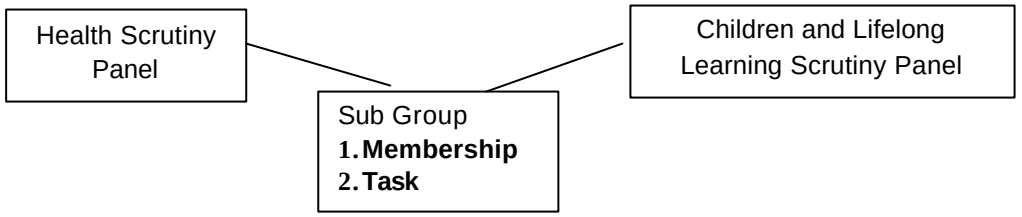
Update to Health Scrutiny & Performance Panel
31st January 2005

Background:
At the meeting of the Scrutiny Panel on the 20th December 2004, Dr Ramaiah gave a presentation on obesity in Walsall. As a result, Dr Ramaiah was asked to come back with recommendations for the panel on how the panel could make most impact on reducing the prevalence of obesity in Walsall.

However, since this meeting, the Children's Services and Lifelong Learning Panel have also met at which, our colleague Dr Linnane, gave a presentation on Childhood Obesity which was well received.

As a result of the 2 meetings, it is suggested that both Scrutiny panels establish a **Sub-Group** to focus on obesity in Walsall looking at for example, tackling obesity in schools.

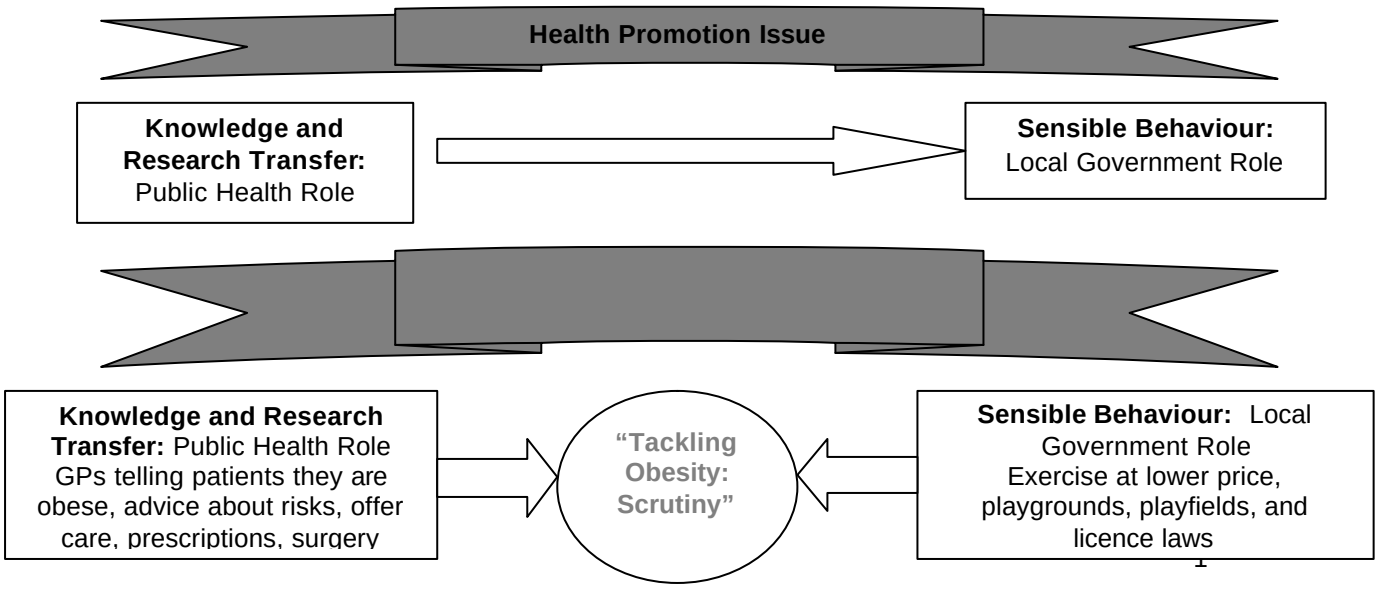


1. The **membership** from Childrens Panel has already been agreed:
It will include Cllr Eileen Pitt, a Social Services senior officer, a leisure and culture services office and Dr Ramaiah and Dr Linnane representing Public Health.

