. In addition the Department for Transport and Department of Health in England have recently announced an increase in funding for Cycling England to the tune of £140 million over three years, which in turn funds *Bike It*.

1,000 Bike It officers, working with 10,000 schools each year and many millions of children, would cost £60 million per annum in contrast to the £50 billion per year the nation can expect to pay by 2050 if the trend of childhood obesity is not reversed.[44]

Analysis

This is a promising intervention: evidence suggests that cycling is a popular exercise option, both in cities and rural areas, and that cycling in childhood increases the likelihood of cycling in later life.[40]

To deliver the benefits, every child should have a safe route to school, which is reflected in the fact that *Bike It* currently targets schools that benefit from infrastructure developments such as cycle routes. Further legislative development would encourage development of the appropriate infrastructure.[45] In Denmark, for example, there is a legislative framework requiring that every child has a safe route to school, and the government should consider ways to stimulate local infrastructure development.

TravelSmart

Description

It is not just children that can benefit from active travel as part of a daily routine. However, sedentary adults are more ingrained in their behaviours, and the key is to conduct outreach work to effect change. TravelSmart uses direct contact with households to identify and meet their individual needs for support, and to motivate people to change their daily travel choices.

Scale

In the UK, a total of around 315,000 households have been targeted in 21 pilot and large-scale projects conducted since 2001. Current projects are located in Exeter, Watford and Lowestoft, each targeting 25,000 households over the next three years.

Outcomes

A successful pilot project conducted by Socialdata in South Perth, Western Australia, in 1999 led to the world's first large-scale TravelSmart programme targeting 35,000 people in the same city during 2000/01. This was successful in achieving a 14% reduction in car trips and increases of 35% in walking, 100% in cycling and 17% in the use of public transport.

In the UK, projects are being evaluated using before and after surveys across the whole target population, which are adjusted to take account of background changes in behaviour measured across a separate control area. Projects have achieved relative reductions in car driver trips of 6% to 14%, with increases of 5% to 45% in walking and 14% to 75% in cycling. Recent evaluations have shown increases in active travel of 7 to 28 minutes each week and the shift from car travel to walking, cycling and public transport resulted in a 15% increase in average daily exposure to physically active forms of travel.

Cost

The most recent TravelSmart programme in Gloucester, funded through Active England (jointly operated by Sport England and the Big Lottery Fund), was the first in the UK specifically to incorporate the promotion of physical activity alongside sustainable travel.

Sustrans estimates that TravelSmart could be delivered at a cost of around £25 per household.[44]

Analysis

The lessons from abroad clearly demonstrate the efficacy of this outreach work, which holds the promise of securing long-term behaviour change. Evidence suggests cycling levels are low in poorer communities - which also have the highest levels of obesity. The outreach work should therefore focus on target populations, and include less strenuous options that do not require equipment, such as walking.

The National Cycle Network

Description

Sustrans has been working in partnership with local authorities, community groups, business, the NHS and others since 1995 to develop the National Cycle Network. In 2006 the Network won the World Health Organisation's Combating Obesity Award for its role in enabling people to be physically active every day.

The Network is designed to facilitate walking and wheelchair use as well as cycling, and other forms of active travel.

Scale

At the end of 2007, 12,000 miles of active transport routes and local links had been established. Following an initial "strategic routes" phase (1995-2000) the concentration has been on creating networks for traffic free travel in urban areas. This more intensive local development is illustrated by two additional national programmes, each based on and linked by the National Cycle Network. Connect2 is creating 79 local walking and cycling networks in locations across the UK, and Links to Schools has now completed over 250 local Safe Routes to Schools projects serving 550 schools and a total catchment of almost 300,000 children.

Outcomes

The National Cycle Network is the biggest single generator of walking and cycling journeys throughout the UK. In 2007 there were 354 million trips on the Network, roughly 50:50 walking and cycling. Usage on existing routes continues to grow at about 5% per annum, and growth is also generated by expansion of the Network itself. 78% of users self-report increased physical activity levels as a result of their local routes, 42% claim to be walking or cycling more than a year previously, and a third plan to walk or cycle more in future. Sustrans monitoring indicates that this usage level represents a saving of 70 million trips by car per annum, significantly boosting active travel and saving an estimated 329,000 tonnes of CO_2.[46]

Cost

A Sustrans Cost Benefit analysis of the transport schemes found benefit to cost ratios of between £15 to £33 pounds of benefit for every £1 spent. This is around ten times better value than traditional, motor traffic focused transport schemes.

Recent funding announcements from the DfT relating to cycling have begun to move England towards continental levels of investment: the three year £140 million allocation through Cycling England approaches £1 per capita per annum, where good European practice would be in the range £5 - £10 per capita per annum.

Sustrans' delivery structure could be scaled up over 2-3 years to handle that level of investment in both the strategic and the local network routes, but it would also be necessary to expand capacity in highway authorities across the country.

Analysis

Department for Transport (DfT) figures show that the number of trips made by bicycle per person per year has decreased from 30 trips in the mid 1950s to 15 trips in 2004.[47]

While Bike It and TravelSmart offer practical ways to reverse this trend, busy roads and a lack of infrastructure remain a barrier. In the UK, Bike It and TravelSmart benefit from a single delivery organisation (Sustrans), which provides on-going monitoring of the impact of these schemes on public health. This information should feed into the National Obesity Observatory. In addition, they offer expert advice and circulating guidance, best practice and evidence to professionals working in areas such as planning, transport, higher education and public health.

Footnotes

[1]The Information Centre for Health and Social Care. Health Survey for England 2005: Updating of trend tables to include 2005 data. London: The Information Centre for Health and Social Care; 2006
[2]Obesity is a condition in which excess body fat has accumulated to such an extent that health may be negatively affected. It is commonly defined as a body mass index (BMI = weight divided by height squared) of 30 kg/m2 or higher. This distinguishes it from being overweight as defined by a BMI of between 25–29.9 kg/m2.
[3]Craig R, Mindell J (eds.) Health Survey for England 2006. Volume 1: Cardiovascular disease and risk factors in adults. London: The Information Centre for Health and Social Care; 2008
[4]Foresight Tackling Obesities: Future Choices – Project Report. Government Office for Science, 2007
[5]In 2005 a systematic review in the British Medical Journal provided evidence that obesity has its roots at a much earlier age than previously thought. It showed that rapid weight gain in the first weeks of life increases risk and that overweight toddlers are 5 times more likely to develop obesity in childhood.
[6]Dr Kerry Swanton, Healthy Weight, Healthy Lives: A toolkit for developing local strategies, London: Department of Health, October 2008
Annual Report of the Chief Medical Officer 2002
[7]•In 2006, over a million prescriptions were dispensed for the treatment of obesity, more than eight times the number prescribed in 1999.
•Hypertension (high blood pressure): it is estimated that people who are obese are five times more likely to have high blood pressure than people of normal weight
•Coronary artery disease and stroke: obesity is a contributing factor to cardiac failure in more than 10% of patients. Furthermore, obesity plus hypertension is associated with an increased risk of ischaemic stroke (stroke caused by blood clots or other obstructions)
•Cancers: 10% of all deaths from cancer in non-smokers are related to obesity. This figure rises to 30% of all deaths from endometrial cancers
•Osteoarthritis: Frequent association has been made between increasing weight and increasing prevalence of osteoarthritis in the elderly
•Reproductive function: 6% of infertility in women has been attributed to obesity
•Liver disease: 40% of people with the liver disease non-alcoholic steatohepatitis are obese
[8]http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/23/23.pdf
[9]Andrew Lansley, No Excuses, No Nannying, available at http://www.reform.co.uk/documents/080827%20Andrew%20Lansley%20speech.pdf
[10]The Chief Medical Officer on the state of public health
[11]This replaces the previous target to 'halt the year on year rise in obesity in children under the age of 11 by 2010
[12]Dr Kerry Swanton, Healthy Weight, Healthy Lives: A toolkit for developing local strategies, London: Department of Health, October 2008
[13]Roux L, Donaldson C (2004) Economics and Obesity: Costing the Problem or Evaluating Solutions? OBESITY RESEARCH Vol. 12 No. 2 February 2004 p. 173-179; GS Goldfield, LH Epstein2, CK Kilanowski, RA Paluch and B Kogut-Bossler (2001) Cost-effectiveness of group and mixed family-based treatment for childhood obesity. International Journal of Obesity (2001) 25, 1843–1849; NHS Centre for Reviews and Dissemination (CRD). The prevention and treatment of childhood obesity. Effective Health Care 2002;7(6)): 12; Summerbell CD, Ashton V, Campbell KJ, Edmunds L, Kelly S, Waters E. Interventions for treating obesity in children. The Cochrane Database of Systematic Reviews 2005, Issue 4
[14]http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/646/646we29.htm
[15]http://news.bbc.co.uk/1/hi/health/7584868.stm
[16]Dame Carol Black, http://www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf
[17]http://www.mendprogramme.org/aboutmend
[18]http://eppi.ioe.ac.uk/cms/
[19]MEND Press release, Free child obesity programmes set to benefit thousands more families, available at http://www.mendprogramme.org
[20]*Sacher PM, Chadwick P, Kolotourou M, Cole TJ, Lawson MS, Singhal A (2007) The MEND Trial: Sustained improvements on health outcomes in obese children at one year. Obesity 15: A92.*
[21]Rudolf M et al, (2006) Watch It: A community based programme for children and adolescents, Archives of Disease in Childhood 91:736-739
[22]WATCH IT received the NHS Yorkshire and Humberside Innovations Award in 2006. It also received the British Association of Child Health CATCH Award in 2004, the 2006 best paper award from the International Journal of Health Promotion and Education and Category (Childhood and Adolescents) and was overall national winner of the National Obesity Forum Awards 2007.
[23]Average 65, as measured by the PedsQoL questionnaire
[24]Drake AJ, (2006) Obesity in childhood and adolescence: epidemiology, management and mechanisms, J R Coll Physicians Edinb, 36:159–161
[25]Rudolf M et al, op.cit.
[26]Average score 80, as measured by the PedsQoL questionnaire
[27]C Spoor, P Sahota, C Wellings, MCJ Rudolf, Costing a pilot complex community-based childhood obesity intervention, Watch It submission
[28]Staff are provided with brief training in the solution focused approach, motivational interviewing, and basic nutrition and healthy lifestyle information during a two week induction period. Training in first aid and child protection is also provided. They are provided with a WATCH IT training manual, the Healthy Eating Lifestyle Programme (HELP) manual, and attend further training in physical activity.
[29]http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthyliving/DH_073787
[30]Baird J, Fisher D et al. Being big or growing fast: systematic review of size and growth in in fancy and later obesity BMJ 2005; 331: 929-37
[31]Learning from LEAP: a report on the Local Exercise Action Pilots (2007) Department of Health
[32]Sedentary is equivalent to less than 30/60 minutes of moderate activity per week (adult/child); lightly active is1-4 30/1-6 60 minutes per week; moderately active is 5 30/7 60 minute sessions per week; highly active is 5 30/7 60 vigorous activity
[33]Buckworth and Dishman 2002 demonstrated that as many as 50% of participants who initiated physical activity interventions dropped out within 6-9 months.
[34]The formulae used by the National Institute for Health and Clinical Excellence to determine what the NHS will fund
[35]Learning from LEAP: a report on the Local Exercise Action Pilots (2007) Department of Health
[36]http://www.bristol.ac.uk/brio/news/
[37] http://www.nice.org.uk/guidance/index.jsp?action=article&o=32423
[38]It is worthy of note that as a final resort, minimally invasive surgical procedures, such as a laparoscopic adjustable band around the stomach can be very effective treatment. This procedure achieves an 87% reduction in excess weight loss in comparison to a 21% standard reduction for non-surgical interventions over a two year period.
[39]Paul O'Brien MD, Outcomes for Surgery for Obesity, available at http://www.conference.co.nz/files/RACP,%20Fri%200950%20O'Brien.pdf
[40]http://www.bhf.org.uk/
[41]Healthy Weight Healthy Lives: Six months on (2008) Department of Health; Department for Children, Schools and Families
[42]There is an increasing recognition of the role of incentives in health promotion. See, for example, 'Paying the Patient', King's Fund (2008) for a review of the literature and 'Working Well: A Global survey of health promotion and workplace wellness strategies', Buck Consultants (2008) for an indication of the widespread use of incentives in health promotion among employers, particularly in the US.
[43]For more information, visit http://www.sustrans.org.uk/default.asp?sID=1102425335218
[44]Sustrans submission, unpublished
[45]Bike It project review (2008) available at http://www.sustrans.org.uk/webfiles/Bike%20It/sustrans_bike_it_review_2008_may08.pdf
[46]More information at http://www.sustrans.org.uk/webfiles/rmu/route_monitoring_report_end%2007.pdf
[47]Craig Moore, Andy Cope and Alex Bulmer, The role of traffic-free routes in encouraging cycling among excluded groups: A case study of the national cycle network, World Trade and Transport Policy Practice 12:3, 2006

Methodology

We drew for this report on DH funded work carried at the EPPI Centre, Institute of Education, University of London. This is reported in Aicken C, Arai L, Roberts H (2008) Schemes to promote healthy weight among obese and overweight children in England. Report. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London. A weblink to this work can be found here: http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=2393 and the searchable database http://eppi.ioe.ac.uk/webdatabases/Intro.aspx?ID=13 .

The evidence for schemes included in Weighing In were developed through dialogue with Local Authorties, Primary Care Trusts, charities, social enterprises and commercial organisations.

Health research at Policy Exchange

An independent NHS will need to find cost-effective ways of preventing ill health; engaging individuals in living healthy lives and improving overall outcomes for patients. And nowhere is the balance between personal freedom and limited government brought into sharper focus than the debate about government interventions in public health.

The NHS is a complex and advanced people-management organisation. Yet, over the last decade, there has been relatively little emphasis on the motivation of its people, particularly its professionals. Policy Exchange aims to study and publish a report on management in the NHS. Ensuring that clinical priorities, and clinicians, form the basis of all NHS decision making can only improve outcomes for patients.

At the end of 2008, Policy Exchange will publish a major piece of research in the NHS' ability to taking up and spreading innovations and existing best practice. The paper will show what can be done to improve this position.

In the coming year, Policy Exchange will publish papers on the most pressing public health 'epidemics' of the 21st century – obesity and alcohol harms – as well as examining specific disease areas where there is strong evidence for early clinical intervention in order to reduce overall burdens to the NHS and social care systems. We will work with patient groups and clinicians. Our approach will be pragmatic and evidence based. Looking further forward, we aim to look at ways of improving integration of healthcare from the patients' perspective.

Publications from the Health Unit

Measure for Measure

All Change Please

About Policy Exchange

Policy Exchange is an independent think tank whose mission is to develop and promote new policy ideas which will foster a free society based on strong communities, personal freedom, limited government, national self-confidence and an enterprise culture. Registered charity no: 1096300. Policy Exchange is committed to an evidence-based approach to policy development. We work in partnership with academics and other experts and commission major studies involving thorough empirical research of alternative policy outcomes. We believe that the policy experience of other countries offers important lessons for government in the UK. We also believe that government has much to learn from business and the voluntary sector.

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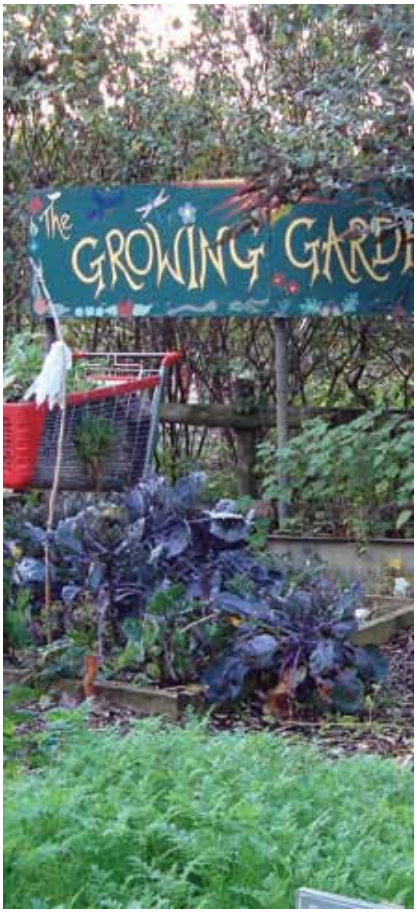
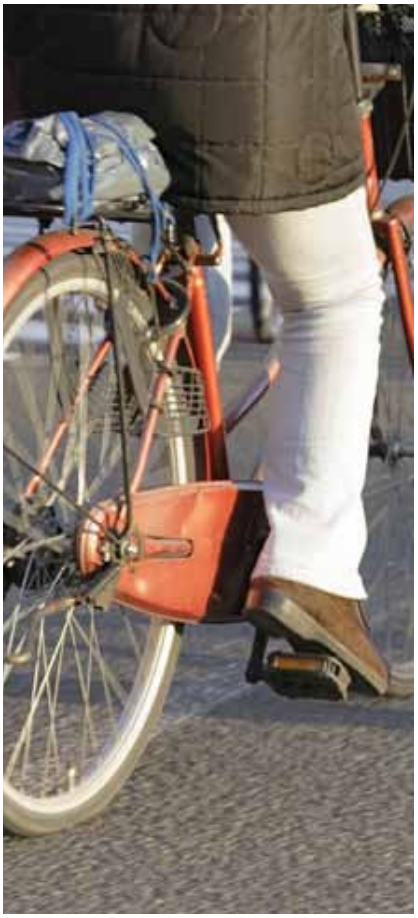




A Tale of Two ObesCities

Comparing responses to childhood obesity in London and New York City

Municipal Responses to Childhood Obesity Collaborative

City University of New York and London Metropolitan University

EXECUTIVE SUMMARY

In the last 25 years, childhood obesity rates in London and New York City have more than doubled, creating epidemics that now threaten the well-being of current and future residents, widen existing socioeconomic and racial/ethnic inequities in health, and impose a growing economic burden. Each city has initiated a variety of policies and programs to reduce childhood obesity, but few policy makers or researchers believe that the current responses are adequate to reverse the increases in obesity. Both the US and England have recently seen a modest slow down in the rate of increase of childhood obesity. While it is too soon to know if these declines will be sustained, the two cities now have an opportunity to accelerate and amplify efforts to reverse the trend of the past 25 years.

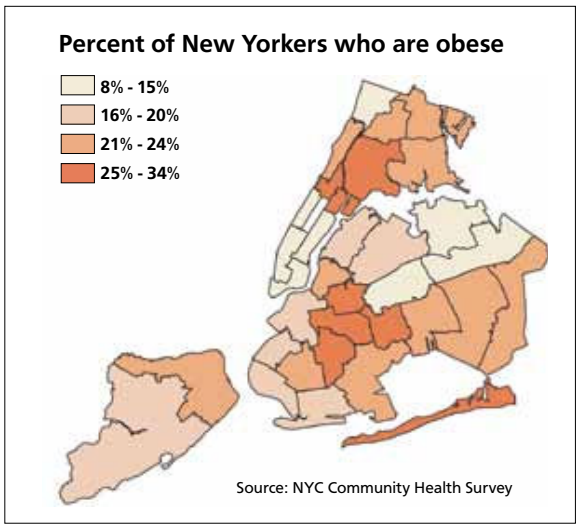
In 2008 and 2009, the City University of New York and London Metropolitan University convened health officials, researchers, advocates and city leaders from London and New York to analyze their epidemics of childhood obesity, compare municipal responses and recommend strategies for reversing these epidemics. By looking in detail at how two leading world cities have responded to childhood obesity, we hope to learn lessons applicable to other cities and to identify areas where our two cities could learn from others. We also expect to gain insights that will help each city to better assist its diverse communities to meet the unique needs of its residents and to reduce the suffering that obesity imposes. This report summarizes our findings.

Why devote attention to childhood obesity in cities now? First, the dramatic increase in rates of overweight and obesity in many cities around the world presents a clear and present danger to future global health. Obesity is increasingly associated with chronic conditions—diabetes, heart disease, high blood pressure and some forms of cancer –that will impose a growing burden on societies around the world. Obese children are more than twice as likely to become obese adults, demonstrating the value of preventing childhood obesity in order to promote adult health. As more people move into cities, urban health problems become global health problems. Moreover, obesity-related chronic conditions are a driving force in the socioeconomic and racial/ethnic inequities in health that are found both within cities like London and New York and between developed and developing countries. Finding ways to narrow these gaps is an urgent health priority.

Second, childhood obesity poses a large and growing economic burden. A CDC study estimated that the medical costs of treating obesity-related diseases in the United States (US) were as high as $147 billion (£738 million) in 2008*. In the United Kingdom (UK), it is estimated that the current costs of obesity will double by 2050. Obesity-related expenses include treatment costs, lost productivity and the social costs of premature mortality. Finally, the obesity epidemic intersects with other urban and global crises such as the financial crisis and climate change. These linkages present both opportunities for multisectoral change (e.g., improving walkability in cities can reduce obesity and energy use) and constraints (e.g., as healthy food becomes more expensive, poor families are more likely to purchase unhealthy food). Taking action now can help to resolve obesity and its related problems before they escalate further.

*References for the Executive Summary can be found in the full report which is available at http://web.gc.cuny.edu/che/childhood_obesity.pdf

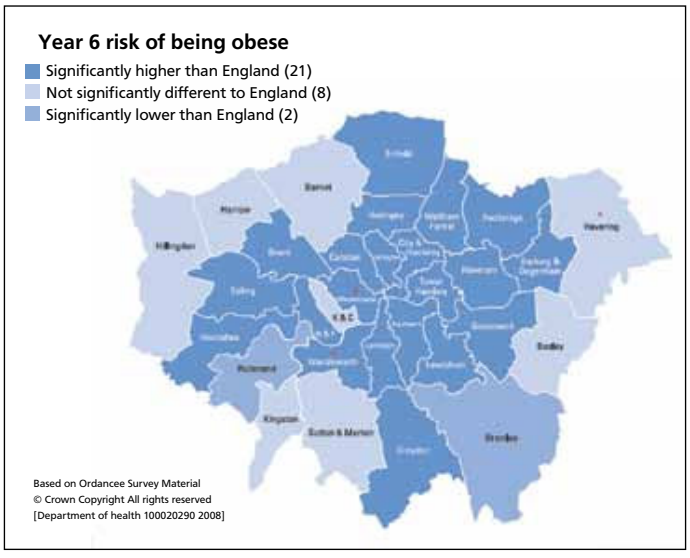
COMPARISON OF EPIDEMICS



In both London and New York City, childhood obesity rates are higher than in the United Kingdom and the United States as a whole. Although differences in data collection make it difficult to make exact comparisons, in London nearly 23% of children entering school are overweight or obese –10.9% are obese and 12% are overweight. By year 6 of school this increases to 36.3% with 21.6% designated as obese and 14.7% overweight.[1] In New York City, nearly 40% of public school children in grades K-8 are overweight or obese. Specifically, 21% of young people are obese and 18% are overweight. In children, overweight is usually defined as having a body mass index(BMI), a measure of body fat based on height and weight, at or above the 85th percentile for age and gender and obesity as having a BMI at or above the 95th percentile.

In both cities, obesity rates are higher in boys than girls and overweight and obesity increase with age. Both cities show big differences in obesity rates by neighborhood and racial/ethnic groups. In New York City, for example, about a third of teens living in the cities' poorest neighborhoods are overweight or obese compared to only a quarter of teens in other city neighborhoods. In London, Hackney has a childhood obesity rate twice as high as in two more affluent areas, Bromley and Richmond upon Thames (14% vs. 6-7%).

Both cities also show striking variation in obesity rates by race and ethnicity. At age 10-11, Black children in London who are from Africa, the Caribbean or other regions had obesity rates of 25% or more while children who were white British, Irish or mixed Asian-White had rates lower than 20%. In New York City, a 2004 study of elementary school children found that Hispanic children had the highest obesity rate, 31%, followed by Blacks at 23%, Whites at 16% and Asians at 14.4%. In each city, any response to childhood obesity must seek to reduce these age, gender, income, neighborhood and race/ethnicity differences.



Finally, both London and New York are characterized by high levels of income inequality and these growing differences between the rich and the poor contribute to the increasing concentration of obesity among poor children. Although all income levels are affected by obesity, recent increases in obesity reflect one more cost of economic policies that cause one part of the population to experience the best of times and another the worst.

COMPARISON OF MUNICIPAL RESPONSES

Municipal governments are uniquely positioned to play a leading role in reducing obesity. Both London and New York City have responded to rising rates of childhood obesity but these responses are shaped by their differing approaches to municipal governance, health care, public transportation and education. By understanding these differences, the two cities may be better able to tailor their response to their unique context and also to apply more skillfully lessons learned elsewhere.

For example, in the United Kingdom, the national government has primary responsibility for health care and education, providing stable and consistent funding and standards for these services but limiting London's autonomy to initiate local action. In recent years, London's government has played a forceful role in transportation policy, encouraging use of mass transit, walking and bicycling, making it easier for residents to find opportunities for physical activity.

In New York City, a strong mayor and relatively weak legislature offers more opportunities for executive branch action. In the past eight years, a mayor concerned about health has used this authority to take action on school food, new bicycle lanes, and improved food procurement guidelines for city agencies. However, inadequate funding for health care and education, especially for the city's poorest residents, sometimes means that deficiencies in the basic necessities of life—adequate housing, education and health care—understandably make obesity reduction a lower priority than daily survival.

Finally, in both cities, financial and business interests have a strong voice in governance and policy making. Thus, when the interests of real estate developers, the financial industry, or foodservice and restaurant trade associations conflict with those of low-income children and families, the powerful usually have more clout to advance their interests than the poor. For example, when Pepsi Cola threatened to move its bottling plant out of New York when the state considered imposing a tax on sweetened beverages, the Governor withdrew the proposal despite advocacy by children's health groups. More basically, in both cities, proposals to close the widening gap between incomes and living conditions for the poor and the better off meet almost uniform opposition from business elites, closing the door to modifying a fundamental cause of the rise in obesity.

Recommendations

To strengthen the two cities' response to childhood obesity and to accelerate efforts to reverse the epidemic of childhood obesity, the CUNY/ London Met Childhood Obesity Collaborative recommends that city governments in London and New York take the steps listed below. These recommendations emerged from our review of current activities to reduce childhood obesity in London, New York and other jurisdictions. They were selected based on their estimated impact, their political feasibility over the next decade, and their potential for mobilizing diverse constituencies. We suggest a mix of modest and more transformative changes in order to advance a balanced portfolio of strategies. We deliberately suggest aspirational changes in the hopes of widening the current policy discussions on childhood obesity.

In particular, we propose as a priority that London and New York City each adopt the most promising approaches the other city has developed, showing the benefits of world cities learning from each other. In future work, the Collaborative will rate each city's progress on these recommendations, propose specific actions each city can take to amplify and sustain its response, and identify opportunities for more systematic coordination in efforts to reduce childhood obesity both within and between the two cities. The recommendations are listed from the broadest citywide actions to more community-based proposals but are not listed in order of their importance.

LAND USE AND PLANNING

1. Use zoning authority, land use review and other municipal authority to limit access to fast food and the promotion of unhealthy foods to children.
2. Use zoning, tax incentives, and city owned property to increase the availability of healthy, affordable, and culturally appropriate food in neighborhoods where it is limited.
3. Incorporate active design principles into building codes, housing strategies, and neighborhood planning.

FOOD

4. Set standards for municipal purchase of food in public agencies and leverage economies of scale to promote food systems that support economic, environmental, and human health.
5. Redefine food safety standards to reflect current threats to health and create new ways to use the municipal food safety workforce to promote healthier eating.

PARKS AND GREEN SPACE

6. Promote and support urban agriculture as a sustainable and health promoting use of green space.
7. Increase access to and safety of places where people can be physically active.

TRANSPORTATION

8. Promote walking and cycling, especially in neighborhoods with high levels of childhood and adult obesity.

SCHOOLS

9. Implement a universal free school meal program with nutritional standards that promote health.
10. Provide drinking water in schools by improving infrastructure for tap water delivery and bathrooms.

RESEARCH AND TRAINING

11. Promote research that helps cities understand how to best address health inequalities and childhood obesity by:
    - Developing and improving the data systems that monitor childhood obesity so that cities can track and report citywide prevalence as well as information about social, economic, and geographic disparities;
    - Tracking the cost and outcomes of municipal policies and programs that address childhood obesity and disseminate this work internationally;
    - Documenting the adverse impact of food marketing practices on children and designing and evaluating strategies to reduce this influence;
    - Finding the best ways to prepare health providers, educators and others to reduce childhood obesity; and
    - Using urban planning as a tool for assessing and changing the built environment to promote health.

Today, both London and New York and their city governments deserve credit for taking action on many fronts to reduce childhood obesity. Few experts believe, however, that current levels of effort are sufficient to avert the growing health, social and economic costs that childhood obesity imposes on our cities. To actually improve health, the modest and small-scale changes that have begun will need to be expanded, strengthened and sustained. Our children and grandchildren depend on us to develop the policies, programs and environments that assure their health and close the gaps in well-being that now divide our cities' residents. By confronting childhood obesity directly, London and New York can show other cities around the world that just as our societies created the conditions that led to rising rates of obesity, so can we reverse this global trend. By engaging those most harmed by the current epidemic, advocates can build a powerful force for change. A Tale of Two ObesCities suggests some steps we can take to realize these obligations and opportunities.

CONTENTS

ACKNOWLEDGEMENTS

Many organizations and individuals contributed to this report and made helpful suggestions for improving it. Their names and affiliations are listed in Appendix 1. We gratefully acknowledge the support that London Metropolitan University and the City University of New York and Hunter College provided the Childhood Obesity Collaborative. We also thank the reviewers who took the time to provide many helpful suggestions to improve this report. In London, Christine Hogg, Alex Bax, Julia Atkins, Rachel Cook, and Grant Pettit played this role and in New York, the reviewers were Cathy Nonas, Jan Poppendieck, Maria Isabel G. Loureiro, and Arlene Spark. The views expressed in this report are those of the authors and do not necessarily reflect the positions of the universities or of the participants in the Collaborative.

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INTRODUCTION

In the last 25 years, childhood obesity rates in London and New York , two world cities that command global attention, have more than doubled.[1,2] This rise in childhood obesity now threatens the well-being of current and future residents, widens socioeconomic and racial/ethnic inequities in health, and inflicts a growing economic burden on each city. Each city has initiated determined responses designed to reduce obesity, policies and programs that reflect the governance structures and political climates of each city. Yet most observers agree that these responses are unlikely by themselves to reverse the epidemic, lower its long-term costs or shrink the growing inequities in health that obesity imposes. By describing and comparing the ways that London and New York have responded to childhood obesity and by highlighting their successes and limitations, we hope to inspire leaders in cities around the globe to consider new, more forceful actions to reduce obesity.

Our descriptions and analyses of London and New York's response to childhood obesity grow out of collaboration between London Metropolitan University (London Met) and the City University of New York (CUNY). Both universities are the largest public sector institutions of higher education in the respective cities and they share commitments to educating underserved groups and applying scientific and technical knowledge to solving the problems that big cities face. During 2008 and 2009, we convened a series of meetings with city officials, researchers, health providers and advocates in London and New York to compare the municipal-level responses to childhood obesity in these cities and develop recommendations for stronger and more effective action to reduce childhood obesity in world cities. Through our links with mayors' offices, public health agencies, service providers and non-governmental organizations, we hope to catalyze action across sectors to reduce childhood obesity. We also expect

to gain insights that will help each city to better assist its diverse communities to meet the unique needs of its residents and to reduce the suffering that obesity imposes. This report summarizes our findings. In the future, we hope to add other cities to our collaborative and learn from them and to take on other complex health and social problems.

Recently several organizations, including the US Centers for Disease Control and Prevention[3] , the National Institute of Medicine[4] and the UK government[5] have released reports on obesity. Our approach builds on and differs from these in several ways. First, our focus is on the role of municipal government. While we acknowledge that many organizations and all levels of government need to act to reduce childhood obesity, we believe that city governments are ideally situated to take the lead in implementing comprehensive, multisectoral and pragmatic approaches to reducing childhood obesity in those areas where it is most prevalent. Second, we are especially concerned about the role of childhood obesity in worsening present and future health inequalities. Reducing obesity is a human rights and social justice priority as well as a public health and economic problem. Because childhood obesity is a condition increasingly associated with poverty, fundamental solutions require reducing the inequalities that contribute to obesity. Within wealthy countries like the US and England patterns of income inequality mirror those of obesity.[6] Third, we believe that London and New York are in the forefront of cities tackling childhood obesity, making an analysis of their accomplishments and limitations a valuable exercise for other cities. Even approaches that have not yet been fully evaluated deserve scrutiny given the high costs of inaction. Fourth, London and New York have tried both universal (e.g., calorie posting in chain restaurants) and targeted (special projects in high obesity neighborhoods) approaches to reducing obesity, making an analysis of these experiences a useful lesson for those seeking a balanced portfolio of obesity reduction strategies.

Finally, as an independent research collaborative, we seek to articulate a vision and strategies for reducing childhood obesity that are feasible but can transcend the political limitations that city governments often face. While our collaborative has consulted with elected officials and public health authorities in both cities, our recommendations are our own.

In the following sections we provide short descriptions of each city and its childhood obesity epidemic, describe and compare responses to each, review the evidence for municipal responses, and conclude with an agenda for action.

COMPARING CITIES AND EPIDEMICS

New York City and London share social and political characteristics. As the following table illustrates, both cities have large and diverse populations. Because London is geographically larger, it is less densely populated than New York. New York has greater extremes of inequality and is more segregated by race/ ethnicity and class than London. Both cities have the highest rates of income inequality in their nations.

Table 1. Demographic Snapshot of London and New York

	LONDON	NEW YORK
Area	607 square miles (1,570 square kilometers)	322 square miles (834 square kilometers)
Average population density	10,500 people per square mile (4,800 people per square kilometer)[a]	25,621 people per square mile (9892 people per square kilometer) [b]
Total Population	7, 560,000[c]	8,250,000[d]
Race/ Ethnicity[d,e]	White 68% Black 14% Asian 14% Chinese 1% Mixed 3%	White 44.9% Hispanic or Latino 27.4%[a] Black 25.7% Asian 11.8% Mixed race 1.9%
Foreign born	32%	36.7%
Poverty[b]	22%	18.9%
Unemployment	8.%[a]	9.6%[f]
Age distribution	19% under the age of 15[g]	22.9% under age of 17[h]

Sources:

a. In the US census Hispanic or Latino is an ethnic not racial designation thus percentages do not add to 100.
http://www.statistics.gov.uk/focuson/london/

b. Poverty is defined differently in the US and UK. In the UK the poverty line is set at 60% of median income after housing costs. In the US poverty is measured using an annual income threshold set by the US Census. The current threshold for an individual is $10,830 (£6534) and for a family of four is $22,050 (£13,304). http://www.nyc.gov/html/dcp/pdf/neighbor/neighbor.pdf

c. Greater London Authority Data Management and Analysis Group, Update October 2008

d. U.S Census Bureau-American Community Survey 2005-2007, 3 year estimates

e. www.london.gov.uk/gla/publications/.../dmag-update-2008-03.rtf

f. http://www.labor.state.ny.us/pressreleases/2009/August20_2009.htm

g. http://www.statistics.gov.uk/census2001/pyramids/pages/h.asp

h. http://www.baruch.cuny.edu/nycdata/chapter01_files/sheet006.htm

Table 2. Overview of Childhood Obesity in London and New York

New York	London
Prevalence In both cities by the end of primary school, about 1 in 5 children are obese. Childhood obesity in both cities exceeds national averages.	
In New York City nearly 40% of public school children in grades K-8 are overweight or obese. Specifically, 21% of young people are obese and 18% are overweight.[a]	In London nearly 22.9% of children entering school are overweight or obese. Specifically, 10.9% are obese and 12% are overweight. By year-six this increases to 36.3%, with 21.6% being obese and 14.7% overweight.[b]
Race and ethnicity	
Among Hispanic children in New York City, 19% of boys and 23% of girls are designated as obese. Among Black children, 21% of boys and girls are obese. Among Whites, 20% of boys and 14% of girls are obese. Among Asians, 18% of boys and 9% of girls are obese.[a] Among teens, one in three teens living in the poor neighborhoods of Bedford-Stuyvesant, Bushwick, the South Bronx, and East and Central Harlem are overweight or obese compared to one in four for the rest of the city.[c]	Black African, Caribbean and other Black children aged 10-11 in London have obesity rates higher than 25%. Bangladeshi and Pakistani children have rates of 22%. White Irish and British children have rates of less than 20%.[b]
Gender In both cities, childhood obesity rates are higher among boys than girls. This gender ratio changes after puberty.	
Between kindergarten and eighth-grade 24% of New York's boys are obese as compared to 19% of girls.[a]	At year six, 23.6% of boys in London are obese as compared to 19.4% of girls.[b]

Sources:

a. New York City Department of Health and Mental Hygiene and the New York City Department of Education. Childhood obesity is a serious concern in New York City: Higher levels of fitness associated with better academic performance. Vital Signs [Internet]. 2009 Jun [cited 2009 Aug 10]; 8:1. Available from: http://www.nyc.gov/html/doh/downloads/pdf/survey/survey-2009fitnessgram.pdf

b. London Health Observatory. Weighty matters: The London findings of the National Child Measurement Programme 2006-2008 [Internet]. London: 2009 [citied 2009 Jul 1]. Available from: http://www.lho.org.uk/Download/Public/14781/1/Weighty%20Matters%20final.pdf

c. Noyes P, Alberti P, Ghai N. Health behaviors among youth in East and Central Harlem, Bedford Stuyvesant and Bushwick, and the South Bronx [Internet]. New York: New York City Department of Health and Mental Hygiene; 2008 [cited 2009 Jul 1]. Available from: www.nyc.gov/html/doh downloads/pdf/report/yrbs_report042008.pdf

SOCIAL AND ECONOMIC DIMENSIONS OF CHILDHOOD OBESITY

Researchers have shown that poor children are more likely to be obese than better off children. Figure 1 shows some of the pathways by which poverty contributes to obesity. While the role of these factors differs in London and New York, in both cities, compared to better-off children, poor children are more likely to live in neighborhoods that contribute to obesity.

Figure 1. Poverty as pathway to obesity

Food	Poor neighborhoods have more fast food outlets and fewer supermarkets or other retail outlets that sell fruits and vegetables; Unhealthy food advertising targets the poor; Those with low-incomes purchase calorie dense, nutrient poor foods because they are cheaper than healthier products; Public food programs often serve unhealthy or low quality food
Physical activity	Poor neighborhoods have fewer parks and recreation centers; Fears of crime prevent low-income people from going out to be active; Heavy traffic and highways in poor neighborhoods discourage walking or bicycling; Parks in poor neighborhoods are less well maintained and may have fewer attractive amenities
Health care	Health care providers provide less counseling and health education to poor children; Poor children (in US) are more likely to be uninsured or lack access to health care
Schooling	Schools serving poor children often offer less healthy school food ; Fewer opportunities for sports and recreation and less nutrition and health education in schools in poor areas
Other	Stressful living associated with poverty can lead to over-eating; Poor children watch more television, itself associated with more exposure to unhealthy food advertising and with higher rates of inactivity

Sources:[7,8,9,10]

In the US the obesity epidemic is estimated to cost $147 billion a year (£738 million*) in direct and indirect costs.[11] In New York State, adult obesity accounts for $6.1 billion (£3.73 billion) in direct and indirect costs and childhood obesity accounts for $242 million (£147.7 million) in medical costs.[12] Moreover, compared to children of normal weight, obese children are much more likely to become obese adults. A growing body of evidence shows that childhood obesity is an important contributor to several chronic conditions—heart disease, diabetes, and hypertension.[13] Childhood obesity also contributes to lifetime mental health problems.[14] These consequences impose a growing burden on overweight children and adults and on health care systems. People who are obese use nearly twice as many prescription drugs as those of normal weight and have 25% to 38% more doctors' visits.[15] Obesity accounts for 9,000 premature deaths a year in England. It has been projected that by 2050 more than 50% of the population could be obese. Nationally elevated BMI accounts for £4.2 billion ($8.32 billion) in health care costs (2007) and £15.8 billion ($31.3 billion) in losses to the wider economy. Obesity reduces the life expectancy of individuals and is projected to reduce the average life expectancy of Americans by as much as 5 years in coming decades, reversing more than a century of public health progress.

Childhood obesity also imposes social costs—an increasing burden of chronic diseases, widening disparities in health status between the poor and the better off, and a diversion of public resources that could be used to address other pressing problems such as inadequate housing and education or environmental pollution.

The childhood obesity epidemic also places social burdens on overweight young people, their communities and cities. The stigma associated with being overweight has negative emotional and economic consequences that may reinforce and feed into obesity's social inequalities. For example, US women who are overweight in adolescence have 22% lower earnings as adults compared to

*All US currency($) converted to pounds sterling(£) and £ to $ using exchange rate at mid-point of year of estimate

their normal weight counterparts. Young people who are obese have lower self-esteem, are more likely to be depressed, have more negative body image, and are more likely to have poor academic outcomes.[16]

GOVERNMENT IN LONDON AND NEW YORK

While many institutions need to act to reverse increases in child obesity rates, city governments are uniquely positioned to contribute to bringing obesity under control. All levels of municipal governments (e.g., boroughs, community districts, mayors) have responsibilities, assets, and connections to families and communities that enable them to take on obesity. Unlike higher levels of government, they interact with people every day in multiple settings. And, unlike communities, they have authority and financial resources to launch initiatives of the scope needed to change aspects of the environment and culture that shape obesity risk. City governments can also urge regional and national governments to act. Cities can't reverse obesity on their own but they are well situated to take leadership. While London and New York are big, diverse and wealthy cities, they differ in the structures of their municipal, regional and national governments that shape their opportunities to exercise leadership.

In the next section, we briefly describe the governmental structure in each city, then compare their potential and limitations in controlling childhood obesity.

London

The Greater London Authority (GLA) is the regional authority for London. It includes the mayor and the 25 members of the London Assembly, all of whom are elected every four years. The mayor is the elected voice of London and sets out and coordinates strategies aimed at improving London and articulating a vision for the city. The principal strategies cover such issues as spatial and economic development, transportation, environment and sustainability and culture. The mayor's health policy team works to ensure that actions across these sectors promote rather than harm public health in London. In England, regional municipal authorities such as the GLA provide policing, fire and emergency services. In 2000, the mayor of London created the London Health Commission to improve the health and well-being of Londoners. Through its reports and partnerships, this Commission has played an important role in calling attention to the problem of childhood obesity.

Since 2007, central government accorded the mayor a statutory duty to reduce inequalities in health.[17] The GLA has the power to order health impact assessments for any policy including those for transportation or the built environment, a potential tool for the control of childhood obesity. While the position of the mayor in London is much less powerful than in New York, the previous and current Mayors have used the office to advance health-related initiatives. For instance, Mayor Ken Livingstone instigated a successful bid to host the

2012 Olympics, which is intended to leave a "health legacy" by investing £7.5 million ($12.34 million) in sports facilities with the goal of improving opportunities for physical activity for all Londoners. Current Mayor Boris Johnson has appointed a high profile food adviser to oversee the implementation of the London Food Strategy.[18]

Most day-to-day public services in London such as education, housing, social services, street cleaning, waste disposal, roads, local planning and many arts and leisure services are delivered by the City of London Corporation and 32 boroughs, geographic areas that include about 200,000 to 250,000 people. Assigning responsibilities for these services to boroughs enables local authorities to tailor them to meet specific needs but makes citywide initiatives more difficult. At the national level, the United Kingdom has responsibility for setting policies for England but has devolved authority for some functions to the governments of Scotland, Northern Ireland and Wales.

Health services are provided by the national government, which operates the National Health Service (NHS), the government body that funds guaranteed health care to all UK residents. Primary Care Trusts (PCTs) have been developed to commission and fund a range of community and primary health services, hospital care and medical prescriptions. In London, 31 local PCTs oversee public health and medical care. These trusts employ more than 200,000 people and their annual budget is about £12 billion ($23.6 billion). PCTs play an active role in responding to obesity by, for example, funding staff to work to improve school food and conducting studies of the prevalence of childhood obesity in London boroughs. The London Regional Public Health Group (LRPHG) is the local body of the National Department of Health and works with PCTs, the GLA, and local authorities to coordinate local action in response to national priorities. For example, LRGHG program managers work with local authorities to address childhood obesity as part of their Healthy Schools initiative.

The NHS is currently undergoing a controversial transformation that devolves authority to more local levels. As in the case of schools, primary care practices may be able to provide more locally sensitive services, but citywide initiatives become more difficult. In London, city government has little direct responsibility for health care or public health.

New York

New York City has a government structure with a strong mayor and a relatively weak legislative body, the City Council, whose members represent 51 neighborhood districts. Most municipal services are delivered by city agencies run by the mayor. Community districts have an appointed board with limited power to coordinate services at the local level and to provide feedback to elected officials. Unlike some other big US cities and unlike London, New York plays a strong role in delivering many services. It operates the public school and hospital systems, and plays a role in transportation policy and zoning rules.

Many public services require cooperation between the three levels of city, state and national government. For example, the city Department of Education purchases food, plans menus and delivers food to the schools, where local staff actually prepare and serve the food. Through its education department, New York State monitors local school food programs and provides technical assistance to local school food programs. The federal government sets standards, specifies products and pays for some food served in school lunch programs. Improving school food requires either changing policies at all three levels or accepting the constraints imposed by higher levels.

In the US, each level of government and the private sector have responsibilities for paying for and delivering health care and assuring public health. The city government has responsibilities for public health and operates a municipal hospital system. Through the State and federal governments, the Medicaid programs pays for health care for low-income people. Current debates about national health reform in the US are unlikely to change this dispersion of responsibility for health care.

In New York, the city's Health Code gives government a unique tool to advance public health without undue political interference. Under the city charter, the Board of Health may enact, alter, amend, or repeal any part of the Sanitary Code and "may therein publish additional provisions for the security of life and health for the city and confer additional powers on the department not inconsistent with the constitution or laws of the State or with this charter". The Health Code, created in 1866 and modified periodically since, was intended to provide public health experts with an opportunity to set health regulations without going through the legislative process. In the last few years, the Board of Health, an independent body appointed by the Health Commissioner and the Mayor, has used its authority to address the issue of obesity. Since 2006, the Board of Health has issued rules requiring chain restaurants to post the calorie content of the foods they sell (2007), [19] child care centers to offer healthier food and more opportunities for physical activity (2007), [20, 21, 22] and restaurants to eliminate transfat from their products (2006).[23] In these and other cases, the city was able to use its authority to make healthier food and activity choices more available. In London, local government has no such authority.

Common Challenges

London and New York have diverse populations that require obesity control interventions to be tailored to meet the specific needs of groups with different cultures, languages and behavior patterns. Both cities also have vulnerable and mobile populations: recent immigrants, children living in poverty, children who are already obese and homeless or precariously housed individuals and families. These characteristics preclude "one-size-fits-all" or static interventions, and require municipal governments to develop flexible and dynamic approaches, often a challenge to established bureaucracies.

In both London and New York, interactions with other levels of government influence the outcome of policy initiatives. On the one hand, for example, UK national statements on obesity and health inequalities have served as powerful levers for local policy change. On the other hand, since the national government and local boroughs control many aspects of urban life that influence obesity, the

GLA has limited authority to influence the drivers of obesity. In New York, the state government has powerful control over health and social services, sometimes blocking the city from acting on its own. A historic tension between city and state government contributes to conflicts over power and turf that can delay or undermine reform. Gerald Frug, of Harvard Law School, has observed that New York State has given New York City a heart but no brain while Parliament has given London a brain but no muscle.[24] Frug has also observed that building a city based on concern for social justice "takes a back seat to building a globalized business environment," [25] an observation that could also apply to London and New York.

Both London and New York have adopted environmental sustainability as a lead value in their future planning. In 2007, New York's Mayor Bloomberg announced PlaNYC 2030, a planning agenda to address New York's growing population, aging infrastructure, and connections to global warming.[26] While PlaNYC does not provide comprehensive recommendations for food or public health, it includes sections on land, water, transportation, energy, air, and climate change. By contrast, London's Sustainable World City strategy (2002), placed healthy school food at the center of a vision for making London the first sustainable world city.[27] In following the United Nations (UN) definition of sustainable development, the London strategy combines social and environmental sustainability. Given the connections between rising rates of obesity and human induced climate change,[28] both cities can benefit from the development of synergistic strategies to address these global problems.

In both cities, private interests such as the financial sector, food services and real estate developers generally speak with a more unified voice than government or advocacy groups. When public interest and private interest groups differ about policy that affects obesity (e.g., more public oversight of the food and advertising industries, zoning changes to limit density of fast food outlets, reductions in the income equality that drives obesity), private interests generally have more resources and political capital to achieve their policy goals Thus, creating cities where health rather than business concerns take precedence, will require new approaches to governance and democracy and a more level political playing field.

In sum, both cities face a variety of factors that facilitate and block changes that could reduce rates of childhood obesity. The table below summarizes some of these factors. In each city, advocates for reducing rates of obesity will need to find new ways to capitalize on facilitating factors and overcome obstacles.

Factors facilitating and blocking municipal action to reduce childhood obesity		
	London	**New York City**
Factors facilitating municipal action	• Strong municipal control of transportation system • Explicit commitment to reducing inequities in health • National health care system that provides coverage to all • Relatively stable national funding for health care and education • Some business support for healthier eating options • National Child Measurement Program and Healthy Weight, Healthy Lives childhood obesity targets and program funding • Stated commitment to social determinants of health approach by Mayor and Regional Director of Public Health • London Health Observatory, an independent monitor of health trends • Olympics and commitment to health legacy	• Strong mayor who supports vigorous municipal public health role • Strong health department with forceful leadership that supports vigorous role for public health • Health Code that enables action outside political process • Active and energetic nonprofit sector with interests in a variety of food and obesity issues • Public support for action to reduce obesity • Central school system with decision-making concentrated in Mayor's office • Many public officials with strong positions on obesity, food and health. • City Council President, Mayor, Governor and President who have said health and food are priorities • Economic crisis that provides window of opportunity • Food and retail industries with deep pockets to influence political process and modest incentive to change
Factors blocking municipal action	• Economic crisis that distracts public and policy maker attention • Food and retail industries with deep pockets to influence political process and modest incentive to change • Limited municipal involvement in public health • Decentralized/ borough level authority over food and education • Competing priorities at different levels	• Economic crisis that distracts public and policy maker attention • Complex, often anarchic system of government that makes implementation of change difficult • Federal control of school food policy • Strong commitment to incrementalism • High value on individual responsibility as solution to social problems and corporate and political promotion of these values • Competing priorities at different levels • Food and retail industries with deep pockets to influence political process and modest incentive to change

COMPARING LONDON AND NEW YORK'S RESPONSES

London and New York have used their specific circumstances to launch distinct initiatives to reduce childhood obesity. Here we give a brief overview of the policies and programs each city employs and compare these efforts. We focus on six sectors: food, transportation, green space, planning and housing, schools, and health care and health inequalities.