2. The **task(s)** of the group need to be looked at in more detail. The group needs to consider some of the following issues:

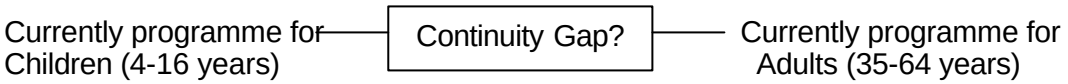
Link with other initiatives
Obesity is one of the areas highlighted in the *White Paper: Choosing Health*, and ties very closely with the work being carried out around life expectancy locally. The Local Strategic Partnership (LSP) has given monies to investigate life expectancy in Walsall. Looking at what is working? What evidence based research is available? What actions do we need to take in next few years to increase life expectancy locally? The sub-group could link in, and work alongside these initiatives.

The group needs to look at ownership of obesity. Agencies need to feel ownership and understand their contribution to reducing obesity in Walsall. **Theory of Ownership, Health Promotion**



Issues to Scope

- Scope areas of concern e.g. age



- Look at perhaps pursuing a setting-based approach e.g. LA, PCT, Voluntary Services etc…
- Or pursuing a risk-factor based approach e.g. diet, exercise
- Or an agency-based approach e.g. WMBC and NHS = 20,000 employees
- There are also data collection issues to be considered
- There is a need for measurable outcomes

Tasks for Today:

1. Agree dates for sub-group meeting
2. Locate resources to task someone to carry out the scoping exercise
3. Identify people to carry out scoping
4. Agree realistic timescale – end of 2005?

4 May 2004

Report to the City Council

Children's Nutrition – Obesity

Further copies of this report can be obtained from:

Scrutiny Support Officer: **Helen Walker**
☎: **0121 464 7457**
E-mail: **Helen.walker@birmingham.gov.uk**

Reports that have been submitted to Council can be downloaded from **www.birmingham.gov.uk/scrutiny**.

1: Summary and Recommendations

1.1 Birmingham, like the rest of the UK, is experiencing a public health epidemic of childhood obesity. Obesity among children aged two to four almost doubled between 1989 and 1998, from 5% to 9%. Among those aged six to fifteen, rates of obesity trebled from 5% in 1990 to 16% in 2001. Conservative estimates predict that if these trends continue, by 2020, one in three adults, one in five boys and one in three girls will be obese.

1.2 Of the 977,087 people living in Birmingham (2001 census), it is estimated that over half the adult population (374,970) of Birmingham is overweight and 18% are clinically obese, that is 135,750 adults. Of the 158,920 children aged 5-15 years living in Birmingham, 39,530 are estimated to be overweight (24.9%) and 19,890 clinically obese (12.5%).

1.3 Obesity is a condition in which body fat stores are enlarged to an extent that impairs health. In scientific terms, obesity is the result of “deranged energy balance”, i.e. when energy intake exceeds energy expenditure causing excess fat or “adipose tissue” to be formed and stored. Poor diet and insufficient physical activity lie at the heart of the obesity problem.

1.4 Childhood obesity predisposes to adult obesity: about 50% of obese children become obese adults. Obesity at 13 yrs is predictive of adult obesity. Normal weight adults who were obese children continue to carry an increased health risk, especially that of cardiovascular disease. Adult obesity reduces life expectancy by 8-10 years, mainly through premature death due to cardiovascular disease or complications of diabetes. In Birmingham an estimated 495 deaths per year are attributable to obesity.

1.5 Patterns of obesity lead to a ‘health divide’ between different social classes and ethnic groups. 14% of people from professional groups are obese, compared to 28% of women and 19% of men from manual groups. Levels of obesity are higher in Black Caribbean and Pakistani women (50% and 25% higher respectively). Around 30% of the Birmingham population are from non-white ethnic minority communities compared to 9% nationally and so there is greater risk of ill health related to obesity in our population.

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1.6 Childhood obesity is a disease with potentially devastating consequences, the most important of which are poor mental health, cardiovascular disease and type 2 diabetes mellitus. Health consequences of adult obesity include an increased risk of heart attacks and strokes, type 2 (non insulin dependent) diabetes, breast, endometrial and colorectal cancers and high blood pressure (hypertension).