LONDON

London's response to childhood obesity uses the Mayor's authority over transportation and planning and builds on its decentralized structure to encourage grassroots innovation and community tailored interventions.

The London Healthy Weight, Healthy Lives Task Force is an example of the city drawing on its network of local authorities and community-based groups to develop a regional strategy for addressing childhood obesity. The Task Force convened in 2008 as an action of the Health Inequalities Strategy and as a regional response to national targets set for reducing childhood obesity to 2000 levels by 2020. The London task force set out to map activities with the city that could reduce childhood obesity and to "identify what action would be the

most effective in London, with particular focus on children and young people." The Task Force recommends 12 actions that build on the Mayor's regional authority and support work underway at the community level. These actions are still under consideration and have informed the policy agenda at the end of this report.[29]

Well London is a lottery-funded initiative led by the London Health Commission that draws together city government, academic institutions, civil society groups, and health care providers to support community-led projects in the city's most deprived areas that promote health.[30] These local projects are part of a citywide evaluation. In effect, they turn the challenge of working with Local Authorities into a living laboratory for health promotion. For example, the Eatwell and Buywell projects work to improve the local food environment and eating habits by making quality, affordable, culturally relevant foods more available and celebrating food through cooking clubs. The most effective local projects can inform the city's approach to tailoring initiatives to meet the needs of its diverse populations.[31, 32]

Unlike New York, London is striving to meet the international standards to be designated as a Child Friendly City. Building on the UN Convention on the Rights of the Child, London's City Hall has a child and young people's unit that facilitates young people's participation in city governance.[33] The child and young people's unit has taken an active stance toward ensuring free access to public transportation and play.

Food

After extensive public consultation, the London Food Strategy (LFS) was launched in 2006 outlining a 'farm to fork' vision for the city's food system and adopting a responsible procurement plan for agencies under the Mayor's authority.[18] The plan emphasizes local foods, improving conditions for the food workforce, celebrating diverse food cultures, reducing the city's ecological footprint, and promoting health. The current Mayor has appointed a food policy coordinator to oversee the implementation of the LFS. The Mayor's health policy team has worked to coordinate local actions into an informed regional response.

Transportation

In transportation and physical activity, London government appears to have more authority than New York's to set transportation policy and to consider the environmental and social consequences of their decisions. For example, London's congestion pricing plan raised £137 million ($270 million) in the last year that will be used exclusively to improve public transportation and to increase bus ridership and the number of bicycle journeys through the zone, while reducing air pollution.[34] Transport for London (TfL) uses a range of strategies to promote active travel as a healthy and environmentally sustainable way to move throughout the city. Examples include supporting

employers' development of workplace travel plans and partnering with PCTs to deliver programs that support adults in transitioning to walking and biking rather than driving.[35]

TfL promotes young people's active travel to school through a 'Walk on Wednesdays'[36] campaign and a Junior Road Safety Officer[37] scheme that engages young people and teachers in teaching children about street safety and encouraging them to walk and bike more. Activate London uses community mapping and participatory design to improve the physical environment and make activity more accessible.[38]

Green space

London has a citywide urban agriculture scheme called Capital Growth that aims to create 2,012 new food growing spaces in London by the year 2012. By getting Londoners to grow more of their own food, the Mayor hopes to make fresh and culturally relevant produce more accessible. The program uses the city's abundant green spaces by matching partners who have space for growing food with people who would like to garden but lack access to green space, promotes school gardening projects, and supports the reclamation of derelict lands and the development of roof top food producing gardens[39]. In addition to supporting local culturally tailored food production these projects can also serve as sites for education on cooking and nutrition.[29]

Planning and housing

Since 2006 all boroughs of London are required to have a Children and Young People's Plan that includes play in their open space planning strategies. These plans are required to be developed in consultation with children and youth. They also must assess the current play facilities and develop plans that meet citywide standards for quality, quantity, and accessibility. A typology of play spaces ensures that there are appropriate play spaces for children and youth of different stages in development. The planning guidance on play also requires all new housing developments to include spaces for young people to play.[40]

Schools

National standards for school foods in the England shifted in 2006 to further restrict candy, sodas, and fried foods while requiring two portions of fruits and vegetables at every meal. In 2008 and 2009 nutrient based standards came into play to further improve the health promoting capacity of school meals. Still, because schools and their meal provision are run at the level of London's 32 local councils there is considerable variation in how, and to what extent, these standards are met.[41] There are no nutrition standards for foods served in day care centers. This diffusion of authority presents both an obstacle to citywide procurement and meal planning and an opportunity for innovation at the local scale. For example, in early 2009 the London borough of Islington passed a budget resolution that includes funding to provide free school lunches. In doing so, Islington is the first local authority in England to pass such a measure. The meal program

will cost £2.9 million ($4.77 million) over two years and serve 12,000 children ages 11 and younger attending 45 schools. Other school initiatives, some mentioned previously, focus on increasing opportunities for physical activity.

Health inequalities

London is the first world city to develop and employ an integrated citywide policy strategy that focuses on reducing inequalities in health. Based on the World Health Organization's Commission of Social Determinants of Health, [42] London's strategy aims to reduce inequalities in health by changing the social conditions that impede people from leading healthy lives while also emphasizing empowerment. The London Health Observatory monitors health and health care at the city level, in the context of its responsibility to track inequalities in health in the UK. New York has no comparable counterpart. The London Health Commission also tracks progress in reducing health inequalities.

NEW YORK

New York's response to childhood obesity exercises the strong authority of the city health code while also encouraging collaboration across departments of health, transportation, buildings, education, and planning. For example, the Office of School Health bridges the city's departments of health and education. Food Retail Expansion to Support Health (FRESH)[43] is another example of such collaboration, this time between the Departments of Health and Mental Hygiene and City Planning.

Food

Through a suite of policy changes and programs, New York is making fresh nutritious food more accessible, especially for its poorest residents. Conceptually, New York has shifted its focus on food from policies that view food safety as protection against food-borne contaminants to one that also addresses chronic health conditions such as obesity and diabetes.[44] The Health Code, the mayor's authority over municipal contracts, and a range of incentives for businesses and individuals are all tools used to accomplish these changes. In early 2007, the Mayor and the City Council created the Office of the Food Policy Coordinator, who was charged with promoting access to affordable, healthy food for low-income New Yorkers.[45] This office has coordinated several subsequent policy initiatives. The City Council Speaker, Christine Quinn, recently announced several new food policy initiatives, providing further legislative support for change.

In 2008, Mayor Michael Bloomberg announced an executive order setting nutritional standards for all food purchased or served by city agencies. The standards will improve the nutritional quality of more than 225 million meals served a year in city schools, jails, hospitals, and senior care centers. They ensure that the food served or sold in municipal agencies does not exceed specified proportions of fat, sugar and salt.[46] Other efforts to reduce the promotion and availability of unhealthy food include a 2009 advertising campaign that urges subway and bus riders, "Don't drink yourself fat. Cut back on soda and other sugary beverages. Go with water, seltzer or low-fat milk instead."[47] Also, in an effort to reduce consumption of soda, several legislators have urged passage of a tax on sweetened beverages, so far unsuccessfully.[48] In addition, a number of initiatives focus in increasing the availability of healthy foods in poor areas. Through the Healthy Bodega[49] Initiative the Department of Health staff works with owners of small corner stores to improve the quantity, quality, and display of fresh foods while reducing promotion of alcohol and tobacco. The city has also issued 1,000 new licenses for Green Carts[50] street vendors who sell fresh produce in areas where access is limited.

In addition to increasing the number of farmer's markets in poor areas, the city is working to ensure that vendors at these markets are equipped to accept electronic food stamp payments and initiated Health Bucks, a program that provides incentives for food stamp recipients to purchase produce at these markets by giving them $2 bonuses for every $5 spent.[51] Unlike London, New York initiatives like these have made farmer's markets and local foods accessible and viable in poor communities.

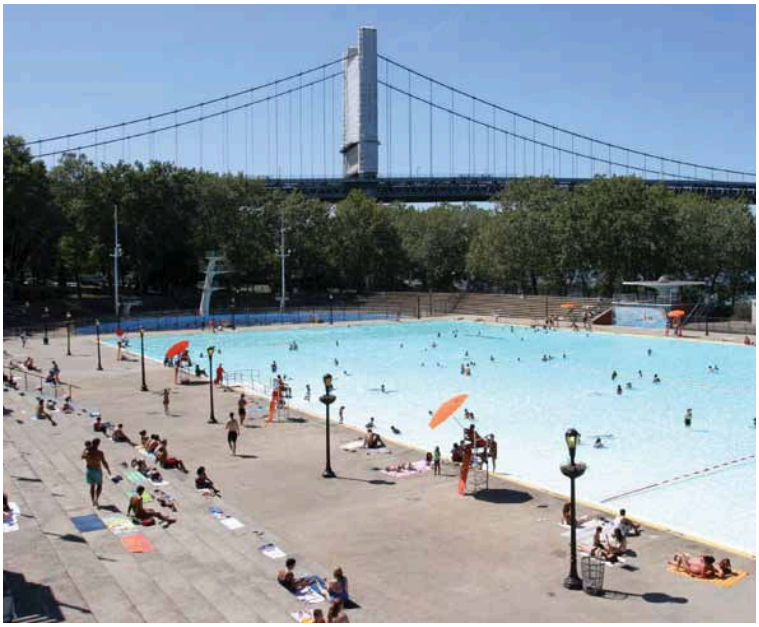
In 2009, New York City presented its plan for promoting supermarket development in areas with high rates of diet-related disease and limited food retail. FRESH supports zoning changes that give developers the right to build larger buildings in exchange for including a grocery store on the ground level, reduces requirements to provide parking, and eliminates land use restrictions on locating supermarkets in light manufacturing areas. Financial incentives include real estate tax reduction, sales tax exemption, and mortgage recording tax deferral.[43] To qualify for these incentives, supermarkets must dedicate at least 30% of their retail space to perishable goods and meet minimum requirements on square footage devoted to fresh produce. The city estimates that the program will help create 15 new grocery stores. Food worker unions and labor advocates are urging the city to attach good job standards to the requirements for receiving financial incentives.

Transportation

While London introduced a congestion charge, the New York State Legislature rejected the city's congestion pricing plan in 2008, a proposal that was based in part on London's successful policy. However, under new leadership in the Department of Transportation, the city has met a Mayoral target of creating more than 200 miles in bicycle lanes and passed new zoning regulations requiring bicycle parking space in new residential construction. New York's Safe Routes to School[52] program conducted an accident analysis for all city schools and identified 135 priority schools where it has made safety promoting improvements to the streetscape around schools. In addition it has prepared school safety maps for all primary and secondary schools with more than 250 pupils.

Green space

The Mayor's 2030 plan includes a number of initiatives for increasing access to parks and recreational spaces. For example, it has begun work on opening schoolyards as neighborhood play spaces, adding lighting to athletic fields so that they can be more fully utilized, and converting asphalt sites into turf playing fields.[26]



Planning and housing

The New York City Departments of Health and Mental Hygiene, Design and Construction, Transportation, and Planning collaborated to produce New York City's Active Design Guidelines.[53] Released in 2009, the guidelines provide planners and architects with a manual of strategies for promoting physical activity through the design of neighborhoods, streets, buildings, and work places.

Schools

Through the city Health Code, the Department of Education and the Office of School Health, New York has taken a number of steps toward improving the health promoting capacities of its public schools and day care centers. It has invested more than $1 million (£544,590) in equipment for physical education and implemented a citywide physical education curriculum. Students' weight and fitness are monitored and reported to their parents using a 'fitnessgram'. This monitoring is also used to track childhood obesity throughout the city.[54]

Starting in 2003, New York has made several important improvements to the food served in its public schools. In New York City, all students are eligible for free breakfasts. Recently the city piloted a program serving breakfast in classrooms. Its goals are to reduce the stigma associated with receiving free meals in school, reduce tardiness as more students arrive at school on time, and increase the number of students eating these school meals.[55] Soda has been removed from vending machines and replaced with water and 100% fruit juice. To reduce the fat content of food served in schools only skim and 1% percent milk are available and french fries are now baked. Fresh fruits and vegetables are on the menu everyday and some high schools now have salad bars. Despite these important policy changes, many New York students report erratic implementation of these changes and many still complain of limited choices and unappealing presentation of food.

Using the city Health Code, new regulations have been put in place that improve nutrition and mandate physical activity for children aged 2-5 attending non-residential group day care. The new laws ban drinks with added sweeteners, limit servings of fruit juice, and require that all milk served be reduced fat. Television and video viewing are not allowed for children less than two years old and are limited to 60 minutes a day for those who are older. Physical activity is required everyday for an hour and

half of this must be structured and guided. Lastly, when weather prevents outdoor play, the law now requires that indoor activities be substituted. To support the implementation of such sweeping changes the city has offered training to teachers and day care inspectors.[20-22]

Health inequalities

New York addresses health inequality through the work of the District Public Health Offices (DPHOs) and partnerships with community-based groups and coalitions. DPHOs are located in the South Bronx, North and Central Brooklyn, and East and Central Harlem, three of the poorest city neighborhoods, and deliver resources and programs to these high need areas. New York is also one of nine cities in the US funded by the WK Kellogg Foundation to take action to reduce disparities in childhood obesity. The New York City Food and Fitness Partnership brings together more than 100 community-based organizations, non-profits, and academic institutions to develop action plans and policy agendas to reduce obesity.[56] In addition, the U.S. Centers for Disease Control and Prevention has supported the Strategic Alliance for Health to build an alliance to reduce the burden of chronic disease in East and Central Harlem and the South Bronx.

REVIEWING THE EVIDENCE

Although there is no proven cure for childhood obesity, strong evidence supports the value of prevention and a growing body of evidence supports the use of environmental approaches for promoting healthy eating and physical activity. In this section we distill these bodies of research to highlight the findings and messages that we believe mayors, city officials, and advocates will find most useful. First, we describe three broad principles that emerge from our review of the evidence– put prevention first, engage whole communities and change policies to support changes in behavior that make healthy behavior the norm. We then summarize the results of research and intervention studies in five domains: the built environment, physical activity and travel, food, primary health care and monitoring and evaluation.

INTERVENTION PRINCIPLES

Put prevention first

Many strategies in multiple sectors will be required to reverse rates of childhood obesity. A starting principle is the value of making prevention, rather than treatment, the intervention priority. Several types of evidence support this approach.

First, according to a recent review, children who are obese are 2 to 10 times more likely to become obese adults.[57] Once young people develop behaviors that lead to weight gain these habits will be difficult to change. Supporting young peoples' development of healthy lifestyles saves them and society the effort and cost associated with trying to lose weight. In addition, prevention can save young people from the distress that obesity imposes by lowering self-esteem and contributing to social isolation.[58] Second, many of the actions necessary to prevent childhood obesity – building activity and healthy eating back into our neighborhoods and lives- will have broad benefits beyond addressing this one public health issue. For example, making walking and bicycling easier can help to reduce future adult rates of diabetes, heart disease, and depression. Third, as we have seen, obesity imposes high costs on city government and society as a whole. Averting these costs will free resources that can be used to address other pressing social problems.

Engage whole communities

New evidence shows that it is possible to reverse trends in obesity at the population level if whole communities are involved for the long-term. These results come from a 12-year study conducted in France that compared obesity rates between a town that implemented a whole community approach and one that took no coordinated action.[59] Over 12 years the town using the whole community approach had significantly lower childhood obesity rates than the control town and lower rates than at the start of the study. Key elements of this approach included school-based interventions, parent and community engagement, municipal support for environmental changes such as building new sports facilities, and communication about these efforts through mass media. School-based interventions promoted healthy eating by improving children's nutritional knowledge and the quality and affordability of food in schools. Similarly, physical activity was promoted by organizing walk-to-school days, improving facilities and hiring sports educators. Parents were invited to family breakfast in schools while doctors, shopkeepers, sports and cultural groups organized family events focused on healthy lifestyles. Based on a school wide survey that reported high levels of unhealthy eating and sedentary behaviors, doctors and dieticians provided tailored advice to families. Newspaper, radio, and television coverage of these events also supported the project. Although somewhat more modest, a similar community-wide intervention in Somerville, Massachusetts also demonstrated success in reducing BMIs in children in the participating community in comparison to those in two similar areas without such a program.[60]

Although London and New York are very different than these small towns, there are some important lessons to be learned from such examples. By combining environmental changes with education and targeted intervention, these towns were able to reduce childhood obesity. There is no magic bullet but local governments can provide support and leadership for communities to create a sustained shift in social norms and health outcomes. Bringing interventions like these to scale in London, New York and other big cities will require forceful leadership at the municipal and community levels, new resources and mobilized communities.

On a different front, public health practice in many settings demonstrates the value of engaging key stakeholders in all aspects of planning, implementing and evaluating change. Young people, parents, community leaders and businesses can play a role in reducing obesity but advocates and policymakers need to make more consistent efforts to bring these constituencies to the table.

Change policies to change behaviors

A third principle for interventions to reduce childhood obesity is the importance of changing the policies that encourage or discourage healthier behavior. A growing body of evidence shows that policies that create food and physical activity environments in which healthy choices are easier and more affordable than unhealthy ones can play an important role in reducing obesity.[61-68] These include both policies that encourage access to healthy affordable food and safe physical activity and those that discourage the promotion of unhealthy options (e.g., marketing high sugar, high fat food to children).

Policy change is also needed to address current socioeconomic and racial/ethnic inequities in the burden of childhood obesity. Individual and market- based solutions to obesity (e.g., membership in a fitness center or nutrition counseling by health providers) will always benefit most those with more income and education, thus widening disparities.[69] Only policy changes that modify the social conditions that create the inequities in obesity (See Figure 1) can fundamentally alter these dynamics.

In some cases, the difficulty of evaluating the impact of policy change has left a less solid evidence base for policy than individual-level interventions. Thus, municipal governments are ideally situated to join researchers to fill this gap in the literature. However, to delay considering policy changes for which the weight of the evidence suggests efficacy until definitive proof is demonstrated will doom many children and communities to continue to suffer from the preventable health problems associated with obesity.

DOMAINS OF INTERVENTION

Built environment

The places where children live, learn and play have a significant impact on their health and environmental interventions are increasingly recognized as efficient ways of increasing physical activity and improving diet. Rebuilding the ties between urban planning and public health can help to create healthier cities for the 21st century. In both behavior and city planning, often the healthy choice is also the green choice.[64-66] Replacing energy generated with fossil fuels with human energy by encouraging walking and bicycling reduces both pollution and obesity. By exploiting this synergy, London and New York can help to reduce two global problems.

Disparities in the availability of resources like safe walkable streets and healthy affordable food contribute to inequalities in health. For example, US studies show that low-income neighborhoods have fewer parks and sport fields when compared to more affluent areas.[67] Research at London Met has shown that even within single neighborhoods "particular groups perceive and experience fear and criminal activity differently" and that efforts to increase access to resources like public transportation and parks must take such differences into consideration.[70] Funding the construction of fitness facilities and food growing gardens without specifically locating these in the communities with the highest levels of obesity may result in widening inequalities in health by increasing disparities in access to these resources. In this and other areas, community participation in planning can help to ensure that resources are spent on projects that people will use and have their intended outcomes. Participation also supports community cohesion and empowerment which are further linked to health and the reduction of health inequalities.

Physical activity and travel

Strong evidence links access to recreational facilities and programs to young people being active.[67] Playgrounds and parks provide important spaces for both relaxation and active recreation. As shown in Figures 2 and 3 below, in both London and New York access to green space is inequitably distributed.

Access and use of parks, playing fields, recreation centers and other facilities varies by gender, socioeconomic status, and age. For girls, levels of physical activity have been linked to how close they live to places where they can be active. Activity levels for boys can be linked to access to parks and neighborhood spaces where they are allowed to play. Very young children are more active when they spend more time outdoors and when they have access to places where vigorous activity is permitted.[67] For example, one US study examining African-American urban adolescents' perceptions of environmental factors related to physical activity found that these factors differ significantly by gender.[71] Many young women saw fear of crime and violence as an obstacle, while young men were more concerned about the opportunities available for physical activities. In designing recreation policies, city officials need to take these gender differences into account. A study examining young Londoners perspectives on environmental influences on physical activity found that the proximity and quality of facilities, youth and parent perceptions of safety, and having fun with friends affect their ability to be active.[72]

FIGURE 2. PLAYGROUND ACCESS BY NEIGHBORHOOD IN NEW YORK CITY

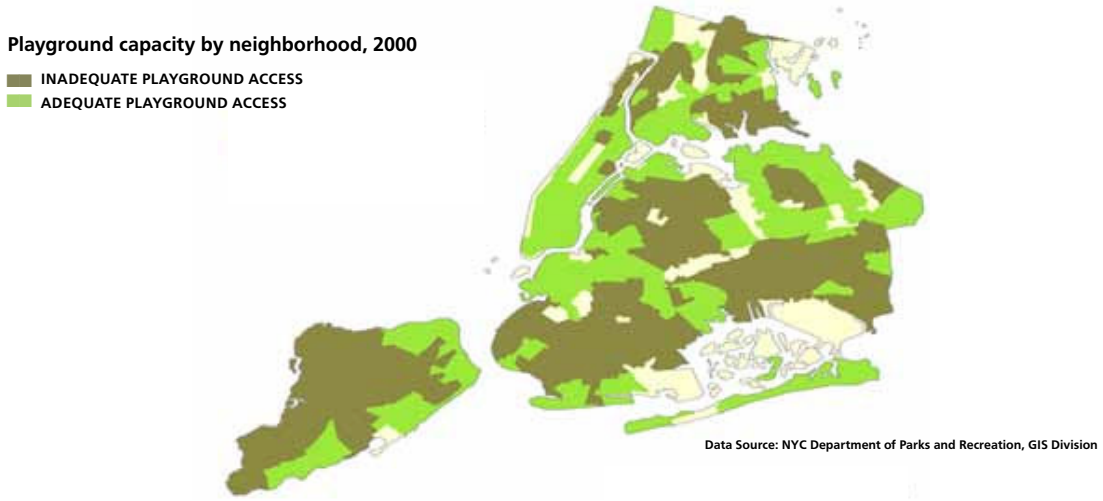
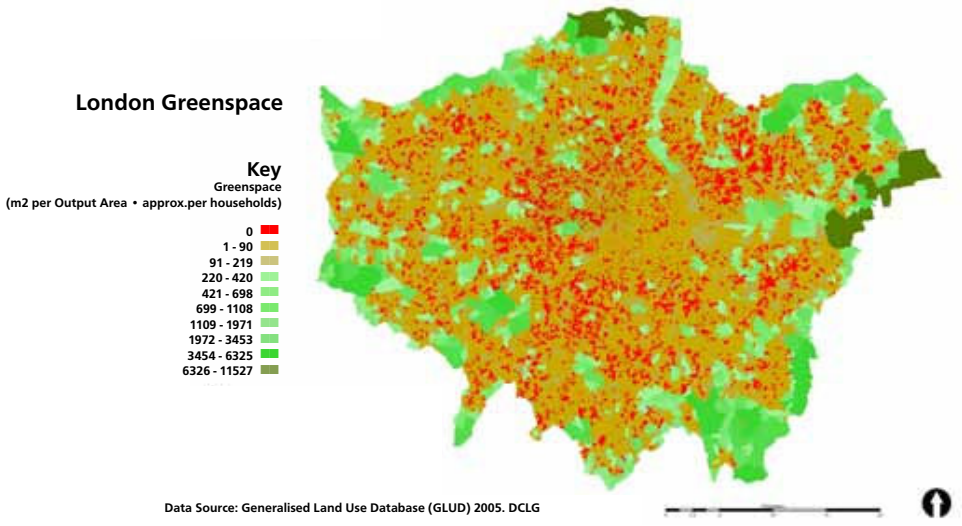


FIGURE 3. GREEN SPACE IN LONDON



Countries with the highest levels of active transportation, such as walking and cycling, have the lowest rates of obesity.[73] European countries have higher levels of active transportation when compared to North America and this may be a factor contributing to Europe's generally lower rates of obesity. For many people, bringing physical activity back into our daily lives is easier than finding time to go to a gym. Even short periods a day of moderately strenuous activity like walking and stair climbing can prevent weight gain.

When people use buses and trains to travel, they usually have to do some walking or cycling to get on and off the public transit grid. Cities like London and New York already benefit from environmental characteristics that promote active travel such as population density, mixed land use, historic structures, high cost and inconvenient car ownership, and well-developed sidewalk and bicycle lane networks. Actions such as increasing bike lane and sidewalk connectivity with public transportation, providing more and more secure bicycle parking, prioritizing pedestrians in traffic regulation and enforcement, neighborhood greening, and increasing the availability of public transportation in areas that have limited access could further increase the use of active travel and reduce obesity. Where these factors combine to create walkable neighborhoods there are significantly lower percentages of people who are overweight.[74]

Children who regularly walk or bike to school are generally more active than those who travel by car.[67] Studies show that the distance between home and school, presence of sidewalks, parental concerns about traffic danger and neighborhood safety, and gender influence the likelihood that children will walk or bike to school. Boys are twice as likely as girls to walk to school.[75] This gender difference highlights the significant impact public safety has on physical activity and obesity for young people. Several municipalities have established "walk to school" programs using "walking school buses" that can supervise young children whose parents are unable to walk them to school.[76]

Food

Today energy dense fast food is less expensive and more available in most city neighborhoods than fresh food. Many parents' concerns about time and cost lead them to purchase, eat, and feed their children more prepared food and fast food, which are often higher in calories and lower in nutrients than fresh food. Increased portion sizes and growth in the percentage of meals eaten outside the home have also been connected to growing rates of obesity.[67] The recent down turn in the global economy and increase in food prices is forcing more people to spend less on food. More people are buying more foods that are cheap, energy dense, and nutrient poor. Left unchecked by government intervention, such trends will only exacerbate health inequalities.[77]

While many environmental strategies for improving diet have not been evaluated in connection with childhood obesity, researchers recommend ensuring that most food available to children meets nutritional guidelines, reducing young people's exposure to advertising for unhealthy foods, and making healthy foods easy to identify and affordable.[67] One British study found that, after watching advertisements for fast food, breakfast cereal and soft drinks, obese children increased their food consumption by 134%, while overweight and normal weight children did so by 101% and 84% respectively.[78]

In London, only 31% of young women and 30% of young men report eating five or more servings of fruits and vegetables a day.[79] In New York only 17.2% of young women and 20.2% of young men report eating five or more servings of fruits and vegetables a day.[80] Food served at institutions that receive support from municipalities, such as schools and recreational facilities, thus presents an opportunity for creating environmental or policy changes that help young people maintain healthy body weight.

Research suggests a number of ways to make the healthy food choice the easy and affordable choice and many of these strategies are cost effective, green, and utilize authority and resources that cities already have. These include increasing the availability of retailers that sell healthy foods, creating more opportunities for people to grow their own food, requiring calorie posting on restaurant menus, and making healthy free food the only food available in schools and other public places. Ensuring that such actions are carried out with a focus on poor and socially excluded communities is essential for reducing inequalities in obesity.

Supermarkets and food retail

Using land use and planning powers to support supermarkets in poor neighborhoods is one way to make healthier food more available and affordable. In the US, poor neighborhoods and communities of color have fewer supermarkets than better-off or white ones, and there are fewer health promoting foods available in these supermarkets. In contrast to studies showing that living near a supermarket reduces risk for obesity, living near convenience stores increases the risk of obesity.[81, 82] The Mayor's food strategy in London identified thirteen wards across three London boroughs as 'food deserts', i.e., areas where there was

limited provision of healthy food.[18] Numerous studies in New York show disparities in food access.[83-85] These studies find that affordable fresh produce is difficult to find in the South Bronx and East and Central Harlem and that poor neighborhoods have more small stores, or bodegas, and fewer supermarkets than wealthier areas.

In England there is mixed evidence supporting links between supermarkets and diet, suggesting that increasing access to supermarkets may not by itself lead to healthier eating.[86, 87] This research suggests that new supermarkets may slightly increase fruit and vegetable consumption for people who switch to shopping at the new store and for those who eat two or fewer servings of fruits and vegetables a day.

Supermarkets also increase competition among food retailers and this can drive down prices. Having lower fruit and vegetable prices in a neighborhood has been associated with lower BMIs among children.[88] In addition to supermarkets, support for food coops, small grocers, farmer's markets and mobile fruit and vegetable vendors can help bring healthy foods into neighborhoods where they are scarce. Some of these strategies, like co-ops and farmer's markets, may have the added advantages of promoting community engagement with the food system and thus enhance residents' knowledge of food and nutrition.

As cities consider subsidizing supermarkets in order to attract them into low-income neighborhoods they should also consider requiring that recipients of public subsidies provide living-wage jobs, increase shelf space dedicated to healthier food, reduce promotion of unhealthy foods, and offer affordable healthy food options. In the UK, some observers fear that the growing concentration of national and global supermarket chain stores may undermine public sector ability to promote healthy food policies.[89]

Urban farms and gardens

Urban farms and gardens can transform abandoned or underused space into productive landscapes where people grow their own fruits and vegetables and beautify their neighborhoods. In addition to making fresh foods more available gardening can positively influence the food preferences of gardeners.[90-92] Children who participate in programs that integrate nutrition curricula and school gardening have shown increased preferences for vegetables and these increases persist for at least six months.[91] Similarly, studies find that people who grow vegetables eat more of them and share them with others in their communities. Gardening can increase the accessibility of foods such as fruits and vegetables that may be prohibitively expensive or culturally specific. Supporting urban food production is also cost effective. Every $1 (£0.61) invested in a garden potentially yields $6 (£3.65) in produce. In Britain, there is a long history of growing food in allotments. These small scale food growing schemes have regained popularity and now most have long waiting lists for gardeners. In the US, historically state support for gardens has been driven by wartime frugality and the need to promote health and values like self-sufficiency and productivity.[93] Today, our financial, environmental and public health crises create an opportunity to draw on similar values while creating green jobs that support local and regional food systems that feed all city residents. Bringing these types of programs to the scale that can have a positive impact on health remains a daunting challenge for local governments and may require additional support from higher levels of government.

Fast food and restaurants

Cities can also exercise their land use and planning authorities to limit the availability of unhealthy foods. Fast food restaurants promote childhood obesity by selling inexpensive and fattening foods and by targeting children with marketing tactics that lead them to develop brand loyalties to fast food chains and to pressure their parents to purchase these foods. These restaurants are local manifestations of a global corporate industrial food complex that relies on agricultural practices that advance environmental degradation, labor practices that deepen inequalities in power and wealth, and aggressively markets products to children that promote obesity. Fast food restaurants cluster around schools and are more prevalent in poor neighborhoods. One recent study finds that children who attend schools near fast food restaurants are more likely to be obese than those whose schools do not have fast food restaurants nearby.[94] In the context of increasing access to healthy foods, limiting the density of fast food restaurants per neighborhood and restricting their proximity to schools may help shift the balance toward healthy food. In 2008, the city of Los Angeles banned new fast food outlets in one area of the city with high obesity rates and set a precedent that other US cities are considering.[95]

Requiring calorie labeling on restaurant menus makes it easier for people to identify which food choice is the healthier choice. Research conducted by the New York City Department of Health demonstrates that when patrons see calorie information they choose to order fewer calories.[96] After calorie posting became mandatory in New York, customer preferences for lower calorie foods has created an incentive for restaurant chains to reduce the caloric content of their products by either reducing portion sizes or reformulating recipes. Thus mandating calorie labeling on menus produces both the primary benefit of enabling people to make healthier choices and the secondary benefit of creating a market-based incentive for restaurants to sell healthier foods. Initial evaluation studies provide mixed evidence of results, suggesting the need for continued studies of various approaches to calorie labeling.[97]

School food and universal free meals

School food has long been an important social policy issues in the US and the England. The school food environment includes more than just meals. It also includes vending machines and practices like using food as a reward and for fundraisers. Even foods sold outside of schools can be considered part of a school's food environment when students are allowed to leave during the day to buy food and when they purchase snacks after school.[98] A growing consensus among food advocates is that providing universal free meals is an effective and efficient way to

ensure that all children have access to nutritious food and to eliminate competitive foods from schools.[99] Free, tasty and healthy school food also reduces children's incentives to purchase unhealthy food outside the school. Numerous political and economic obstacles make free school lunches for all an ambitious goal.

Providing universal free school meals has a positive impact on students' eating habits and behavior. Eat Well Do Well, a 3-year study of a universal free meal trial conducted in Hull England, provided free meals and snacks to students. All meals met nutritional standards and discussion of food and health were integrated into the curriculum. During the trial, fewer students reported skipping breakfast or eating breakfast on the way to school, going to bed hungry, and drinking soda for breakfast. After three years, more students reported: eating school meals, feeling healthy, and making healthier food choices even outside of school. Teachers reported that students had gained nutritional knowledge and were calmer and better behaved. School food personnel reported reductions in the administrative costs associated with collecting lunch money and in the cafeteria trash from packed meals. Principals found that lunch periods ran more efficiently, leaving more time during the day for instruction. Perhaps most importantly, the stigma associated with qualifying for or eating free meals, was removed thus making it possible for more students who rely on such meals to obtain them. Survey results showed that after three years there were fewer differences in the overall diets of students who would be eligible for free meals and those who would not.[100] The impact of this program on obesity was not assessed.

Assessing the impact of healthier and free school food programs on obesity is an important research priority. A number of studies show that changes in school food menus and policies can contribute to reductions in obesity.[101]

Primary health care

The health care setting is another important arena for intervention. Health care providers can promote breastfeeding, an important protection against childhood obesity.[102] New York City has recently developed hospital programs and policies to encourage breast feeding.[103] They can counsel parents about the importance of and strategies for preventing obesity in the preschool years, providing advice on diet, physical activity and television viewing.[104] Health care settings can also serve as sites for more intensive behavioral interventions that in some cases have been demonstrated to lead to reductions in children's BMI.[105, 106]

Monitoring and evaluation

Even though several reports and major reviews conclude that 'upstream', 'whole community', and community-driven approaches to reducing childhood obesity are needed, research that tracks the effectiveness of such efforts is sparse. As major players in the fight against childhood obesity and key consumers of research on this issue, cities have the opportunity and responsibility to monitor trends in obesity and evaluate the effects of policy interventions. A related priority is to develop more research and evaluation studies where children and young people are active participants in shaping the programs and places that aim to support their health and development. Finally, more research is needed on the impact of food advertising and marketing to children and effective strategies to protect children from its adverse effects. Partnerships between academic institutions and city governments can help to fill these gaps in the knowledge needed to reduce childhood obesity.

RECOMMENDATIONS

London and New York are already acting to reduce childhood obesity but reversing these epidemics will require stronger, better coordinated, and more sustainable action. The policy agenda presented here recommends actions that can be enacted at the municipal level, will reduce inequalities and the overall burden of suffering that obesity imposes, are either well supported by research or already practiced in either city, use existing city assets, and are both green and healthy. By moving to implement this agenda, both cities can expand a balanced portfolio of obesity interventions that include both targeted and universal approaches and seek modest and more transformative changes.

Based on these criteria, we selected recommendations suggested by the partners in our collaboration and in recent reports on local government actions to address childhood obesity by the US Centers for Disease Control [1] and Institutes of Medicine[2] and from the work of the London Task Force on Childhood Obesity and the recently circulated draft of the London Health Inequalities Strategy. [29]

The agenda recognizes that city governments play an important role in creating policies and structures that support community action, create incentives for responsible business practices, and deliver essential goods and services. While city government can lead the charge on this agenda, community and user engagement are essential elements of shaping the messages, programs, and policies that will be its tangible results. In particular, more active engagement of parents, young people and community residents can create additional pressure for change. Regional and national governments and businesses must also play a role if municipal changes are to be sustained and brought to scale. The recommendations are listed from the broadest citywide actions to the more community-based. In each city the priorities for action may be different based on political opportunities and constraints. The recommendations are followed by Table 3 that provides an overview of our recommendations by sector and the key actors in each sector.

LAND USE AND PLANNING

1. ***Use zoning authority and land use review processes and other municipal authority to limit access to fast food and the promotion of unhealthy foods to children.***

   In both London and New York zoning to limit access to fast food has been discussed. In New York City, legislation has been proposed that would prevent new fast food restaurants from opening near schools. The London borough of Waltham Forest has developed a supplementary planning document to provide guidance on the permitting for "hot food take aways" that aims to reduce the negative impact of these shops on the local economy, public health, and environment by limiting their density to 5% of all retail units and 'resisting' them near residences or within 400 meters of parks and schools. The ubiquity of fast food outlets in both cities makes a freeze on new establishments only a partial solution but a step in the direction of limiting availability of the most unhealthy products. The combination of improving quality and reducing the cost of school food and restricting the number of outlets selling unhealthy food in the "school fringe" can help to improve children's diet. City governments can use their own powers or urge other levels of government to tax unhealthy products (e.g., sweetened beverages) and launch counter-advertising (e.g., New York's "Don't pour on the fat" campaign) to reduce the availability or attractiveness of unhealthy foods and beverages.

2. Use zoning, tax incentives, and city-owned property to increase the availability of healthy, affordable, and culturally appropriate food in neighborhoods where it is limited.

Recently New York has presented a plan for promoting supermarket development in areas with high rates of diet-related disease and limited food retail. The FRESH plan includes both zoning and financial incentives for supermarkets. Zoning changes give developers the right to build larger building in exchange for including a grocery store on the ground level, reduce requirements to provide parking, and eliminate land use restrictions on locating supermarkets in light manufacturing areas. Similar action could be taken in London. In both cities, these supports should also be extended to food cooperatives, and other community-based food retail outlets. In addition, when cities provide supermarkets with public subsidies, they should expect these stores to expand shelf space for healthier foods, restrict promotion of unhealthy food (especially to children), provide good jobs for their workers, and make healthier food more affordable.

3. Build active design principles into building codes, housing strategies, and neighborhood planning.

Both cities have polices that support new developments that encourage physical activity but these efforts could be expanded based on the experiences of the other city. In addition, devising new ways to retrofit older buildings and streetscapes to encourage physical activity could expand opportunities, especially in older, often poorer neighborhoods. New York's Active Design Guidelines could include more specific guidance on expanding opportunities for children's play and London's Housing Strategy could include more of the active design principles that New York is advancing.

FOOD

4. Set standards for municipal procurement and leverage economies of scale to promote food systems that support economic, environmental, and population health.

By combining the best elements of London's Food Strategy and New York's nutrition standards for municipally procured meals, both cities could further strengthen their roles as the city's prime food purchaser and distributor. By using this role to actively promote healthier food and reduce the promotion of unhealthy foods, city agencies such as schools and preschool and afterschool program could become "healthy food zones" serving the city's poorest children. Just as no smoking zones expand places where the air is clean, these designated areas could serve as growing zones where only healthy food is available.

5. Redefine food safety for the 21st century and retool the food safety workforce.

By using the city health code to address obesity and other diet related chronic diseases, the New York City Department of Health and Mental Hygiene has extended the role of food inspectors beyond the prevention of food-borne disease outbreaks. Although London does not have the same legal powers over food as the New York City Health Code provides, it can still find new ways to retrain and redeploy its food safety staff and systems to directly address obesity and chronic disease.

PARKS, GREEN SPACE, AND PUBLIC RECREATION

6. Promote and support urban agriculture as a sustainable and health promoting use of green space.

By encouraging Londoners to grow more of their own food, Capital Growth hopes to make fresh and culturally relevant produce more accessible. The program helps match partners who have space for growing food with people who would like to garden but have no access to green space, promotes school gardening projects, and supports the reclamation of derelict lands, and development of roof top food producing gardens. New York has a strong network of community gardens and urban farms as well as thousands of acres of underutilized open space that could be expanded through a similar program.

7. Increase access to places where people can be physically active.

Both cities have publicly funded pools and active recreation facilities where access could be expanded by reducing or eliminating usage fees and by extending their open hours and seasons. In addition, by opening schools and school yards to the community in the evening and on weekends and during the summer, residents would have more places for sports and other physical activity.

TRANSPORTATION

8. Promote walking and cycling, especially in neighborhoods with high levels of childhood and adult obesity.

Both cities have taken significant steps to expand active travel infrastructures. Furthering these efforts could entail added focus on expanding this infrastructure with community guidance in neighborhoods with high levels of childhood and adult obesity. Borrowing from other European and American cities may yield other feasible approaches. London's success in reducing traffic delays may eventually help New York to overcome political opposition to congestion pricing.

SCHOOLS

9. Implement a universal free school meal program with nutritional standards.

New York City already provides free breakfasts to all students and has found success in providing these meals in classrooms. The borough of Islington's decision to subsidize free school meals will provide an opportunity to assess implementation issues and benefits. Free, nutritious and tasty school meals can encourage life time good food habits, reduce competition from unhealthy food outlets, and reduce socioeconomic disparities in access to healthy food. In addition, by linking school food to nutrition education and by engaging parents in school food programs, schools can play an important role in establishing healthier lifetime food choices.

10. Provide tap drinking water in schools by improving infrastructure for water delivery.

Tap water is a cost effective and calorie-free alternative to other beverages served in schools. Creating an infrastructure for delivering filtered water that students and teachers can collect and drink from re-usable containers promotes both human and environmental health. Since sweetened beverages play a key role in obesity, offering free, accessible alternatives may help to reduce soda use.

RESEARCH AND TRAINING

11. Promote research that helps cities understand how to best address health inequalities and childhood obesity

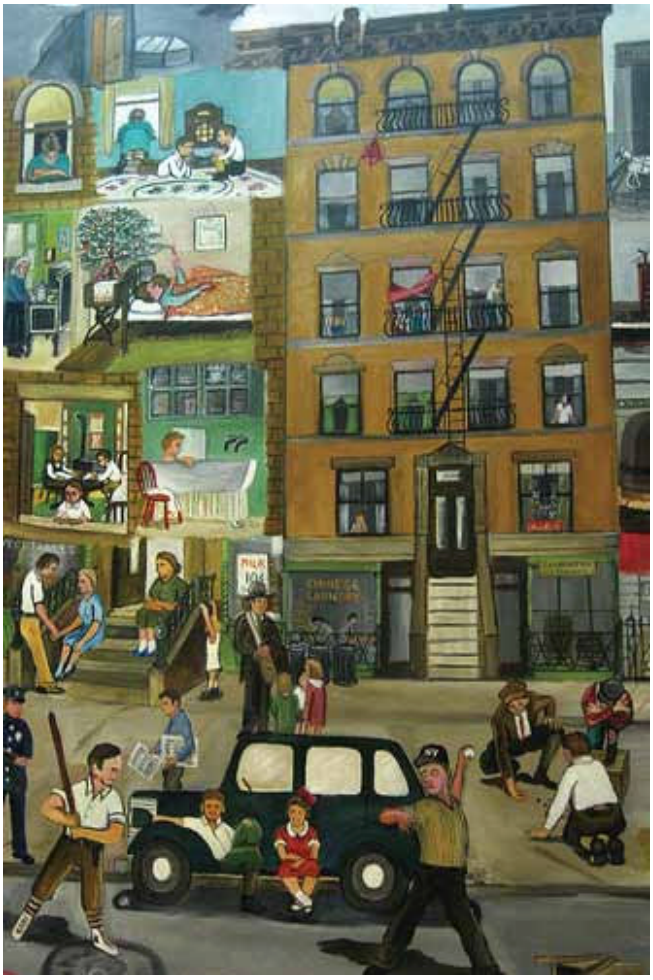
London and New York should cooperate in using their data and research capacities to inform future obesity reduction activities and inform other cities' efforts. By continuing to improve the data systems that monitor childhood obesity, health officials can track citywide prevalence of childhood weights as well as the changing dynamics of social, economic, and geographic disparities. In addition, in partnership with universities, the cities can track the cost and health equity impact of municipal policies and programs that address childhood obesity and disseminate this work internationally. By studying the impact of food advertising and designing and evaluating interventions to counter its adverse effects, the cities can help diminish a powerful influence on obesity. Many professionals, including health providers, educators and youth workers, can contribute to reducing obesity and new efforts are needed to develop and evaluate the needed training programs. Finally, by using urban planning as a tool for changing the built environment to promote health, the cities can foster collaboration between local planners and urban designers, city level planners, health care researchers and providers, and communities.

Table 3. Summary of Recommendations by Sector

Recommendations	Key Actors	
	London	New York
Land use and planning		
1. Use zoning authority, land use review and other municipal authority to limit access to fast food and the promotion of unhealthy foods to children. 2. Use zoning, tax incentives, and publicly owned property to increase the availability of healthy, affordable, and culturally appropriate foods in neighborhoods where it is limited. 3. Incorporate active design principles into building codes, housing strategies, and neighborhood planning.	Mayor's London Plan London Councils Mayor, HCA	Dept of City Planning, Mayor, City Council
Food		
4. Set standards for municipal purchase of food in public agencies and leverage economies of scale to promote food systems that support economic, environmental, and human health. 5. Redefine food safety standards to reflect current threats to health and use the municipal food safety workforce to promote healthier eating.	Mayor London Councils London boroughs' environmental health officers	Mayor, Dept of Health, , Board of Health, food businesses, consumers
Parks and green space		
6. Promote and support urban agriculture as a sustainable and health promoting use of green space. 7. Increase access to and safety of places where people can be physically active.	Mayor and Metropolitan Police	Mayor, Dept of Parks and recreation, advocates
Transportation and Physical Activity		
8. Promote walking and cycling in neighborhoods with high levels of childhood and adult obesity.	Mayor and TfL London Council	Mayor, Dept of Transportation, Metro Transport Authority
Schools		
9.Implement a universal school meals program with nutritional standards that promote health 10. Provide drinking water in schools by improving infrastructure for tap water delivery and bathrooms	Department for Children, Schools and Families. London Councils	NYC and State Depts of Education; food, parents and youth advocacy groups
Research and training		
11. Promote research that helps cities understand how to best address health inequalities and childhood obesity by: • Developing and improving the data systems that monitor childhood obesity so that cities can track and report citywide prevalence as well as information about social, economic, and geographic disparities; • Tracking the cost and outcomes of municipal policies and programs that address childhood obesity and disseminate this work internationally; • Documenting the adverse impact of food marketing practices on children and designing and evaluating strategies to reduce this influence; • Finding the best ways to prepare health providers, educators and others to reduce childhood obesity; and • Using urban planning as a tool for assessing and changing the built environment to promote health.	NHS/PCTs London Health Commission London Health Observatory London Met Academics	Mayor, Dept of Health, universities, researchers

CONCLUSION

Today, both London and New York and their city governments deserve credit for taking action on many fronts to reduce childhood obesity. Few experts believe, however, that current levels of effort are sufficient to avert the growing health, social and economic costs that childhood obesity imposes on our cities. To actually improve health, the modest and small-scale changes that have begun will need to be expanded, strengthened and sustained. Our children and grandchildren depend on us to develop the policies, programs and environments that assure their health and close the gaps in well-being that now divide our cities' residents. By confronting childhood obesity directly, London and New York can show other cities around the world that just as our societies created the conditions that led to rising rates of obesity, so can we reverse this global trend. A Tale of Two ObesCities suggests some steps we can take to realize these obligations and opportunities.



Growing up in New York City, 1926-1938
Adolescent Years in New York City, 1934-1944
Robert Burghardt | 1982-1984
Oil on canvas | Collection of Mrs. Robert Burghardt, 04.38.1-2

APPENDICES

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APPENDIX 2 DEFINITIONS AND MEASUREMENT OF CHILDHOOD OBESITY

Note on definitions: There is debate about defining overweight and obesity for children and how to develop internationally relevant standards for population based monitoring of weight in young people. In the US, childhood obesity is defined and measured using Body Mass Index (BMI) and growth charts developed by the Centers for Disease Control (CDC). Specifically, young people between the ages of 2 and 18 who have BMIs equal to or greater than the 95th percentile of the age and gender specific BMI charts developed by the CDC are defined as obese. In England, the National Child Measurement Programme also uses BMI to define childhood obesity. Prevalence rates are calculated by referencing BMIs to age and gender specific UK National percentile classifications, again using the 95th percentile to define obesity and the 85th percentile to define overweight. Making international comparisons of childhood obesity prevalence is complicated by the fact that the growth charts that underlie the percentile classifications may be based on nation specific reference populations. The World Health Organization and the International Obesity Task Force (IOTF) have each developed international references for childhood obesity. The IOTF standard is based on pooling international data on children's growth and weight. London Met researchers have shown that waist circumference gives a more accurate and reliable measure of body fatness than BMI. This measure is more sensitive to differences amongst ethnic minority groups, and a better marker than BMI for risk for type 2 diabetes.

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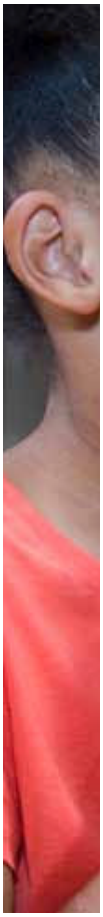


LONDON metropolitan university

CUNY The City University of New York

Subject: A Review of Childhood Obesity in London

Report Number: 7

Report to: Health and Public Services Committee

Date: 9 June 2010

Report of: Executive Director of Secretariat

1. Recommendation

1.1 **That the Committee agrees the terms of reference for the review into childhood obesity as outlined in paragraph 3.20.**

2. Background

2.1 This paper proposes that the Committee conduct a review into childhood obesity in the capital, focusing on the Mayor's role in tackling this problem.

Childhood obesity levels in London

2.2 One in five young Londoners is obese and one in three is either obese or overweight.[1] Childhood obesity levels in London are higher than the national average: 21 per cent of year six pupils in London are obese, compared to 18 per cent in England.[2]

2.3 Internationally, childhood obesity rates in England are significantly higher than those in some European countries such as France, Denmark and Germany but are lower than those in the USA and some Southern European countries.[3] However, definitive international comparisons are difficult to make because data from different countries covers different age groups and years.

2.4 Levels of obesity vary across the capital. In general, inner London boroughs have higher rates of obesity than outer London boroughs. Worryingly, the levels of obesity in Southwark, Tower Hamlets and Lambeth for 10-11 year olds are higher than anywhere else in the country.[4] Figure 1 overleaf shows childhood obesity rates in different areas of London.

2.5 Childhood obesity levels are higher in deprived areas, and in areas where there are large populations of certain BAME groups. The proportion of young Londoners from the most deprived households who are obese (26 per cent) is almost twice as high as the proportion from the least deprived households (14 per cent).[5] Obesity is more common among certain

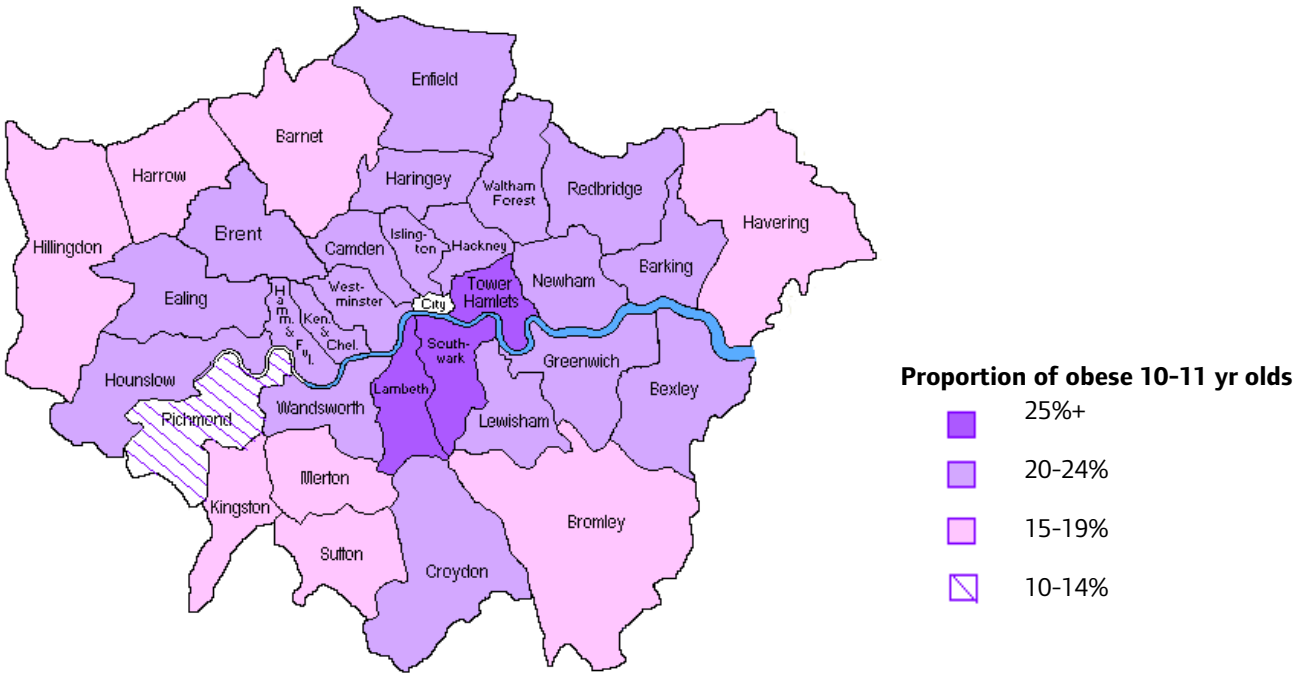
[1] Health Survey for England, 2008- data shows that for Londoners aged 2-15: 18% of boys and 20% of girls are obese and 31% of boys and 32% of girls are either overweight or obese. Overweight is defined as being at or above the 85th and below the 95th percentile for Body Mass Index (BMI). Obesity is defined as being at or above the 95th percentile for BMI.
[2] National Child Measurement Programme 2008-09 – Table 3 – Percentages of Year 6 pupils classified as obese
[3] International comparisons of obesity prevalence, 2009, National Obesity Observatory
[4] National Child Measurement Programme 2008-09 – Table 3 – Percentages of Year 6 pupils classified as obese

[5] London Analysis of the 2007-08 National Child Measurement Programme; London Health Observatory

ethnic groups in London, including those from Pakistani, Bangladeshi, Black Caribbean, Black African, Other Black groups, and Other White groups (not British or Irish).[6] The correlation between obesity, deprivation and certain ethnic backgrounds helps to explain the extremely high rates in Southwark, Tower Hamlets and Lambeth, which have high deprivation levels and large populations of these ethnic groups.[7] However, the correlation between obesity and ethnicity is complex – children from Chinese, Indian and White and Asian Mixed groups are significantly less likely to be obese than the London average.[8] Plus, on average, adults from BME communities tend to eat more healthily (consuming less fat and more fruit and vegetables) than the rest of the population, but do less physical activity.[9] It will therefore be useful to further investigate the relationship between childhood obesity and ethnicity in this review.

2.6 The prevalence of childhood obesity has increased significantly in recent years. The proportion of boys in London classified as obese rose from 14 per cent in 1996-98 to 18 per cent in 2008, and the proportion of girls classified as obese rose from 14 to 20 per cent over the same period.[10] However, there are some signs from national and London data that the proportion of children who are overweight or obese has been flattening out in the past few years, although analysts believe that more years' data are needed before long-term trends can be clarified.[11]

Figure 1 – Proportions of 10-11 year olds who are obese by London borough[12]



[6] Weighty Matters – the London findings of the National Child Measurement Programme 2006-8, 2009, LHO
[7] 2009 London Borough Stat Pack, 2009, Greater London Authority http://www.london.gov.uk/who-runs-london/mayor/publications/society/facts-and-figures/borough-stat-pack-2009/boros2009#03c
[8] London Analysis of the 2007-08 National Child Measurement Programme; London Health Observatory
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[10] Health Survey for England 2007, 2008 data for 2-15 year olds - Figures from previous years listed in 2007 survey
[11] Health Survey for England 2008; National Child Measurement Programme 2006-07; 2007-08; 2008-09; http://www.heartforum.org.uk/downloads/Child_Obesity_short_Oct_09.pdf
[12] National Child Measurement Programme 2008-09 – Table 3 – Percentages of Year 6 pupils classified as obese

The causes and effects of childhood obesity

2.7 The rise in obesity in recent years has been caused by changes in eating patterns and levels of physical activity.[13]

- Fewer than one in four young Londoners eat the recommended five portions of fruit and vegetables a day.[14]
- Only one in three boys and one in four girls in the capital meet the recommended level of sixty minutes of physical activity per day.[15]
- Half of boys and six in ten girls did not participate in any formal sport in the past week, according to a national survey.[16]

It is therefore clear that more work is needed to get young Londoners to get active and eat healthily.

2.8 There are a number of factors contributing to low physical activity levels and unhealthy eating including:

- Feeling unsafe. Young Londoners in many boroughs feel less safe in their local area and on their way to and from school than young people in other areas. This is likely to affect how much they walk or cycle in their area, as well as whether they are happy going to local parks to play or participate in sports.[17]
- The increase in sedentary activities. Popular activities such as playing computer games and watching TV contribute to low levels of physical activity.[18]
- Difficulties of providing a healthy diet. The low price and easy availability of 'junk food'; a lack of knowledge and confidence about cooking healthy meals, and the perceived cost of healthy food all affected parents' and carers' choices about what food they gave their children.[19]
- The lack of understanding about weight and health. Most parents do not make the link between a child's unhealthy weight and long-term health,[20] which could limit whether and how they address any weight problems their children have. Most young Londoners also have positive views about their health - 96% of people aged from 11 to 16 say that their health is either good or very good. The remaining 4% think that their health is fair. None think their health is bad.[21]
- Difficulties in getting people to change their behaviour around diet and physical activity[22].

[13] Preventing Childhood Obesity, 2005, British Medical Association
[14] Health Survey England, 2008: among 2-15 year old Londoners, 24 per cent of girls and 23 per cent of boys eat five or more portions of fruit and vegetables a day. The World Health Organisation promotes the consumption of fruit and vegetables to help maintain a healthy weight. http://www.who.int/dietphysicalactivity/media/en/gsfs_obesity.pdf
[15] Health Survey England, 2008: among 2-15 year old Londoners, 33 per cent of boys and 24 per cent of girls do at least 60 minutes of physical activity every day. Physical activity includes walking, sport, active play, cleaning and gardening.
[16] Health Survey England, 2008: among 2-15 year olds in England, just 49 per cent of boys and 38 per cent of girls did any formal sports or activities in the past week. Formal sport includes football, tennis, swimming, running, athletics etc.
[17] Tell us 3 – survey of Year 6,8 and 10 pupils available at www.ofsted.gov.uk
[18] Preventing Childhood Obesity, 2005, British Medical Association; Healthy Weight Healthy Lives Strategy, 2008, Department of Health and Department of Children Schools and Families
[19] The Effect of Fast Food Restaurants on Obesity; Currie, J et al, 2009, available at http://elsa.berkeley.edu/~sdellavi/wp/fastfoodJan09.pdf Healthy Weight, Healthy Lives: Consumer Insight Summary, 2008, Department of Health and DCSF; Healthy Weight Healthy Lives Strategy, 2008, Department of Health and DCSF
[20] Healthy Weight, Healthy Lives, One Year On, 2009, Department of Health and Department of Children, Schools and Families
[21] Young Londoners Survey 2009, GLA
[22] Tackling Obesities: Future Choices – Foresight Project Report; 2007, Government Office for Science; Commissioning and Behaviour Change, Kicking Bad Habits Final Report; 2008; King's Fund

2.9 Childhood obesity can impact on a number of different aspects of health and well-being. Obesity in childhood is a risk factor for heart disease, some cancers, osteoarthritis and diabetes. These are no longer just long-term risks since many obese children are now developing type 2 diabetes.[23] Childhood obesity can also lead to psychological problems including low self-esteem and depression.[24] Obese children are more than twice as likely to become obese adults, so preventing child obesity can be an important tool in promoting adult health.[25]

2.10 Obesity is also a major drain on the nation's finances. The Department of Health estimates that obesity costs the NHS £4.2 billion a year, and costs the wider economy around £16 billion a year.[26]

3. Issues for Consideration

3.1 There are a number of strategies and initiatives that aim to reduce childhood obesity through encouraging healthy eating and physical activity which includes everyday activities such as walking and cycling as well as formal, organised sport.

Relevant Mayoral strategies and initiatives

The Mayor's Health Inequalities Strategy

3.2 The Mayor published his Health Inequalities Strategy in April 2010. This strategy's delivery plan contains a number of proposed actions to tackle childhood obesity including: developing a city-wide schools challenge to get children more active; working with partners to reduce the fear of crime in public spaces; supporting delivery of new and improved facilities for sport, play and physical activity; expanding support for initiatives that build skills for healthier cooking and eating; and improving the availability and affordability of healthy food. The press release issued with the consultation draft of the Health Inequalities Strategy focused on the initiatives in the strategy to tackle childhood obesity, with the Mayor stating:

> *"My perfect 2012 legacy would be a leaner, fitter London and I want us to work swiftly towards the elimination of childhood obesity."* Boris Johnson, September 2009

The Mayor's Food Strategy

3.3 Healthy and Sustainable Food for London is the Mayor's Strategy to improve London's food and reduce the environmental impact of the food industry. The budget for delivering the Mayor's Food Programme is £4.8 million over three years from 2009-10 to 2011-12. One of its aims is to improve Londoners' health through food. A number of the initiatives in the strategy and its implementation plan are relevant to efforts to tackle childhood obesity. For example, one of the initiatives in the implementation plan is a training programme to train public sector caterers and procurement managers to provide healthier food to schools and hospitals.[27] A new implementation plan is due to be produced in autumn 2010.

The Mayor's Sports Strategy

3.4 'A Sporting Future for London', published in 2009, sets out the Mayor's vision to create a fitter, healthier, more active London, backed up by a £15.5 million investment from the London Development Agency in grass-roots sport. The strategy aims to secure a sustained increase in Londoners' participation in sports.

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[23] House of Commons Health Select Committee Report on Obesity, 2004, from www.publications.parliament.uk
[24] Preventing Childhood Obesity, 2005, British Medical Association
[25] A Tale of Two Obescities, 2010, City University of New York and London Metropolitan University
[26] http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Obesity/DH_078098 . This figure includes the costs of both adult and child obesity
[27] *Healthy and Sustainable Food for London,* 2007, London Food

The London Plan

3.5 The Draft London Plan contains several policies relevant to tackling obesity including policies to encourage greater use of cycling and walking, a policy for supporting development proposals that increase or enhance provision of sports and recreation facilities; and a policy to protect allotments and encourage new food growing spaces. The Supplementary Planning Guidance on Play and Informal Recreation also includes a standard for new housing developments to include at least ten square metres of play space per child.

Other Mayoral initiatives

3.6 Other initiatives that the Mayor is involved with to tackle obesity include:

- The London Health Commission's Well London Projects in 20 of the most deprived neighbourhoods in London. These projects aim to improve healthy eating through improving access to fresh and healthy food (Buy Well), and through encouraging local people to develop their cooking skills (Eat Well). The projects also aim to encourage local people to be more active by improving local open spaces, increasing the range of sports and active recreation activities available to the community through signposting existing opportunities and delivering new activities. The projects are led by the local community in collaboration with a range of partner organisations.
- Capital Growth Project – this Mayoral project aims to set up 2,012 new food growing spaces by 2012. One aspect of this project is a schools food growing competition.
- Transport for London active travel to school programme – this includes a 'Walk on Wednesdays' campaign and a Junior Road Safety Officer scheme that teaches children about street safety and encourages them to walk and bike more.
- The Big Dance Biennial Festival – which aims to encourage Londoners to get involved in and learn about dance.
- The annual London Youth Games - this involves 20,000 young Londoners representing all London Boroughs, and participating in 30 different sports. The Games is run by a charity, supported by partners including the Mayor, Boroughs, and London Councils.
- Other projects to encourage participation in sports and physical activity include the "Make a Splash" mobile swimming pools project, Street Athletics for disengaged and disaffected young people and the Panathlon Challenge to get young disabled people involved in competitive sports.

National strategies and initiatives

Healthy Weight, Healthy Lives

3.7 This is a joint Department of Health and Department of Children, Schools and Families Strategy that aims to: *"reverse the rising tide of obesity and overweight in the population… Our initial focus is on children: by 2020 we will have reduced the proportion of overweight and obese children to 2000 levels."*[28] Healthy Weight, Healthy Lives focuses on five main policy areas – promoting children's health; promoting healthy food; building physical activity into everyday life; supporting health at work and providing incentives more widely to promote health; and providing effective treatment and support when people become overweight or obese.

3.8 Change4Life is a major component of the Healthy Weight, Healthy Lives Strategy. It is a £75 million national social marketing campaign that aims to encourage people to eat more healthily, become more active, and live longer. The first phase of Change4Life is focusing on

[28] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_084024.pdf

pre-teen children and their parents and aims to give families the simple tips and tools they need to eat better and do more activity. The programme has involved national TV advertising, a 'How are the kids?' leaflet encouraging people to sign up to the Change4Life Programme to get recipes, and tailored action plans for individual children.

Other national initiatives

3.9 Healthy Schools is a national programme to improve the health of school pupils through a range of initiatives on healthy eating, physical activity and emotional well-being. Schools wanting to achieve 'Healthy Schools' Status have to meet a range of criteria such as a Whole Schools Food Policy. The majority of London schools have achieved Healthy Schools status, and the programme is co-ordinated on a regional basis.

3.10 The Schools Food Trust is an independent charity set up by the Government to improve school food and food preparation skills, increase take up of school meals and decrease diet inequalities. It also provides information to schools about the required nutritional standards for school food and how these can be met.

3.11 The Youth Sports Trust and Sport England are working together to deliver the 'Five Hour Offer' to all school pupils. This offer should ensure that all school pupils have two hours of sport and other physical activity a week within school time and are offered a further three hours a week outside it.

Local strategies and initiatives

3.12 In addition to the national and regional strategies, boroughs also have their own strategic approaches to tackling obesity. Many, including Barking and Dagenham, Tower Hamlets, Wandsworth, Greenwich and Southwark have obesity strategies. Others, such as Barnet and Lambeth include actions to tackle obesity in Local Area Agreements, or other strategies.

3.13 Tower Hamlets is one of nine national "Healthy Towns" to receive central government funding, as part of the Healthy Weight, Healthy Lives Strategy. The Tower Hamlets Healthy Borough Programme is piloting environmental approaches to make it easier for people to eat healthily and be active.

Details of the proposed investigation

Other work in this area

3.14 A number of other projects could be relevant to this project

- The Economic Development, Culture, Sport and Tourism Committee (EDCST) is planning to conduct a review into the Olympic legacy commitment to increase sports participation during 2010/2011. This review is likely to focus on progress in meeting the targets for increasing participation in sport, and further work needed to meet these targets by 2012.
- The London Healthy Weight, Healthy Lives Taskforce compiled a report in 2008 that aimed to identify what action was needed to tackle obesity. The report included a recommended list of actions to tackle obesity at a regional level, some of which have been taken through to the Health Inequalities Strategy.[29]
- The London Obesity Learning Centre has recently conducted an assessment of PCT and local authority strategies in the capital, and is working to develop an effective evidence base of local initiatives in the capital. The Obesity Learning Centre was set up by the National

[29] The Mayor of London's Health Inequalities Strategy, April 2010, GLA; A Tale of Two Obescities, 2010, City University of New York and London Metropolitan University

Heart Forum and is supported by the Department of Health and Department of Children, Schools and Families.

- A Tale of Two Obescities is a 2010 report by City University of New York and London Metropolitan University that compares responses to childhood obesity in the two cities and makes recommendations for how the cities can learn from each others' initiatives for tackling obesity. This report also outlines the evidence for the effectiveness of different kinds of initiative to tackle obesity.
- The Change 4 Life social marketing programme included a large scale analysis of consumer views on what messages are effective in achieving behavioural change and getting people to eat more healthily and become more active.
- GO London is an NHS London initiative to get Londoners more physically active, linked to the Change 4 Life programme. However, this initiative is only aimed at people aged 16 and above.
- IDeA and Policy Exchange have both produced information about good practice in tackling obesity. The good practice examples included in the Policy Exchange report include evaluation data showing that particular projects work in tackling obesity.
- The Government Office for Science published a Foresight Report into Tackling Obesities in 2007. This includes details of the evidence on what works in tackling obesity. It outlines the complex and varied factors that influence behaviour, what can work in achieving behavioural change, and the barriers to achieving it. It states that changing the environment through urban design, planning regulations and increasing the availability of healthy food could be one of the most important strategies for increasing physical activity and healthy eating.

The need for this review

3.15 It is clear that childhood obesity is a major public health issue for London. London's children are more likely to be overweight or obese than children in other parts of England, and in some boroughs more than one in four 10-11 year olds is obese. Most young Londoners do not do enough sport and other physical activities to meet government guidelines, and only a small minority eat enough fruit and vegetables. The impacts of obesity on individual physical and mental health are extremely serious; both in the short and long term. Obese children are twice as likely to become obese adults compared to other children, at higher risk of diabetes, heart disease and some cancers.[30]

3.16 The long-term financial costs of dealing with obesity are huge, and are likely to rise in the future, meaning that tackling obesity must be a priority. Plus, the large sums of money being invested in tackling childhood obesity mean that it is important to ensure that initiatives are adding value rather than duplicating other initiatives.

3.17 In order for the review to have a manageable focus, and add the most value, it would seem best to focus on the range of initiatives the Mayor is involved with to help tackle childhood obesity, rather than trying to look into the plethora of other local, regional and national initiatives. The Committee could therefore conduct a review on the Mayor's role in tackling childhood obesity looking at how the Mayor's work fits in with other local, regional and national initiatives, the vision behind the Mayor's work, the sustainability of the Mayor's approach, and whether there is anything else the Mayor should be doing to tackle obesity.

3.18 It will be important for any London Assembly review to complement rather than duplicate the existing body of work outlined in paragraph 3.13. Most notably:

- The London Healthy Weight, Healthy Lives Taskforce looked at what further work was needed to tackle obesity at a regional level in 2008. Their report will therefore provide a

[30] A Tale of Two Obescities, 2010, City University of New York and London Metropolitan University

useful starting point for this review. However, the Taskforce did not scrutinise the effectiveness of the Mayor's existing work to tackle obesity, and because it was conducted two years ago, it does not include information about relevant new Mayoral strategies and initiatives such as the new Health Inequalities Strategy and the new draft London Plan.

- Liaison with representatives of the EDCST Committee will be used to ensure that their review into sports participation complements this review as much as possible.

Age range for the review

3.19 It is suggested that the review focuses on children aged 0 to 15. It would be valuable for this review to look into obesity from birth onwards, because evidence shows that nutrition and weight during the early years can have a lasting effect into adulthood. Young people aged 16 and above are often covered by adult initiatives on obesity (such as the Go London initiative), and therefore would be beyond the scope of this review.

Suggested terms of reference

3.20 To review the Mayor's role in tackling obesity among young Londoners (aged 0-15) trhough encouraging healthy eating and participation in sport and physical activity by focusing on the following questions:

- What strategic role should the Mayor have in tackling obesity?
- How does the Mayor's work fit within the national, regional and local context of work to tackle obesity?
- What is the overall vision behind the Mayor's initiatives to tackle obesity?
    - Why has the Mayor chosen to take forward this range of initiatives?
- Is there anything else the Mayor should be doing to help tackle child obesity?

Methodology

3.21 There should be three main phases to this review: a call for written views and information; a formal meeting with Mayoral representatives and other key stakeholders such as obesity experts; and a site visit to a good practice initiative to tackle child obesity.

Suggested timetable

3.22 A new implementation plan for the Mayor's Food Strategy will be published in autumn 2010. The Health Inequalities Strategy First Steps to Delivery Plan was published in April 2010, and a further action plan is likely to be published in autumn 2010. It would therefore seem sensible to conduct this review from late summer 2010 to winter 2010/11 to ensure that information from these new plans can be fed into the project.

3.23 The table below sets out a suggested timetable for the review.

Stages	Timings
Project launch	June 2010
Call for views and information	July to September 2010
Site visit	October 2010
Formal meeting/s	November 2010
Report launch	February 2011

4. Strategy Implications

4.1 This review will be relevant to the Health Inequalities Strategy that the Mayor is obliged to develop under the new responsibilities given to him by the Greater London Authority Act 2007. The review will also be relevant to other Mayoral strategies, including A Sporting Future for London (The Mayor's Sports Strategy), Healthy and Sustainable Food for London (the Mayor's Food Strategy) and the London Plan.

5. Legal Implications

5.1 The Committee has the power to do what is recommended in this report.

6. Financial Implications

6.1 There are no financial implications.

Background Papers: None

Contact: Susannah Drury, Scrutiny Manager: 020 7983 4942

Health and Public Services Committee

3 November 2010

Transcript of Item 4: Childhood Obesity in London

James Cleverly (Chair): We move onto the main part of the meeting which is our investigation into the levels of childhood obesity in the capital and an investigation into the Mayor's role in helping to reduce this. I would like to thank all our guests for coming. We have guests from a wide range of organisations here, from both within the Mayoral team, from industry and from communities and academics. Could you efly introduce yourselves and the organisations that you represent.

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): My name is Andrew Emmerson. I am the Business Development Director for Domino's Pizza Group; I am responsible for franchising and finding new stores across the UK and Ireland.

Paul Sacher (MEND and University of London): My name is Paul Sacher. I wear a number of hats. I am Chief Research and Development Officer for Mind, Exercise, Nutrition, Do it! (MEND) MEND is a social enterprise based in London. We are the largest provider of child weight management services worldwide. I am also a Senior Research Fellow and Head of MEND Research at the University College London (UCL) Institute of Child Health as well as a principal specialist paediatric dietician at Great Ormond Street Hospital.

Kimberly Libman (City University New York): Good afternoon, I am Kim Libman, I am a researcher at the City University of New York, I am also on the faculty of the New School in their Food Studies Department.

Kate Hoey MP (Mayor's Sports Commissioner): I am Kate Hoey, the Member of Parliament for Vauxhall and the Mayor's Commissioner for Sport, particularly relating to grass roots legacy from the Olympics.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I am Pam Chesters, the Mayoral Advisor for Health and Youth Opportunity. We are going to be joined by Rosie Boycott, who is the Chair of the London Food Board and part of the Mayor's team.

James Cleverly (Chair): I think the most fundamental question that we need to look at is: why is childhood obesity worse in London than in any other part of the country?

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I suppose there are two main points to that question: one, what is happening in London, and the second point is: to what degree does it really matter? It is helpful to understand it; but, actually the issue is how we get on and deal with it.

In terms of childhood obesity, I think we would say it has multiple and complex causes. It is not simply a question of, at its most simplistic, eating too many calories and exercising too little. A fair amount of research is known about the risk factors which contribute to the situation which we have, which can include pre- and post-natal behaviour by mothers. Factors such as the normalisation of perception within cultural and peer groups in terms of what people perceive to be weight issues, and a societal shift actually towards weight gain as being seen as different to what it was perhaps in the past.

There is some academic research, a piece of work which was done in New York, that suggests that new immigrant communities, with newly gained affluence and an unfamiliarity with the food available in the country to which they came, changed their eating habits. It changed it in a way that is not always necessarily helpful for this particular agenda. Of course, advances in food production have meant that more fast food, some of which has high calories, salt and saturated fat, is not necessarily obvious to the purchaser on behalf of the child. They all have a part to play as, indeed, do some of the wider issues, such as links to deprivation.

There are indicators which would suggest that in London we have differential issues amongst our ethnic communities. This can be seen with the black ethnic community, which has a higher rate of childhood obesity than, for instance, the white community.

I think the factors are multiple and complex. I go back to saying, from the Mayor's point of view, we would not set ourselves up to be experts in determining these factors. What we would be seeking to do is galvanising people to being mindful of where we are, and seeing what we could do to improve the situation that we are in.

Kimberly Libman (City University New York): I would also just like to add, as Pam has noted, the factors influencing childhood obesity rates are multiple and complex. However, not everybody's children have the same likelihood of becoming overweight or obese. The academic evidence shows that people who come from poorer backgrounds and certain minority ethnic groups are more likely to become overweight or obese.

It is just a simple fact, that you have greater concentrations of those communities living in world cities like London and New York. I think that that is really just the simplest reason why you have higher concentrations here in London.

Rosie Boycott (Chair of London Food Board): Just to add to that. You get this enormous range: in Richmond it is only 12% in Year 6 that are overweight, whereas in Southwark it is up to 27%; you begin to get a kind of obesity spiral. As poverty means that the shops are not selling vegetables, they are selling more cigarettes, they are selling more stuff, and then Waitrose or Marks and Spencer would not dream of coming in there. Therefore, it winds down so that actually it is extremely hard for someone, even if they want to do it, to go and get vegetables.

I think that it is true what Pam [Chesters] was saying, certainly in terms of ethnic communities and people who are coming here as first generation immigrants; they are not cooking because they cannot necessarily find the ingredients. We certainly find in our growing spaces that a lot of people who have, say, come from Pakistan or Bangladesh, they want to grow their herbs and once they do they start cooking again.

James Cleverly (Chair): One of the big challenges I suppose with any piece of research is looking at cause and effect. So, whilst we recognise that there are differentials in terms of ethnicity, income levels and that kind of stuff, and London has higher proportions of communities that fall into those groups: are we where we are because those groups are inherently more likely or circumstantially more likely to have childhood obesity as a problem and we have lots of those communities in London? Or is it a fact that London, by its geography or whatever, detrimentally affects those people disproportionately?

I suppose, by extension, the other question that I might want to ask is: people from similar demographic and ethnic groups in another part of the country, do they suffer as badly as they do here London? So, is it London doing it to them or is it, as it were, them doing it to London?

Kimberly Libman (City University New York): That is a great question. I think I am inclined to say that it is a bit of both. If there is one thing that has been clear with the major reports like the

Foresight Report, it is that there are lots of influences, and they are all mutually reinforcing; I think it is probably a bit of both.

I am not an expert on what is happening in the outer parts of the country, my focus is really on urban environments and urban communities. I do not really feel like I am the best person to make that kind of comparison.

James Cleverly (Chair): I have not had a chance to go through your report in as much detail as perhaps I should have done or I would have liked to have done. However, there are certainly correlations between what goes on in London and what goes on in New York; are there any significant points of differential necessarily or is it an urban thing perhaps?

Kimberly Libman (City University New York): I think the way that epidemics have been evolving have been remarkably similar; with the one in New York we are just a little bit ahead of you, so our rates are slightly higher. I think in both places there is some evidence that the increase in childhood obesity maybe plateauing. It is still an open question whether or not this is a statistical artefact, or, whether or not this is a result of just maxing out the genetic proclivity that people have for becoming obese - it just cannot go on with the rates going up and up forever. Also, there is some optimism that maybe the widespread action to try to tackle obesity and bring down these rates has just begun to show some results.

I think in both places you are seeing very similar patterns in terms of the time that obesity sets in and the dynamics between gender and age.

Andrew Boff (AM): I do not want to get too bogged down in statistics, but I am trying to understand where this comes from. Do you have any statistics, for example, for higher income groups and whether or not there is a difference amongst the higher ethnic groups? You could then say, "Well there is a real issue with regard to particular ethnic groups," rather than unfortunately, of course, when a lot of ethnic groups are in that lower quartile of earnings it is, therefore, difficult to get a handle on this. Or, whether or not we are just talking about people's earnings or whether or not we are talking about cultural differences for the many groups that make up London's diverse capital.

Kimberly Libman (City University New York): That is again a great question. In New York I can tell you that we have just collated our first round of city-wide data on children's obesity and rates of being overweight. It is geographically coded based on where they go to school, but we do not actually have data looking at this kind of very detailed breakdown about the children's backgrounds. To my knowledge, I do not think that people have done any fine-grain analysis, specifically, just for London. I do not know.

Paul Sacher (MEND and University of London): My understanding is that in areas in London and across the UK we obviously collect what is called data from the National Child Measurement Programme (NCMP). All children are measured at school entering Year 6. We know what school the children go to, but we do not know, for example, what the total income of the family is. So, we do not have data down to that level, so, it is very hard to understand the question.

Andrew Boff (AM): It is difficult to try to see where the issue is: whether or not it is a cultural one, whether or not it is an economic argument and if these are the main drivers, or whether or not it is both. Without that kind of detail, it is a bit hard to know where the problem really lies.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): Paul is right. I do not think I have ever seen anything that would allow you to do it with that degree of fine grain. I guess you could say if you have got 21% of children in Year 6 coming into that category, how much does it really matter? It does, but it does not. We know there is a very large problem; we know it is a problem that is not going away; if anything it is moving in the wrong direction. So, I

think the focus needs to be - this is from our perspective - to look at what interventions would make a difference. It is interesting intellectually but I do not think it is the --

Andrew Boff (AM): I understand; it is where you make the interventions, that is the point. We are going to discuss that later on: whether or not you need to make interventions, and where you make those interventions. If it is a worthwhile course of action to make an intervention just make sure that you are making it in the right place, rather than having a false target.

Paul Sacher (MEND and University of London): I think it is helpful when you are looking at child obesity to remember that children do not exist on their own, they exist as part of a family. I think the whole backdrop to this problem is that we are looking at obesity incidents in adults at between 50% and 60%, and we know that there is a very strong correlation between adult obesity, parent obesity and child obesity.

If a child has both parents that are at least overweight, so not even obese, they have about a 60% more chance of becoming obese themselves. I think it is important, when you are looking at targeting interventions, to just remember that children do not co-exist, apart from maybe at school or generally part of a much wider environment which is the family environment.

Andrew Boff (AM): I am ever so pleased that you have used that word 'parent'. I noticed in the recommendations, both from the Mayor's Healthy Weight, Healthy Lives action plan and indeed in the recommendations from a 'Tale of Two ObesCities', the word 'parent' does not come into it. I would have thought that is absolutely critical when you are talking about childhood obesity, that the parents should be in there somewhere; I am sure they were in the report.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): With respect to the Health Inequalities Strategy, obviously, we do talk about promoting effective parenting. It depends where you access it, it may not be under food, but absolutely the role of parents is a feature. Section 1.1.1 probably gets you there, but it is there Andrew, trust me!

Andrew Boff (AM): It is poor reading on my part then.

Navin Shah (AM): Whether it is there in the report or not, I do not truly, 100% agree with this whole issue about what parents could be doing. It is fine that the Mayor and other agencies etc have a role, but surely parents have a vital role to play. This is something we all need to collectively remember, and see what best we can come up with on that.

Going back to the black and minority ethnic (BME) grouping issue, I wonder if we have clear statistics or some picture emerging in terms of London wide boroughs. You have got for example, Newham, Tower Hamlets, the areas I represent in north west London, Harrow and Brent for example, where you have got substantially large BME communities. Whether there is that clear evidence emerging, that within those groups there is clearly disproportionately high incidence of obesity?

I do not know whether Rosie or Pam have got any real evidence of that.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): Taking the statistics a whole, I am happy to go away and see if we can dig out further ones. The top four boroughs in terms of Year 6 children at risk are Southwark, Tower Hamlets, Lambeth and Newham. I think if you want us to try to pull out further questions it would be really helpful outside of the meeting to be quite specific about what you find helpful to ask; then we can see whether it is available in a reasonable format.

Navin Shah (AM): I think that could be very useful, if we could look at the ethnicity of demography with each of the boroughs, and see how they rate, and then relate that to something

like a vitality profile for each of the boroughs, and then see how that relates to obesity. That is where in the matrix you will not just have the BME population, but in terms of the economic factors, housing and so on and so forth.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I defer to Paul [Sacher] but I am not sure in the way it is collected - because this is all based on NHS data - that would allow that ethnicity code to be read through.

Paul Sacher (MEND and University of London): I think there is the Health Survey for England data, but that is a bit old now. The most current data that we all seem to be working from is this NCMP which is collected at school by school nurses and then sent through to the Primary Care Trust (PCT) which then compiles it all and sends it off to the Department of Health.

I am also aware that the National Obesity Observatory has pretty detailed analysis on the different boroughs broken down by everything that you want to break it down with, depending obviously on what is collected. So, it is worth having a look that. There is also the Marmot Review[1] which was done recently, this review looked at health inequalities which, was very clear about this gradient in health between BME populations, income and deprivation.

Navin Shah (AM): I think this is going to be an important piece of work; when you consider dietary practices within certain BME communities, I think that is where the whole programme of awareness and how those dietary practices could be altered to reduce the level of obesity. Not only at childhood level, but I think it becomes a greater problem in terms of health inequalities at middle age or older ages. That is very clear when you look at the health picture of the BME communities at large.

Rosie Boycott (Chair of London Food Board): I think it is also really important to look at the distribution of the really cheap fast food outlets in the various boroughs. There are up to 23 to 24 fast food outlets within 10 minutes walk of a school gate. We ran a project which we now no longer do, which was called 'Buy Well' where we put fresh fruit and vegetables into Costcutter shops.

Talking to a lot of the councillors - these were in Tower Hamlets and some were in Southwark - in boroughs where there were very high obesity levels, the view was very much that it was the fifth meal, as such, was the killer. You could really influence the school - although that is another whole debate we can have as well - and you can work around the parents. However, while you have a situation that while you are walking along and for 50p to 70p you can get chicken and chips, you have a really big problem.

Walthamstow has tried banning them, other people have tried various things, but actually it is very difficult. I think it was Tower Hamlets that spent £130,000 on trying to say to all those fast food outlets, "Look, we will supply you with better oil, with this, that, and the other,", and they did not take it.

Navin Shah (AM): I certainly want to talk about that later on in our discussions, in terms of proximity of some of these outlets to schools; it is a very important issue.

Rosie Boycott (Chair of London Food Board): We have a project that we are doing to try to address that, but we will come onto it later.

[1] In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose strategies for reducing health inequalities in England.

James Cleverly (Chair): Before we move onto diet, which is where we are going next, Andrew brought up a point with regard to interventions. I am conscious this is the kind of question that could take up the next hour, but I want to try to limit it to perhaps just the next few minutes.

So, if we could go to the most significant opportunities. With regard to intervention, obviously we have the balance between diet and exercise; so, between calories in and calories out. We have discussed the nature of food, and food available already. What kind of interventions do you feel – as I say top line stuff – would be potentially the most effective? As we are looking at the Mayor's role in this, is the Mayor currently equipped to drive those interventions and, indeed, should he be equipped to drive those interventions?

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): There are a lot of questions in there. Can you set me off on one?

James Cleverly (Chair): If we had a magic wand and were able to say: "Here is the perfect intervention," – let us not constrain ourselves too much about what is legislatively or financially realistic for the time being; we will come onto that later – if we had that magic wand solution, what would be the intervention or interventions that we would put in place to help reduce childhood obesity in London?

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I think the opening thing I would say is: I do not believe there is one single bullet. I think if there were, cities around the world that had this problem would have cracked it. You do need that multi-faceted response from us: the Mayor's office – and I will talk more specifically about our role; the call to action, call to arms, talking to Londoners, engaging with partners alongside specific work on both food, what people do eat, how easy it is for them to buy it, sport and exercise from Kate's [Hoey] point of view. Also, very targeted interventions such as the one that Paul [Sacher] runs which we know is a very cost effective, good outcome programme.

I do not think any one programme will get us there. It is going to be a whole range of things, and it is about getting together all the partners who have a stake in this, which in London includes local authorities and the NHS in its ever changing format; it also includes the voluntary sector, and mostly importantly it includes families themselves, to work out with them what are the strands that would take us forward at pace.

James Cleverly (Chair): Does anyone have any strong criticisms of that point that was just made or want to dissent from that?

Paul Sacher (MEND and University of London): I do not have criticism; I have support. I think it is also important when you are looking at this issue to realise that there are two quite distinctive groups here. There are kids that, obviously, are currently a healthy weight, that are at risk of becoming overweight and obese. A lot of the adults we see who are obese were not obese as children, so there is obviously that risk.

Then there is also the third of children currently who are already overweight or obese. I think you need quite different strategies to deal with those two distinctive populations. Some are more focused on primary prevention, things done within schools and in the communities and social marketing.

Then you very much need evidence-based, outcome-driven interventions that have been proven to work, that are cost effective. These are specifically for those children or families that need the additional support around eating, physical activity and behaviour change.

Rosie Boycott (Chair of London Food Board): I would just make a couple of general points too: the new research that came out this summer from the University of Plymouth was that you get

fat, and then you stop exercising; they said food comes before lack of exercise, and once you are fat, to get you to exercise is fantastically difficult because you are humiliated, and you feel embarrassed about plodding along.

The other bit of new research which I find personally very exciting has come from California. It is the first time that it quantifies the effect of getting primary school kids, once they start growing vegetables, to see whether they do change their eating habits. It has always been anecdotally, people have said: "Of course they do" but, now it has been finally been proven by the University of California. There are many different statistics but one is:

> *"Where you have a school garden for primary kids, vegetable uptake was almost one serving per day greater in the schools with a beefed up food curriculum and combined fruit and vegetable consumption increased by 1.5 servings. 80% of this increase came from in season, home produced produce. In comparison, researchers found nearly a quarter serving drop in the produce intake among other students."*

So, I think it is a huge thing to do with involving schools, making food part of the curriculum, making, cooking and, understanding what is in the food you eat, and key to this, bringing the parents into the school. You are absolutely right; it is completely meaningless if you go home and get fed chips for the rest of the night. I think there is no work that seems to be being done, to bring those on a really concerted borough wide effort, to bring all those strands together.

Navin Shah (AM): I have got a cluster of three issues in terms of diet: one is the role of the Mayor in terms of promoting healthy food. The second one is about planning; like Rosie mentioned, issues about proximity of some of those fast food outlets. The third one is a special initiative in terms of breast feeding and the impact of that.

Starting with the first one on the Mayoral role: what was very interesting on a Saturday recently, we had a group of young pupils who came over, aged from about 7 to 14 or so; they were very excited about the idea of training school cooks to provide healthy meals; so, we had some interesting feedback. The first question is: what do we know about the relative cost effectiveness of programmes such as food growing, such as training cooks in schools, as well as working with shops?

Kimberly Libman (City University New York): In terms of cost effectiveness?

Navin Shah (AM): Cost effectiveness, yes; so, something which our Mayor can promote and consider within his duties.

Kimberly Libman (City University New York): I will connect my answer to this with what I wanted to say about the previous question; that is: from an academic perspective, the results of most of these intervention studies are pretty dismal. If you are looking for statistically significant results, most intervention studies do not find them, particularly when they are looking at interventions that are taking place at this community level.

If you are looking at things that are happening on an individual level, where you are doing very intense behaviour modification training, and you are teaching young people to eat better and getting them to exercise more: these are the targeted approaches that are working to treat young people who are already overweight or obese. There are some strategies that work there. Individually, any one of these strategies for reducing population levels of obesity: a) there are not really cost effectiveness studies on them and b) individually they do not really do much.

The one promising approach, and we cite this in the report of 'A Tale of Two ObesCities' is a study that was done in France a few years ago where they found that a whole community approach did bring down city wide levels of obesity. That whole community approach really required doing

things in the school, doing things with shop owners, doing things with local provision of spaces for play and sport. So, doing all of these things together, they were able to bring down the population levels of obesity, but that is really the only study that I have seen where this is happening, again, on a community level.

Paul Sacher (MEND and University of London): Just to add that; I am aware of this study: it was in a much smaller city than London so it was much easier to do than trying to do something similar in London, which is not to say that it could not be done.

I think, unfortunately, the evidence, in terms of school based obesity prevention programmes across the board, does not show reductions in child obesity. So it is not to say you should not do the cooking at school and growing vegetables and more Physical Education (PE). All of those things are great but in terms of reducing child obesity, there is no clear link between the two. What has been shown to be effective and what is recommended by the National Institute for Health and Clinical Excellent guidelines for the prevention and treatment of child obesity is what I call multi-component targeted interventions.

So, those are interventions that include nutrition, physical activity, behaviour change done within local communities, delivered to the family, specifically for all families that are at risk of becoming overweight. So from maybe BME communities or where parents are overweight or obese, or where one sibling is above a healthy weight already, or in families where the children are overweight or obese, there is good evidence that those work. On everything else, there is very little evidence that they have an impact on child obesity rates.

Navin Shah (AM): Could it not be that because of either real reasons or fabricated ones that it is not cost effective to provide healthy food and, therefore, strategies are not quite taken forward; whether it is about what type of school meals that one does or in terms of other strategies which could benefit at school level.

Paul Sacher (MEND and University of London): The problem is that a lot of interventions that are done, for example, in this country giving every child one free piece of fruit daily at school, which we all think is a great idea, costs £50 million a year, whatever it may be; I think the cost has come down. There is no evidence to show that that actually impacts overall on child obesity.

Rosie Boycott (Chair of London Food Board): I would just like to interrupt with a point. I have been round schools with members of the Food Board who work in training and things like that. One of things that completely astonishes me is the level of choice in school meals. I have been into schools where you have a choice of three or four different first courses and then you have a choice in your desserts: one of which is fruit but the other is treacle tart. So, what the heck is the point of putting on the fruit? When I was a kid you did not have any choice, you got the tart or you did not get the tart, but it is pointless putting in the fruit if you have also got the tart. It is as though we live in a culture where everyone expects to get choice.

Paul Sacher (MEND and University of London): The point I am trying to make is giving more fruit or encouraging healthy eating. There is no evidence that that actually impacts obesity, so reduces obesity rates. There is no evidence that recommending a healthy balanced diet actually reduces obesity; these are general public health recommendations for health. In terms of actual recommendations to reduce population obesity there is no evidence that these work and can be implemented at scale.

Rosie Boycott (Chair of London Food Board): The NHS also supports the estate on which we have Capital Growth gardens that won a competition we had a fortnight ago. The person from the local PCT that had invested £7,000 in it said she thought it was the most cost effective way to improve health, and to start to bring down obesity. The kids were outside, they were safe, they

were outside with their parents, they ran a cooking club, a gardening club, all within public housing area on a very, very small amount of money.

Paul Sacher (MEND and University of London): Anecdotally there is a lot –

Rosie Boycott (Chair of London Food Board): I know it is only anecdotal. There is not one bullet.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I think we also need to recognise that in the NHS and in academia, when people talk about evidence, they expect longitudinal surveys or whatever, that truly can demonstrate an outcome; that is the way in which evidence is generally used. I agree with Rosie on eating a better diet. We know that the doctors would say these are good things. That is not the same as saying one particular thing, like eating a banana every day, will have this outcome. I think they are not incompatible positions to take.

Paul Sacher (MEND and University of London): It might just be the fact that we have not collected that evidence, that it actually does work, but the evidence is not currently there.

Navin Shah (AM): I would like to move forward to other strategies that the Mayor could consider. What would be the role of little shops or large outlets, whether they are fast food outlets or anything to do with food? Is there any mileage in looking at strategies pan London which would then help address the issue of obesity?

Rosie Boycott (Chair of London Food Board): One of the things that we are in the process of doing is that we have identified there are three manufacturers to most of the fast food, not McDonald's obviously, not the big ones but the small ones. They come up with the spices, the seasoning, the stuff that you put over the chicken before you chuck it in fryer, and sauces.

We are going to write to them on behalf of the Mayor to say: "Would you come to a meeting here with Mayor and discuss whether you could look at starting to lower, gradually - we do not want to put you out of business - the sugar, salt, etc content?" That is where the stuff is, it is not in the actual bit of chicken. We want to work with them rather than trying to, in a sense, get aggressive with people on the street and talk about using different oils and stuff like that. We want to work from the top and use the Mayor's influence to do that; it may not work at all, but it might.

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): I would like to make a comment there. Obviously I cannot speak, Rosie, on behalf of other food manufacturers and other businesses, but you are right in saying that the longer term solution about products is about recipe change. Now, the British palate is used to certain levels of salt, sugar and fat whether one likes that or not.

It is a palette change; over time I believe the recipes will need to change and subtle reductions in salt, sugar and fat levels will bear fruit much further on in the future. You cannot do these things overnight; so, responsible retailers would work with you on that basis and I think that is a great idea.

Rosie Boycott (Chair of London Food Board): We have one of the heads of Sainsbury's on our Board, so we know a lot about what they do. They have brought their levels down enormously. Public catering is still a long way behind on the whole. We now work with Sodexo and companies like that in terms of doing the procurement because procurement is so important. It can be done, I think, if it is done in the right way

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): It is a subtle long term change, I genuinely believe so.

Navin Shah (AM): Andrew, it is a good idea, as you said, changing the palate and, therefore, expectations of what we eat. Is this something you are representing that you do? Is this something that you are already looking at? So, when I order pizza I get less salt or sugar than I would have previously, as part of a gradual change. Is there something happening?

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): It is subtle change. We offer a low fat mozzarella option for our customers. I will be honest with you, not many customers order that product even though we make it available. Our best seller still remains our Pepperoni Passion which is with pepperoni and extra cheese.

Rosie Boycott (Chair of London Food Board): How many calories?

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): I am sure quite a few. The typical Domino's customer, however, only orders every 30-odd days so we are not part of a regular recipe of people's day to day consumption. Over time, we are working with the Food Standards Agency as well as other bodies to reduce the level of fat, salt and sugar in products. I think most of the industry, if they are responsible, will need to do that.

Navin Shah (AM): I would like to move onto the Mayor's Health Inequalities Strategy. Can Pam or Rosie tell us the pan London initiatives for local food outlets?

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I think with respect to the Mayor's contribution, in a way, there is a strategic contribution that would apply to all the aspects of health that we have been talking about. These would include: the power of convening, the ability to get people to take up Rosie's offer about coming to sit round the table about salts in food, for instance. I think there is something about a voice for Londoners. I am kind of struck a bit by Andrew's response. Part of me is tempted to say, yes, palate change needs to happen and it does not happen overnight, but there is always a tension from the point of view of the commercial provider about not wanting to be the leading person down that path - let me not put words in your mouth. I think there is a responsibility for us to think how we educate the public, with local authorities and NHS colleagues, to be more demanding of different levels of additives. The reality is: if you go into your doctor's surgery and they say you have a heart condition and you need to stop taking salt so much, people do not have any difficulty about adjusting their palate quickly.

I am not suggesting an overnight response like that. I do think you need the push and the pull, and we need to think about how our voice is used there. I think there is a voice to Government on areas where we have a concern, there is a voice to talk to businesses, whether it is those in the food industry or others who are interested through Corporate Social Responsibility about supporting initiatives that will help us tackle these problems.

Clearly in all our own GLA plans, not just the statutory health plan, but whether it is Transport for London (TfL) or the housing plan, we have to be mindful of impact on this area. So, I think there is a whole range of high level strategic things where you would expect the Mayor to take leadership.

It is the case he is not funded, actually, to do anything specific on health. It is because of his commitment that he has found ways of scraping together money that has allowed Rosie to take forward these initiatives in a very practical way. I think that is to be commended, and does show his commitment to the area. I wonder whether, Rosie, you would like to expand a bit at this point on some of the initiatives that have been going on.

Rosie Boycott (Chair of London Food Board): I think I have mentioned odd things that we do at the Food Board. One of our big projects has been creating gardens, both vegetable gardens in schools and in communities, which have the effect of bringing communities together as well as getting people to eat, getting people to cook.

I do not know quite how you prove this as such, but the fact is people do not cook. One in four households does not have a dining room table, people are eating a different meal, in a different room at a different time. It became a fashionable snack culture and we have stayed with it. When you are in a snack culture you are then victim to the food manufacturers who want to give you food to which they have "added value" because there is only so much you can charge for a piece of broccoli, you cannot mark it up very much.

The moment you start to turn it into a pie, add lots of sauces and all the rest of it, and masses of calories then you can make people fat very quickly. We have dropped cooking in schools; in a sense we have farmed this out, the whole idea of food and what it means and why it is important. It exists in, I think, 19 different Ministries; I think it has been fantastically neglected by the Government. We have created not only a health time bomb but it is an enormous part of climate change. There are all sorts of things that are problematic about food.

Unless we get people back to cooking, I think it is going to be, quite frankly, very difficult. We have to get the manufacturers to turn round. If people go on snacking it is my belief they will also carry on getting jolly plump; the way through is to re-engage. I like this idea of doing it through a whole community, I like that story. I think you have told me, Kimberly, about some town in America off a prairie that has a bucket when you drive into it showing the amount of fat in the town and they are all on a diet so it goes down.

I know you could not do that but it is quite a good way of that sense of all getting together. We work with that, we are working with the food outlets and we are working in a big way on public procurement. If you do not have decent ingredients you will not have decent food. You need fresh, seasonal, local vegetables where you can and good quality meat where you can. Actually, we all ought to be eating a bit less meat and moving it towards a more pulse and rice based diet.

So we do that and we are going into public procurement in a big way.

James Cleverly (Chair): Now, obviously, we have been speaking about the type of food and some of the behavioural changes with regard to diet. It strikes me that in the same way that, Andrew, you are saying that if you dramatically reduced the composition of your recipes overnight then the chances are you would be driving customers away to one of a number of other competitors, who I am quite sure would be more than happy to pick them up. Obviously, I think there is a general agreement about the need to change some of the behaviours and some of the habits that have crept in with food, particularly children's food.

I am thinking particularly of things like total calorific content, portion sizes and that kind of stuff. Is there something that can be done? Navin [Shah] has already mentioned that we have spoken to a number of young people. There is a lot of buying of meals between leaving school and getting home, through fast food outlets.

If we accept that behaviour has become habitual, can we change what levels of calorific intake or the nature of what is going on inside those youngsters if they do that? Is there something that can be done between your research and industry to make that improvement?

Paul Sacher (MEND and University of London): There is a lot of evidence particularly in children that you can replace bad habits with better habits. So, we spend a lot of time on our programmes teaching parents how to change their own children's behaviour around healthy eating and physical activity.

A very simple example would be if you leave a packet of biscuits on your kitchen table, children are much more likely to walk past and eat a biscuit, if the biscuit is not on there and they are replaced

with fruit, children are much more likely to eat fruit. It is simple internal and external triggers. The evidence shows that you can change behaviours.

Everything we have mentioned we do teach on our programme. However, I think it is very difficult in a culture where we are very conscious of value for money and when you do have your pizza - if it is a once a month treat - why are you going to chose the one that does not taste as good, the one that does not have as much pepperoni and the low fat cheese.

One of things we do, for example, is we teach and we show families; we do not say, "Don't drink sugary soft drinks" but we show them that in a 500ml bottle of cola there is 11 teaspoons of sugar. We say: "Would you drink tea or coffee with 11 teaspoons of sugar?" the answer is always no, "So why are you drinking the cola with 11 teaspoons of sugar?" People just simply do not know. So on one level it is about education, but doing it in an appropriate manner in a way that is engaging, practical and interactive, with parents and children.

Unfortunately, a lot of this does not happen in schools any more and I think it really should happen in schools. Unfortunately, parents today did not learn how to do this when they were at school and it is not being done with their current children. I was the child health expert for 'Jamie's School Dinners' and this is exactly the issues we faced.

When we just did stuff with kids at school it was great, they interacted, they were interested, but if it was not reinforced at home by their parents we did not see any long term changes. You have to work with the whole family, and people have to be prepared to engage and be interested in what you are doing, and not just this top down approach of us telling the masses what they should and should not be doing; that does not work.

James Cleverly (Chair): Andrew, you have already mentioned the recipe changes. I am thinking also of things like portion sizes and that kind of stuff. Are there things that you could do as an industry?

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): Absolutely. Again it is difficult for me to speak on behalf of an industry because I am very narrowly focused on fresh pizza; so, I have to be mindful. Equally I am not going to be critical of other brands that might not do the same as us. I will just talk about what I know, and I will talk as a parent about what I feel and hopefully that is good enough for you.

I think that information is critical. A brand like ourselves having calorific information available on our website, a dedicated website to talk about the freshness and quality and the calorific content of our ingredients is key. A large element of our business now is done online. 35% of our sales this year will be over the internet, where there is no-one calling, no-one going to a store, they are purely ordering online.

Therefore, having our ingredients and our calorific contents available online is critical to customers, if they so wish, to make an informed choice in that way. So having availability of information is key.

Number two, a business like Domino's is a franchise business and that means that the people who run the stores are not a faceless corporation in Milton Keynes, where I am based, or anywhere else. They are individual owner operators. So, in our community here in London we have 15 franchisees and I could talk about a dozen of them at least who do schools tours, bringing kids in from schools, talking about fresh ingredients. The whole process of that is to talk about vegetables and how you could have a different type of pizza.

Now we are very, very careful; we do not market to children, we feel as though that is not what we should do, it is not what we do, and it is not our business. They cannot afford our prices, to be

perfectly frank and we cannot make money selling them an 80p chip sandwich because that is not our business.

We do feel as though, because we are part of the community, we should take a part in that CSR. I have got franchisees here in London who organise those events and who talk to kids about, not necessarily about pizza, but about fresh ingredients. In the Domino's world all of our products are fresh, they are not frozen, they are not fried, they are just fresh vegetables and meats.

James Cleverly (Chair): I am not trying to put words in your mouth. It strikes me that, if anything, you are using the opportunity of promoting a healthier option to an extent, as a business advantage. Part of your selling point is the fact that you have got vegetables where some other options on the high street do not give you vegetables as part of it.

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): I think it is a really difficult position for us to talk about health and be known as Domino's Pizza. I do not think we can use those two words together and I am just being realistic here.

What I would say to you, however, is that freshness and quality and high quality ingredients is a key determinant. What tends to annoy me about this debate, I must admit, is that because we operate within the A5 planning category we get tarred with the same brush as every other A5 operator and we are not at all like them. We will come on to talk about what that means in a moment because I think it is critically important for this Committee to understand the differences of planning usage class in this country.

So it is very difficult, because we are trying to be a responsible retailer and at times our industry gets tarnished with a very tough image. I think Rosie made a point about the dozens of chicken shops that she sees in Walthamstow High Street. I get that.

Paul Sacher (MEND and University of London): I'd like to make a point on that: you specifically mentioned serving sizes. I think a lot of people think that people are fat because they eat too much pizza, burgers and chips. Actually a lot of people are fat because they eat too much and that can be healthy food as well. So, with many of the families in our programmes, the kids are not living on junk food, they are eating a very balanced healthy diet, but the children are eating adult sized portions; so, I think there is a very important piece around educating parents on how much their children need in order to be healthy or to grow healthy.

Andrew Boff (AM): What you have just said is quite interesting. Going back, we did a little bit of scrutiny work on binge drinking. We found that the real problem with binge drinking is that young girls who did not realise how much they can drink, tried to drink as much as young boys did, and they do not have the capacity to do so. I think that came out from that report. What you are saying is that it is this understanding of portions and what you are capable of eating, or what is a reasonable amount.

To go back to the bit that made me raise my hand, it was about this parental issue. To what extent are the measures we are talking about trying to make children healthy generally or are we specifically targeting young people who have problems brought on by ill-informed parenting over their diet? I am getting a strong message from MEND that it is individual interventions with particular children with problems, rather than a broad-based approach as though we can change everybody's habits by re-siting fast food outlets.

Kimberly Libman (City University New York): It is both. I think also your approach really depends if you are just trying to bring down rates of obesity or if you are also trying to reduce inequalities in health. As Paul [Sacher] pointed out before, there really are two sides to this.

There is the primary prevention to make sure that the young people and adults in London who are currently at a healthy weight, stay a healthy weight. Then there is the need for more targeted work to help the people who are already overweight or obese to reduce.

I do not think you can really separate them, I think you need to have them operating two streams at the same time. I know Michael Marmot talks a lot about this idea of the Nutcracker and using these universal, city-wide, all-communities approaches in combination with targeted approaches that focus on working with communities, or in this case, perhaps individuals as well that have higher rates of obesity or are themselves obese. I do not really think that you can do one or the other. I think you really need to do both.

Navin Shah (AM): I do not think we can have any meeting without talking about austerity measures. Indeed, as we know there are cuts proposed to the London Development Agency (LDA). The question to Rosie is what impact will the LDA cuts have on the London Food Board programme?

Rosie Boycott (Chair of London Food Board): I hope it is all going to be fine. The Mayor says we are carrying on, all guns blazing! The truth is nobody quite knows; I am not really quite sure how to answer that question right now.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): There are probably two aspects: I think the whole question of where the LDA funding is is obviously a matter that is being actively taken up by the Mayor with the Coalition Government. We do not yet know where it is going to land; it will land where it lands. I think there is a separate issue about what we need to do to tackle this problem.

I think the White Paper gives us some opportunities to think. Irrespective of whether it is LDA money or whether we have to look elsewhere, I do sense a real appetite and inclination on the part of local authorities who are now being brought in to health improvement in a way they were not before. Also, GP consortia often have a much greater focus on primary care and can see how we can land this. The role of the voluntary sector in that is critical.

It would be nice to think the LDA will continue to sort out all our problems in the way we have had and certainly we would be seeing what we can do there. I think there is a much wider question. I really think there is evidence that we might be able to land that really well in terms of having a shared understanding across London's leadership that some of these big issues need to be tackled with greater gusto on a pan-London basis.

With everybody thinking about what they do with the resource available to them rather than simply saying, "It's OK; it is up to the Mayor to find some small pot of money and to be doing this single-handedly." I do not think you will get the impact that we could get if we manage landing the White Paper well.

Navin Shah (AM): My question and concern is that it is not just about the Mayor finding a small pot money, or some resource from somewhere. It is a question of having the priority, having a clear understanding and a strategy, that this is something very important to the whole issue that we are talking about: children at risk.

Therefore, that is something that cannot be lost, no matter whether LDA funding runs into problems, or how we will reconfigure health services under the new White Paper. The new White Paper itself will take time to find its own base and its footing really. The worry is that whilst all of that is happening we could lose the whole perspective of attacking this issue fairly and squarely.

Rosie Boycott (Chair of London Food Board): The Mayor certainly knows what a priority it is; it is not going to go away.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I was at a conference only this morning where Colin Barrow [Leader of Westminster City Council] and I were both speaking about looking at the totality of the health budget and the totality of the social care budget and thinking what are the things you need to do to improve health and wellbeing for Londoners.

The key part of that is for example preventing people expensively becoming type 2 diabetics. Whatever your motivation for getting on this agenda, I think there is plenty of evidence that people are looking at the totality of the challenge that they have to face and what they should be doing about funding. Actually, the local authority challenge is already upon them.

They are already saying, "How am I going to make this 7% cut, or whatever it is, year on year? What does that do for my social care budget? How do I adjust my work with PCTs, to look at the health and wellbeing of the whole population, and then obviously within that the children?"

Navin Shah (AM): It is not just the White Paper and LDA funding; we are also looking at the full public health area on which, obviously, there will be more information available, I think in December, isn't it?

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): Yes. Encouragingly, people are already saying that the public health change is great; we know we have to work together. However, actually the public health pot money is a small proportion of the total amount that we are all spending on health and wellbeing and social care. We need to look for the biggest possible prize about how we allocate resources and to be mindful of that and not just say that it is £1million or £2million that each local authority may get through the public health improvement programme. Whatever number of millions it is, I do not know that yet.

Navin Shah (AM): If we can move onto a planning related discussion. Some boroughs are trying to limit the number of fast food outlets particularly near schools in such sensitive locations. To what extent should the Mayor support this and how can this be done?

Obviously, Andrew [Emmerson] you mentioned A5 and general use class aspects when it comes to planning. You might want to start off the discussion and then a contribution from the panel members. I know of a couple of locations where this is a serious problem, when you look at where you have got some of those shops like I think Paul [Sacher] mentioned, whether they are fish and chips or large fast food stores. So can you start off on that please?

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): Obviously I have got a vested and probably, you would imagine, quite a biased interest in this subject as I mentioned what my job title was in terms of development of new stores. Obviously, it does not help me if you were to introduce or support a blanket ban on new A5 within the proximity of schools.

Just so that everyone understands usage class, because I think most people get very confused about this, in order to operate a unit on a high street or any shopping area the type of unit needs to be a particular type of planning class. So I will give you some examples of that so you can understand what I mean. Do you mind me doing that, Navin, because I think it really informs the debate?

Navin Shah (AM): Very briefly please, yes.

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): It is A1 planning class for a clothes shop or any form of normal retail. Interestingly enough, Subway and

Greggs are included within A1. A2 is a bank or building society. A3 is a café or a KFC or McDonald's. A4 is a pub and A5 is a hot food takeaway unit of which we are trading in.

So a blanket ban on A5 development in a particular area, 400 metres around schools was the policy that was used in Waltham Forest. If you map that across the whole of the borough, that represented a blanket ban. If you did the maths, and I did a diagram to show a 400-metre radius around every school, leisure facility or playing food - they were the three policies of Waltham Forest - that meant that no more fast food ever would be able to open in Waltham Forest.

Now, at the time, and remaining so, we do not particularly have a dog in that fight; we are not looking to open a new store in Waltham Forest. It was more the principle and the policy we were concerned with. It is my belief that the same end can be achieved by not having such a blanket ban. Responsible operators like us would accept certain planning conditions that perhaps the type of operator that you are talking about would not and I will give you one or two examples.

The first concern is that because we operate in A5 we are suddenly going to start frying our products and selling chips and chicken and things of that nature. Now, in order to resolve that, a planning condition can be attached to the permission that said pizza only. So, therefore, you can understand that we are Domino's Pizza that is what we do, our customers are not targeted towards frequent usage, they are towards a home delivery business.

Secondly, we would accept, for example, a restriction on the opening of our customer carry out area during the times where schoolchildren may be about at lunchtime or in the immediate hour after school. We would be happy to accept a condition like that because we realise we want to play a part in the community. If there is a concern that children use our stores then we would be happy to accept that condition that just allows us to continue our delivery business.

Just to make a point that 70% plus of our business is delivered to somebody's home; we are not really in the carry-out or the serving people as we move business. So it is my belief that the current planning regime allows conditions to be attached by local authorities to ensure that that over-proliferation of concern that was expressed by Waltham Forest can be resolved.

So responsible operators like us can continue to legitimately go about growing our business, opening new stores, employing more people, investing in run-down buildings and carrying out our legitimate business. At the same time we can be part of caring for our community if it is such a concern that our brand might impact on children.

Navin Shah (AM): Before we move onto other panel members, have you got examples of any Section 106 agreement benefits that could also become part of conditions?

Andrew Emmerson (Business Development Director, Domino's Pizza Group Ltd): So that everyone understands what that means, typically, if we make an investment, we also make an investment in the community. I bought the most expensive bin in Birchwood, Warrington for a Section 106 commitment. For those of you who do not know that, that is where we invest a bit of money locally.

What we did in order to secure our planning permission in this particular part of Warrington, we had to provide bins in the local area. I have just provided in Irvine in Scotland a customer security rail near a walkway, near a zebra crossing near our store. We are quite happy to do that and as appropriately, we are quite happy to invest in those types of things. They have obviously to be proportionate and affordable by our franchisees but under the two examples I gave, we are quite happy to do that.

Navin Shah (AM): We would like to move onto the last question on our diet related topic, that is the issue about breast feeding. There is evidence to suggest that children who are breast fed are

less likely to be obese. To what extent do you agree with this and, particularly, what can the Mayor do to support such an initiative?

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I think we would agree with that as a statement; I think it is well evidenced that that is the case. It is something that we want to work with London Councils on because essentially the local authority has the most immediate contact with the types of institutions involved, like pubs. I know in Camden it meant that some institutions could advertise that they were particularly pro that. I think we can get on our megaphone and say we think it is a good thing.

Navin Shah (AM): Also the issues surrounding breast feeding in public places; that again needs to be part of the initiative.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I think we would look to local authorities who are the people who have contacts on the ground with the kind of outlets that people would wish to breast feed in and to work with them and to support them. I am very happy to say that the Mayor thinks breast feeding is a really good idea. If you want to have traction on the ground, we need to do this in partnership with local authorities and we are definitely up for doing that and it would be part of our discussions with them.

Kimberly Libman (City University New York): Also, it is just important to keep in mind the issue of promoting breast feeding that is not just about social awareness and it is also not just about breast feeding in public, it is also about infrastructure and creating places where women who make the commitment to breast feed their children for the first year or more of their lives.

Many women are working these days and if you are breast feeding and you return to work, you are going to need a place at your work site where you can go during the day, that is clean, private, where you can keep your breast milk pumps and where you can refrigerate the milk for the duration of your work day so that you can take it home with you. I think supporting that kind of infrastructural change as a first course of action within all municipal facilities would be a great thing to do; then also encouraging employers to take this seriously, and do it at work sites across the city.

Rosie Boycott (Chair of London Food Board): Have you done that in New York?

Kimberly Libman (City University New York): It is something that we are trying to do at the City University of New York.

Rosie Boycott (Chair of London Food Board): Is it working?

Kimberly Libman (City University New York): It is very hard to do. Space, I would imagine, in most institutional buildings here, just like in New York, is tight.

James Cleverly (Chair): We have got a space that we could maybe set aside. I want to make sure we move onto the other half of the equation. We have had quite a good discussion about the 'calories in' side of the equation and we will move on now to the calories out' side of the equation.

Andrew Boff (AM): I am rather put off by this since I have now been told that kids get obese first and then the exercise is not crucial! I am sure, Kate [Hoey], you would disagree with that. What needs to happen to achieve an increase in sports participation amongst people? I am assuming if a child, for example, stops doing sport it is more likely that they are going to become obese. So what can we do increase participation?

Kate Hoey MP (Mayor's Sports Commissioner): I would not want to say that everybody who takes part in sport or physical activity are doing it because they think it is going to make them

more healthy, because they do not; a lot of them are doing it because they enjoy it. Obviously the side effects of that are that anyone who does any kind of sport or physical activity we do know that they should be healthier. Of course there are other factors involved as well.

In terms of the children, in schools at the moment, every child should be getting two hours minimum of sporting activity. So it is in a sense wrong to say that any child is totally inactive, because they should not be. The reality is, of course, that some schools are better at it than others and some areas are better than others. Can I just say, before you ask that our £15.5 million from the LDA via the Mayor is, in fact, safeguarded and we are still intent on spending every penny of that with the match funding. So, we will be able to continue our programme to try to increase the participation levels generally.

Some of it is to do with facilities, some of it is to do with travel distances, some of it is to do with, again, the parental influence which can be really, really important, whether they see other people in their families participating in sport, whether their parents have or not. Also, the important thing for us is that any funding we are putting in is actually aimed at the inactives; they are the people we are really trying to get involved.

So, every bid through our facilities fund, our skills and coaching fund or our increase in participation through social development fund, all of it has to have some way of showing that they are going to increase the number of people getting involved in sport. That is to be the legacy that is the important part of the legacy of the Olympic Games.

Obviously, we are all worried and concerned about funding generally. The one thing that the new Government has continued to do is to allow the governing bodies their full funding, so that whole sport plan for the governing bodies of sport, who are absolutely crucial along with the local authorities in delivering sport and ensuring that the basic infrastructure is there, will continue.

Also, because of the change of Government policy on the National Lottery, the increase to sport from the National Lottery will come over the next three years. There will be increases gradually over the next three because they are changing some of the areas that the Lottery had been diverted into instead of into sport.

I think what we want to see also, and we are pushing this quite a lot, is a greater range of sports being offered to children. Whilst I am a great supporter of traditional sports and the traditional competitive game sports, in certain parts of London it is more difficult.

What we are trying to do is sports like skateboarding, BMX, which are great for young people if they can get involved in those sports, and they are, perhaps, more excited about getting involved in that than going off and playing a traditional game of another sport that we might have been more likely to have grown up with. So, there are a number of ways that we can try to increase participation, but the role of the Mayor overall without the statutory responsibility is to be the lead in terms of galvanising, being the catalyst, being the person who tries to make everyone work together and that is what we are doing through our London Community Sports Board.

Finally, bringing all the local authorities together, working through London Councils and, getting particularly in, relation to this Committee, links with health and the PCTs; some of our funding streams in improving participation - we are just about to make decisions on those in the next week and a number of those bids are linking in with health and PCTs' other health initiatives.

There is quite a good link between what would be seen as traditional health funding and our funding. Of course, what I would personally like to see is the NHS generally seeing a larger amount of money being put into preventative sport and recreation; long term that could pay off in terms of saving the NHS money.

Andrew Boff (AM): In terms of the evidence that we have from the cost effectiveness of these schemes, of course, we have so it is difficult to say whether or not we are going to get the maximum out of them. I wonder if there is any other evidence about schemes for involving young people in sport?

Kate Hoey MP (Mayor's Sports Commissioner): I would argue that even if there is not specific evidence to say, "If you play sport every day you are going to be less likely to become obese." I am sure that is factual. But, also do not forget it is all the other sporting benefits that are important in terms of young people learning about leadership and discipline and working in teams and all of those factors.

Again, when we are talking about funding cuts, local authorities are very aware of that. The more we can prove, not just on the obesity side but on all the other things, that is more likely to see that the local authorities when they are being cut are not going to immediately jump in on one area that is not statutory which is sport. I must admit I am not someone who reads all the evidence about these because I just believe that sport and physical recreation are good for you.

If other people want to come up with lots of scientific evidence, great, but in the meantime I shall continue to fight for the money anyway.

Andrew Boff (AM): What about in regard to the Two ObesCities report? You must have done some work in increasing young people's physical activity.

Kimberly Libman (City University New York): In New York City, one of the things that we have done is a new programme that the Department of Health and the Department of Education have teamed up to - train teachers on how to do physical activity inside classrooms, to try to build it into the everyday part of being at school. Not all the schools in New York City have playgrounds and school yards where they can go outside and be bold and active. They are working on getting this built into the day-to-day activity inside the classroom. I think that if the Department of Health and Department of Education are doing it in New York City it is definitely an evidence-based programme that provides some value for money; so I think schemes like that do work.

James Cleverly (Chair): Just a quick point of detail; in New York, the Department of Health and Department of Education, what is their statutory inter-relationship with the Mayor of New York? Do they come under his remit?

Kimberly Libman (City University New York): Yes.

Paul Sacher (MEND and University of London): From my perspective, again I think there are two issues. I think it is incredibly important to provide opportunities for children to be physically active at school. No one would disagree that that is important. However, one needs to acknowledge that a third of children are overweight or obese and obese children do have different requirements.

I would not recommend skateboarding for an obese child, they are much more likely to sprain their ankles, and they have much higher incidences of fracturing their bones. So, the type of physical activity we provide is a much safer, lower impact type of physical activity than a healthy weight child might engage in. Often all that is required is to work specifically with that child to improve things like their balance, skills, agility, and co-ordination before they can join in with the mainstream physical activity in sport.

Let's not forget, a lot of these kids are the kids that are not picked for the team, they are the kids that come last, so they are the kids that are most likely to be excluded from mainstream sports.

Kate Hoey MP (Mayor's Sports Commissioner): School sport has changed a lot. There was a phase when people would have assumed that that is what happened about the poor kid who never got picked. Sport in primary schools now is very different, and there are a lot more of the imaginative ways of doing it. I was not suggesting every child goes skateboarding, I would not even suggest that you do skateboarding.

The problem with using the word 'obesity' is that it means absolutely nothing to a young child, to tell them they are obese; and we are not allowed to use the word 'fat' anymore I presume. For a lot of this, for our young people it is meaningless; I think we have got to find a way that is coming through parents particularly to do it from the positive side; why it is good for you to be doing enjoyable things and then the benefit of it. If you just go around saying to a child they must do something because statistically you are obese, I do not think that really gets through to them.

Paul Sacher (MEND and University of London): I agree with you. We know that you can tell people to stop drinking, smoking, taking drugs until you are blue in the face; that is not how you change behaviour. What I do think is happening, which is a good thing, is that parents are, through the NCMP, getting letters telling them whether their children are a healthy weight, or above a healthy weight. I do not think they are using the word 'obese' and I think there is a lot of emotion around the word 'obesity'. It is a medical word and it should be used in medical circumstances. I think you will find a lot of kids who are obese would call themselves fat and they know they are fat.

Navin Shah (AM): I wanted to repeat a comment which was repeated by several kids when we met them here in City Hall. They do not think there is much focus at all on physical education in schools. I wonder what the panel thinks about it; also whether there are enough sporting activities within schools to add to the health and wellbeing of pupils and obviously, therefore, the effect of obesity.

Kate Hoey MP (Mayor's Sports Commissioner): I think it has got better. I think we did go through a phase in this country where sport and physical education was not taken perhaps as the right as when I was at school a long time ago. I think the whole question about competition, which became that sort of thing where everyone was saying, 'We had better not compete' and all of that. That is now a bit of a myth; I think there is a lot more competition and, indeed, we are very much involved here in the Mayor's Office in supporting the London Youth Games which is hugely competitive, supporting the Panathlon [Challenge] for children with really severe disabilities. There is a lot more competition going on.

I was a former PE teacher; I do not think we train physical education teachers nearly as well as we used to do. I think there is still a shortage of primary physical education teachers and the answer to that, because it was very expensive, was to bring in more coaches in different sports, which is fine. The point earlier about basic skills: it is the basic skills of being able to handle a ball, throw a ball, catch, all the skills that you learn at a very early age which were taught to you as physical education teachers taught, it is not, I think, being done in the same way.

Having said that, I think our school sport and the after-school curriculum and the links with sports clubs which is really what we want to see, so that you do not just leave school and then have nowhere else to go; that is definitely happening a lot more in London.

Navin Shah (AM): Something surely could be looked at in terms of extended schools at a community level?

Kate Hoey MP (Mayor's Sports Commissioner): We would not give any money to anything that isn't opening for the longest hours possible. So many of our schools do open after school, but there is still the perennial problems that has been going for years, about caretakers and things. A

lot of that is being solved. There is an awful lot more sport going on after school now than there was 20 years ago, definitely.

Paul Sacher (MEND and University of London): It is also just worth saying, I think, that a myth exists that fat people do not like doing exercise; it is not true. The kids in our programme absolutely love the exercise; nationally we have a 78% attendance rate for a twice a week programme. In terms of the programme, the kids come because they have a great time going crazy and having fun and being physically active.

Whenever we allow the parents to join in they have just as much fun. I think a lot of it boils down to confidence; if you are not confident because you are overweight or you have not learnt the basic skills, it is very hard for you to engage with sport clubs and maybe compete or to be compared to other kids who maybe have better skills.

I just think it is worth saying that obese kids do like being physically active, but it is about finding the most appropriate things for them to engage with as well.

Andrew Boff (AM): If we talk now about sport particularly, what about increasing young people's general activity as well? What could the Mayor do to encourage young people to walk and cycle more?

Rosie Boycott (Chair of London Food Board): The Mayor certainly does both cycling and he does the gardening and vegetable growing which we have invested a lot into and continue to do.

Andrew Boff (AM): I think there an extreme contradiction in the Mayor's stance, in so far as he is very much supportive of free bus travel for young people, which seems to militate against the idea of young people walking, really.

Kate Hoey MP (Mayor's Sports Commissioner): Perhaps if there is not so many of the fast food around schools, they will have to walk further to get to them.

Andrew Boff (AM): They get a free trip to the kebab shop, wouldn't you say?

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): There are always issues to do with TfL and one can always keep them under review. Actually a lot of children travel quite some distance to get to school, so it is not simply quite as straightforward as simply saying, "Why don't you walk?"

Kate Hoey MP (Mayor's Sports Commissioner): Can I just say, I personally think that it should not go on all evening because we get a lot of complaints from people in the evenings of children using their free bus passes late at night when they should not be out.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): That seems like a wider conversation. I do think it is worth thinking about the year of walking next year which we are beginning to spend some time looking at; whether there are things that we can do with New York. I do not know the answer to that yet, but I think we are mindful of walking and it will be hard to think of a Mayor who is more positively enthusiastic about the benefits of cycling than the current incumbent.

Paul Sacher (MEND and University of London): I think one of the things London does have is one of the most beautiful cities in the world. It is one of the only cities where I personally walk and cycle everywhere just because it is much better than using public transport in terms of exercise, fresh air and just looking around you. So, I think that is definitely an innovation that London has. I have been so proud to be a Londoner when people come to London and they see the bike hire scheme. However, as far as I am aware those bikes are designed for adults, not for children.

Andrew Boff (AM): Young people do ride everywhere, don't they? They use public transport a lot. In some areas of London it is perceived as being unsafe to go out and walk; I know I live in one. Young people feel that they cannot venture out too much.

Kate Hoey MP (Mayor's Sports Commissioner): Young people definitely have their own territories and we find that sport is a way that that can be broken, because people are competing against each other, or you get a particular basketball group that has young people coming from different areas. It can help to create a cohesion that is not just based on, 'You are not from our area' and, ' We are not going to go into the area' and I think that it is probably why a lot of people, particularly youngsters, do not walk around.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): The launch of the Safer Parks Award is designed to encourage not just parents, but children themselves, to feel that there are safe public parks in their vicinity where they can go and exercise and play and have open space.

Rosie Boycott (Chair of London Food Board): I was at one in Tottenham Lordship Rec on Friday, which is right by the estate where Police Constable Blakelock was killed. It is a tough area and now it has been completely restored through various grants and bits of funding. They have a group called Trax every Saturday morning and then on summer nights as well. It has got 100 kids involved with their bikes and they have bike routes in the park.

They also do walks which come from the two GPs surgeries that are nearby, and they are run by volunteers and they take groups, primarily women, on walks two or three times a week. The parks thing is enormously important in that sense of reclaiming the space and once you have done that, then initiatives start to come up.

Andrew Boff (AM): What about the availability of open spaces? Of course there is great pressure on development of land.

Rosie Boycott (Chair of London Food Board): I can only speak from what we do with our Capital Growth Project, which is that we worked with TfL and we came up with a thing called a Meanwhile Lease. You go onto land that is in some sort of partial state of development or not yet in development but they are never going to allow it to be given away to an allotment.

The whole nature of an allotment is that is there for ever and ever. These are leases that are good for up to five years. Both the landlord or the developer is happy to give it over. The other great joy about this kind of gardening, is that you can have a raised bed or a bed in a skip, in a supermarket trolley or in whatever you want, and you do not necessarily have to dig down, so it can be on contaminated land. It is a wonderful way to use what is otherwise dead space, dirty space or downright dangerous space.

It just needs, sometimes, a bit of encouragement to some of the huge landowners, the Waterways etc, etc, to say, "Actually, co-operate and open that up". It does happen. We get blocks of land here and there.

Andrew Boff (AM): There are various estates in London where there is not any real play space for young people.

Kate Hoey MP (Mayor's Sports Commissioner): In our next round of facilities funding which will be going out next week, we are soliciting bids from smaller tenants associations and areas to try to do something about that. There are a lot of abandoned bits of sports grounds and playing areas where we would really like to see the community take control of them again, and with a small amounts of money we can make those quite playable.

I was defending strongly some of the adventure playgrounds that are left in London, because I think young people also want play in a slightly less organised way sometimes. You just have to go and visit a real adventure playground and see young people doing things that they would get no other chance to do. It is totally different from being involved in a competitive sporting activity and we have to defend those areas.

You are absolutely right, as the pressure grows with the housing crisis, with or without money, the pressure on those small spaces will become greater and greater. I think we do have to try to defend them as far as possible.

Pamela Chesters (Mayoral Adviser on Health and Youth Opportunities): I do think we need to be clear about who has the prime accountability for that and that is the local authority. We would want to support them in their task but I do not think it is for us to be directing them in what they should do in a top down way. Certainly, the borough leaders that I talk to would see that sense of place and the environment in which their residents live as something for which they have prime accountability.

I think we should be holding them to that prime accountability, but doing so in a way that is supportive of initiatives they want to take and encouraging best practice through things like the Safer Park Award Scheme. Also, where money is available, to encourage people to bid for it who want to do it, but I think we need to be careful of not blurring our accountabilities there.

Andrew Boff (AM): What is the New York parallel with regard to making available spaces for children to either take part in sport or just play?

Kimberly Libman (City University New York): I think we are in a much worse situation than you are in New York. My understanding is that London has about three times as much open space as we do in New York City. I think the distribution of open space in London is more equitable than it is in New York City. Unfortunately the areas that do not have the open space, short of designating certain buildings to just get knocked down, the prospects of creating more open space are pretty slim.

So we have people who are fiercely defending community gardens, we have got in the Mayor's 2030 plan, which is really focused more on environmental sustainability, a call for ripping some of the pavement tops on schoolyards and trying to create more green, play-friendly spaces than we currently have. There is not that much opportunity for creating more open space. I would say from our example, what you have got you should defend fiercely because once it has gone it is really gone forever.

James Cleverly (Chair): Thank you. I think that has been a very interesting, very useful session. I want to thank all our guests for speaking so candidly. It may well be that the Secretariat will contact you because there are a number of points which I have whispered across that I would like to get a little bit more detail from. Thank you very much.

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Draft INTERIM REPORT

Review of childhood obesity and sports provision for secondary and primary children

1. Introduction and background

1.1 This is an interim report on the review of childhood obesity and sports provision for secondary and primary children. The Education and Children's Services Scrutiny Sub-Committee decided to conduct a review on 12 July 2010. The aim is to make recommendations to the Cabinet for improvements to the education of children on healthy eating and the dangers of obesity, and to examine whether sports provision is adequate

1.2 The committee set out to address these questions :

- What programmes of study are followed by primary and secondary pupils on nutrition, cooking, healthy lifestyles? Are they adequate?
- How are pupils consulted with regard to sport and exercise? Is there sufficient variety and accessibility for different interests?
- What facilities are available to young people and there parents if they acknowledge there is a weight problem and want help?
- Are we making best use of London Olympics?

1.2 The sub-committee chose this subject because Southwark has very high levels of childhood obesity. The Childhood Measurement Programme measure Reception Year and Year 6 pupils. We have had nationally the most obese Year 6 pupils for the past 3 years and, despite a small reduction, and we are likely to have the highest percentage again for 09/10.

1.3 The committee chose to look at sports provision because of its link with childhood obesity and because during the last administrative year the education representatives had raised concerns that many children in Southwark were not doing the 2 hours recommended exercise in schools.

2 Evidence considered so far

Population prevalence

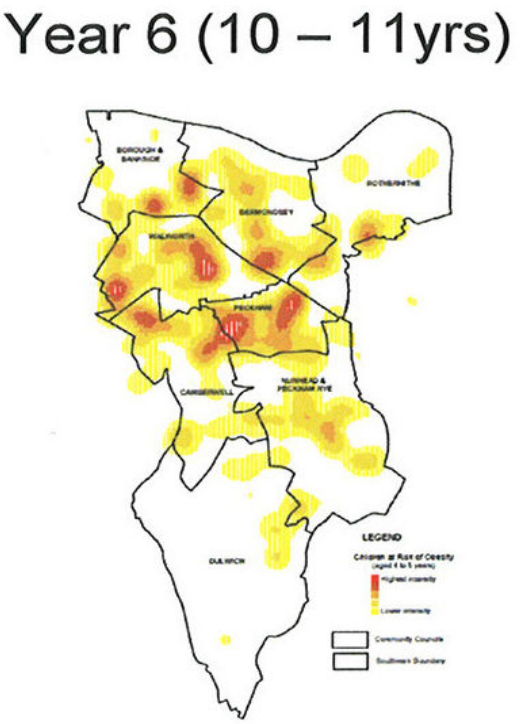
2.1 The committee has received evidence on the rates of childhood obesity and it prevalence amongst different segments of the local population. This is a national problem; 32.6 % of children in England are overweight or obese by year 6 and 38.9 % of Southwark's children are either overweight or obese by year 6. (Prevalence of underweight, healthy weight, overweight and obese children, with associated 95% confidence intervals, by PCT and SHA, England, 2008/09)

2.2 The national Health Survey for England suggests that the prevalence of childhood obesity is increasing in Southwark across all ages. Local measurements of Reception Year (4 – 5 years old) and Year 6 children (10 – 11 years old) confirm this: for the last 3 years (06/07, 07/08, 08/09) Southwark has had the highest obesity rates for Year 6 and the second highest for Year R for the last 2 years (07/08, 08/09). The latest childhood obesity measurements (09/10) indicate 25.7% (Year 6) and 14.8% (Year R) of pupils are obese.

2.3 Data sets were presented that indicated that as children move from reception to year 6 the percentage of overweight and obese children increases.

2.4 Nationally certain ethnic populations are more at risk; obesity is most prevalent in Black or Black British children; 25.3% at year 6. Asian, mixed and other groups are also more at risk with rates between 21 and 22 % at year 6. White children have a rate of 17 % and Chinese children are least at risk with rates of 16%. (Prevalence of underweight, healthy weight, overweight and obese children, with associated 95% confidence intervals, by ethnic category, England, 2008/09)

2.5 Obesity is related to socio economic deprivation. Data sets by community council area were presented and it was noted that there is a link between obesity and social deprivation. Particular hot sports were identified:



2.6 Boys in Southwark are more at risk than girls; at year 6 38 % of girls are overweight or obese where as 43 % of boys are overweight or obese.

Childhood obesity and healthy weight

2.7 Officers presented information on NICE guidance and Foresight report on what works for childhood obesity; both agree that the approaches must include environment, schools, workplaces and families with an emphasis on a multi faceted, holistic approach. The 'obesogenic' environment must be addressed i.e. opportunities for physical activity encouraged (e.g. walking to school as part of the school transport plan; access to green space) and the proliferation of unhealthy fast food outlets tackled.

2.8 Southwark has a Healthy Weight Strategy. This has four main strands; early intervention, shifting the curve (i.e. prevention at a population level); weight management and targeting populations at great risk of obesity. This is a multi agency plan which sets out the key areas of work. The priorities involve a range of settings and different professionals and communities. The strategy is informed by national guidance, best practice and evidence of what works. For

interventions to be effective, they have to be multi-component (i.e. inputs to include nutrition, physical activity and mental health).

Strategy Plan Priorities 10/11

Strand 1
Early Years prevention

- Maternal health
- Baby Friendly Status / La Leche training / peer support
- Training for early years staff
- Children's centres:
  - Healthy eating policies
  - Physical activity policies

Strand 2
Shifting the curve

- Physical environment
- Whole school approach to promoting Free School Meals
- Working with parents and families
- Physical activity for the most inactive
- Led walks
- Training for community leaders
- Southwark Food Strategy

Strategy Plan Priorities 10/11

Strand 3
Targeting 'at risk'

- Training for at risk BME communities
- Training for providers of LD services
- Health checks for high risk groups
- Training for Primary care on brief interventions

Strand 4
Weight management

- Intervention for families
- Weight management options for adults
- Training for frontline professionals

Sport and physical activity

2.9 The NICE recommendations for increasing physical activity emphaise the need to improve the physical environment to encourage physical activity and promoting evidence based behavior change. NICE has produced a detailed review of the evidence supporting the promotion of physical activity for children and young people[1]. The key recommendations relate to:

- Promoting the benefits of physical activity and encouraging participation at national and local levels
- Ensuring high-level strategic policy planning for children and young people supports the physical activity agenda
- Consultation with, and the active involvement of, children and young people
- The planning and provision of spaces, facilities and opportunities
- The need for a skilled workforce
- Promoting physically active and sustainable travel

2.10 Southwark has a Physical Activity Strategy. Overall the strategy seeks to increase sport and physical activity participation. Put simply, enabling more people to be more active, more often. It has 7 strategic themes:

- Using physical activity for both the prevention and management of ill-health
- Maximizing the use of planning policy in providing for sport and physical activity
- Providing a network of appropriate places and spaces for sport and physical activity
- Improving access and choice for the whole population
- Building and maintaining an effective multi-agency delivery system for sport and physical activity
- Maximizing the use of London 2012 to promote physical activity

2.11 Southwark Leisure and Well Being Team are continuing to provide a host of programmes, through Southwark Community Games and SCG Superstar Challenge Programme, Sport Unlimited and a Young People with Disabilities programme. The funding for the School Sports Coordination is coming to an

[1] PH17 Promoting physical activity for children and young people: guidance Jan 2009

end at the end of March 2011. Officers reported that the current economic climate is raising a host of questions regarding on going provision and discussions are underway regarding budget pressures and further delivery.

2.12 Leisure centers are currently undergoing major refurbishment: there is investment spread across all the council owned facilities.

2.13 Officer's highlighted three locally effective interventions. MEND (Mind, Exercise, Do it) was part of a national trial and had been effective at decreasing children's BMI (Body Mass Index) and reducing waist circumference. The 'Superstars Challenge' had been similarly effective. Lastly the Bacons School Partnership has seen a year on year increase in physical activity.

2.14 Public health, in partnership with the leisure and wellbeing team, successfully delivered the MEND programme (family based weight management intervention) for almost 4 years using lottery funding, which has now ended. The programme evaluated well. Without ongoing funding from external sources the challenge is to now to embed what worked well within on-going programmes such as the Southwark Community Games (SCG), Superstars Challenge obesity programme and the School Sports Partnership's Family Wellbeing programme.

2.15 'Southwark Superstars Challenge' is a pilot project. So far six schools with the highest obesity rates have been recruited to the programme. The programme introduces intensive physical activity in yr 5 (age 9-10). The 10 week programme runs three times a week for 45 - 50 minutes of physical activity and 10 minutes of nutrition education. At the start and end of the programme children do fitness test and have their measurements taken. School staff and heads have been very enthusiastic about the programme so impact to date has been highly successful.

2.16 Bacons College has a physical education and school sports partnership team. In seven years the partnership ensured schools have progressed from 23% of our their young people participating in two hours physical education and school sport a week to over 90%. They have developed a Health and wellbeing being programme that integrates some of the learning from MEND and promotes health 'literacy'. The programme's emphasis is on working with schools to increase the coaching skills of teachers in PE and introducing the Health and Eellbeing programme in sustainable way. The funding for the School Sports Coordination is coming to an end in March 2011, however the partnership has secured some funding for the next year.

Targeted work

2.17 Officers reported that their is a strong association between obesity and ethnicity. There has been targeted work with communities. There has been a community based intervention for families with children aged 4-7years targeting at risk BME groups. In late 2009 the National Change4Life team worked with Southwark and Lambeth PCTs to deliver two campaign launch events, one for community leaders and another for staff working with West

African groups. Public Health delivered a two-day training session on healthy weight for the Somali Refugee Council in November 2009.

2.18 Online obesity care pathways for adults and children are being promoted to GPs, practice nurses, school nurses, health visitors and child development workers. Pathways ensure up-to-date clinical guidance is embedded as well as local opportunities and contacts for interventions and self help.

2.19 The Council is currently also working with community members (community volunteers) in Peckham and Faraday who will facilitate the gathering of information from their peers on local social issues as well as possible solutions. One area that they may potentially explore in this pilot could be around child healthy eating/weight as data shows that this is a prevalent issue in this area particularly around the BME groups. The exact focus is yet to be decided by the community through their discussions.

Schools and free school meals

2.20 The Healthy Schools Partnership has been working in all schools to develop policy and practice on a range of PSHE related activities, including healthy eating and physical activity. In order to achieve Healthy School status, schools have to provide evidence against a set of National Standards. Currently 86% of schools in Southwark have achieved Healthy School status with a further 25% of schools working on enhanced status. The central funding for the Healthy Schools Programme is also finishing at the end of March. Current discussions are taking place with schools to develop a locally agreed enhancement model to ensure further work on health and education is taking place and is being evaluated for behavioral impact on our children and young people. This shall be launched in the spring term.

2.21 Healthy Schools is supporting the development of a whole school approach to sustainable food. 18% of schools are participating in the Million Meals campaign to increase uptake of school meals (13 primary and 4 secondary).

2.22 Free training and 1:1 support sessions for school cooks are provided with involvement of a food consultant (funded until March 31st). Guidance is currently available for school governors on selecting nutrient analysis software to ensure school lunch menus are compliant with food and nutrient based standards.

2.23 It was noted that Southwark's recent commitment to free school meals will be part of a whole school approach to reducing childhood obesity. The 'whole school approach' emphasizes engaging with pupils, teachers and parents, embedding healthy eating in the curriculum, encouraging healthy behaviour in and out of school and linking transports plans with the physical environment and the food strategy.

Physical Environment

2.24 There are evidence-based recommendations on how to improve the physical environment to encourage physical activity. They are for NHS and other professionals who have responsibility for the built or natural environment.

This includes local transport authorities, transport planners, those working in local authorities and the education, community, voluntary and private sectors. The recommendations cover strategy, policy and plans, transport, public open spaces, buildings and schools.[2] They include:

- Ensure planning applications for new developments always priorities the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life.
- Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads.
- Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity.
- Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity.

2.25 Southwark has a fast food outlet strategy aimed at limiting the saturation by reducing the number of new outlets in certain areas and promoting healthier menus at existing outlets.

3. Initial responses to questions from the Scoping Document from officers

3.1 What programmes of study are followed by primary and secondary pupils on nutrition, cooking, healthy lifestyles? Are they adequate?

- Programmes of Study range from school to school.
- Schools work on Healthy Eating as part of their Science, PSHE and DT lessons. Each school develops this work individually according to their programmes of study and in line with other curriculum commitments. The previous government had stipulated a wish for all secondary schools to have cookery lessons by 2011 and provided free training for Design and Technology teachers on how to integrate cooking into the curriculum. This is currently not the case.
- 86%of schools have provided information about a whole school approach to healthy eating for the Healthy School status, indicating that work is taking place to promote healthy eating with an understanding of nutrition and what constitutes a healthy meal.
- The amount of time allocated to this area of work also varies from school to school. Many schools have an active School Council that is involved in the development of healthy school meals.

3.2 How are pupils consulted with regard to sport and exercise? Is there sufficient variety and accessibility for different interests?

- The National curriculum for PE provides school staff with an opportunity to work on a range of physical activities. Dance has been introduced to many schools as

[2] PH8 Physical activity and the environment: guidance Jan 2008

part of the curriculum and others have piloted a range of activities such as yoga and Tai Kwondo. The latter was initially funded through NRF opportunities and has been successfully financed by schools themselves.

- As part of a whole school approach, the Healthy Schools team advocates strongly that pupils are involved in the decision making process around curriculum and after school activities.
- Unfortunately it is more difficult now to hear what pupils say across the borough as surveys such as the Pupil Voice or SHEU are no longer used.
- Most schools are providing some physical activity after schools with a range of activities but this is dependant upon individual schools also.
- Southwark Community Games provide a range of sporting opportunities inside the school time and additional After School clubs. SCG made a concerted effort to address the range of sports on offer to ensure there was a greater equity and appeal for girls to engage; this was shown to be important and effective as the ratio of girl/boy engagement improved as a result.

3.3 What facilities are available to young people and their parents if they acknowledge there is a weight problem and want help?

- In the first instance the family GP or school nurse would be most accessible and they will have had access to local training on how to support families on this issue, and informed of the Map of Medicine care pathway to support decision making re treatment.
- A wide range of internet based support and self help is available, and the PCT and Council have both set up links to the government's own Change4Life website which provides useful suggestions for effective behaviour change and links to further support. The Council and PCT have supported schools with several workshops and information to promote use of the campaign with their pupils and parents.
- The National Child Measurement Programme has been running for four years, whereby pupils in reception and Year Six are measured. From this 09/10, school nurses follow up children of very unhealthy weight, providing advice and sign posting to parents.
- Prior to this year, there had been a MEND programme (Mind, Exercise, Nutrition, Do it) whereby a self-referral process was established and parents of obese children could attend, with their child, a twice weekly programme for nine weeks. Funding for this has now ceased. Lessons from the MEND inform the Superstars Challenge and School Sports Partnership programmes.

3.4 Are we making best use of London Olympics?

- A termly newsletter of sporting and cultural opportunities is being sent to all schools.

All schools are being encouraged to:

- join the Get Set London 2012 network [100% schools by Easter 2011]
- join the Change for life campaign and the WOW campaign [walking to school]
- take part in Dance Challenge 2010 and 2011 [target of at least 40 school and community groups in 2010]
- take part in the Programme of sporting activity for schools related to Olympics values, Led by the Schools sports partnership, this will be a series of Olympic based sporting activities for schools including the Southwark Schools Olympics (July 2012)

- There are currently a series of pilots operating across the country, known as the School Style Olympic Project which brings new sports to young people on school sites. This will involve a series of competitions throughout the terms. This is currently in its early stages, and will develop over the coming months.

4 Issues and emerging recommendations

4.1 Early Years / prevention

Evidence of need - the most recent Childhood Measurement Programme shows that Southwark has the highest levels of Reception Year obesity nationally. In Reception year pupils 14.8% were obese and a similar proportion (15.0%) were overweight. In year 6, one in four children (25.7%) was obese and 14.5% overweight. Locally maternal obesity is also of concern and is a factor in poorer maternity outcomes and higher infant mortality.

4.1.1 Implement NICE guidance (2010) for maternal obesity "Weight management for before and after pregnancy". Local authority leisure and community services should offer women with babies and children the opportunity to take part in a range of physical or recreational activities. This could include swimming, organised walks, cycling or dancing. Activities need to be affordable and available at times that are suitable for women with older children as well as those with babies. Where possible, affordable childcare (for example, a crèche) should be provided and provision made for women who wish to breastfeed.

4.1.2 Develop and implement consistent healthy eating and physical activity policies across Southwark Children's Centers that promote breastfeeding and ensure compatibility with the Early Years Foundation Stage Framework and Caroline Walker Trust nutrition guidelines.

4.1.3 Develop and carefully promote courses using professional chefs on cooking, shopping and nutrition through aspirational marketing to appeal to parents and carers.

4.1.4 Active encouragement for all nursery staff to attend under 5's healthy weight training to support implementation of policies. Extend also to anyone caring for a child under 5 (there may be a high proportion of children being looked after by unregistered childminders e.g. family members).

4.1.5 Consider the potential for undertaking a local weighing programme using school nurses to weigh children in early years.

4.2 Population level change

Evidence of need - Creating healthier environments (activity- and food-related) and integrating healthier behaviours into our everyday living have been demonstrated as a necessary part of any response to support change of behaviour patterns associated with obesity. Solutions include changes in transport infrastructure and urban design

as they are more likely to affect multiple factors influencing obesity than individual changes and support a healthier, sustainable environment.

4.2.1 Promoting active travel - ensuring every school has a healthy transport plan that encourages active travel i.e. walking and cycling to school.

4.2.2 Create a healthier environment for our children and young people by restricting the licensing of new hot food takeaways e.g. within 400m boundary or 10min walking distance of schools, children centre's, youth-centered facilities. High concentrations of fast food outlets are currently in Peckham Town centre, Queens Rd Peckham, Walworth Rd. Other London boroughs have been very effective in their planning restrictions (e.g. www.barking-dagenham.gov.uk/2-press-release/press-release-menu.cfm?item_code=3761), supporting more healthy eating opportunities, greater diversity of local outlets as well as reducing litter and anti social behaviour.

4.3 Schools and Free school meal pilot

4.3.1 Ensure a whole school approach to implementing the universal free school meals programme by involving all staff, children, parents, governors and the wider school community. A whole school food policy should promote the uptake of school meals, nutrition based standards, healthy behaviours and environments and sustainability issues (could include PSHE lessons, farm trips, and breakfast clubs, grow cook and eat clubs, stay on site lunchtime policy etc).

4.3.2 The 'Superstars Challenge' ensured that children received 3 hours of sports provision and that included 45 minutes of constant cardio-vascular movement. Time spent travelling to and from the activity was not counted, whereas this usually can be. Officer reported it took take time to negotiate this level of provision with schools as this was 3 hours less academic time delivered. Integrating the 'Superstars Challenge' with the free school meal offer might be the most effective strategy.

4.3.3 Concern was expressed that that lunches provided are often prepared hours in advance. The food is often insipid tasting and then children choose the tastier bits, which may not be the healthiest parts of the meal. Moreover sometimes the food at delivery point has little resemblance to the menu description. There was concern that that responsibility for school meal provision has now moved to the governors which may not be realistic for them to adequately monitor.

4.3.4 Ensuring there is delivery of high quality physical activity and school sports throughout the borough and that school are asked to report on levels of engagement in physical activity and sports as measures of health and wellbeing. The SCG Superstars Challenge programme is directly linked to Healthy Schools programme and is incorporated into the obesity challenges throughout the borough. In addition Southwark Community Games wider programme is additionally targeted at very precise areas of population in local neighbourhoods and the link with sport and physical activity as part of the

London 2012 brand. This should be linked into the LBS Olympic Delivery Board, and the Health Factor Steering Group.

4.3.5 The NICE recommendations and the Bacons partnership emphaise that for sports to be effective it needs to be fun and of high quality; coaches need the right level of skills. Ensure that all school can get sports coaching for relevant teachers. Encourage active and outdoor play in schools during playtime.

4.4 Working with populations at greater risk

Evidence of need – There appears to be a higher risk of obesity for people from some groups in Southwark including lower socioeconomic groups, some ethnic minority groups (the Black or Black British population have a higher prevalence of obesity) and people with other needs such as learning disabilities and mental ill-health can find it more difficult to maintain a healthy weight.

4.4.1 Enhancing healthier eating knowledge and behaviours amongst at risk populations, working with relevant geographic and ethnic communities.

4.4.2 Supporting people with learning disabilities and mental ill-health, as well as the carers and staff that work with them to encourage healthy eating and physical activity behaviours.

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