1.7 The social and mental health consequences of obesity, especially for children, are social isolation, bullying and peer problems. Obesity in childhood and adolescence is associated with poor self-esteem, being perceived as unattractive, depression, disordered eating, bulimia and body dissatisfaction.

1.8 The World Health Organisation (WHO) estimates that 58% of type 2 diabetes, 21% of heart disease and between 8-42% of certain cancers are attributable to excess body fat.

1.9 Deaths linked to obesity shorten life by 9 years on average. The estimated human costs for England include a loss of 18 million sick days a year, 30 000 deaths per year resulting in 40,000 lost years of working life.

1.10 It is estimated that, in England, there is a financial impact on the NHS of approximately £0.5 billion in treatment costs and approximately £2 billion on the economy.

1.11 In Birmingham, it is also estimated that reducing the prevalence of obesity by 5% could save 25 lives each year, and reducing obesity by 25% could save 124 lives a year.

1.12 Reasons for the increase in childhood obesity include:

<u>Poor diet</u>

- snacking and over reliance on fast food and processed foods which are high in salt, sugar and fat
- predominance of a “cafeteria culture” in many of our schools and access to vending machines providing energy-dense foods and snacks
- low intake of fruit and vegetables in many children
- poor knowledge amongst children about nutrition, food skills and what constitutes a healthy diet
- over-marketing and advertising of fatty and sugary foods
- poor access to healthy food and retail outlets selling fresh fruit

and vegetables

Decline of physical activity

- an increase in sedentary behaviour (e.g. watching TV) in children
- fewer children walking or cycling to school
- less curriculum time spent on physical activity (PE) and sports
- poor access to or less use of parks and recreational areas and facilities

1.13 Tackling childhood obesity requires action in a number of areas - behaviour, dietary intake, physical activity, and the wider environments to which children are exposed.

1.14 The broad conclusions of the review group are that:

- Current measures to tackle obesity in the City are failing. At present there is no coherent pan-Birmingham inter-agency approach to tackling obesity. Policy-making and strategic planning are not sufficiently integrated between the NHS and local government and a bold approach and strong leadership are required if the health of Birmingham's children is to be protected.
- The evidence base of effective interventions for preventing and treating obesity in children is weak: many aspects of the management of childhood obesity have either not been subject to systematic evaluation or have limited robust evidence of support. Much research is needed to clarify what works for whom and in what circumstances, but currently there is sufficient guidance to permit the development of sensible service models.
- Treating childhood obesity is difficult and services are not well developed. Current utilisation of the community nutrition and dietetic service for children is low in relation to need.
- The current arrangements for surveillance monitoring childhood obesity prevalence in Birmingham are unsatisfactory and urgent action is required to put in place information systems required to support needs-based planning and to monitor the impact of interventions.
- Potentially, schools are important social as well as health promoting environments for children and young people. Schools should be part of the solution to control the childhood obesity epidemic, not part of the problem.

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- Food manufacturers' marketing strategies include incentives for schools to promote their products by offering schools resources in the form of equipment, books, and income from vending machines. These products are often energy dense and high in fat, sugar and salt, for example items such as crisps, confectionery and fizzy drinks.

- Currently the LEA has not issued policy guidance to help schools make a judgement on what are acceptable ways to generate income and what is expected of them as organisations responsible for protecting and promoting the health of children.

- The governance of local schools may also fail children, as the quality of nutritional or physical activity opportunities provided is not scrutinised adequately by many school governing bodies. Currently there is little school governor training to help governors examine how the school environment impacts on children's health and well being.

- The importance of food poverty and its impact on rising obesity prevalence in those who are socio-economically disadvantaged cannot be underestimated. Of particular concern is the inability of some high-need groups to access affordable high quality fresh fruit and vegetables, and the transformation of neighbourhoods, where once a diversity of small retailers provided for local food needs, into areas characterised by food retail outlets selling takeaways, junk food, and long shelf-life energy-dense processed foods high in salt, fat or sugar. A joined-up approach is needed to develop local retailing strategies for tackling food poverty and lack of access to healthy eating opportunities.

1.15 Whilst the Committee has uncovered the depth of the problem and identified many the issues that need to be tackled, there is much work that needs to be done to explore, negotiate and commission interventions for reducing obesity in the City. The Committee therefore recommends that:

	Recommendation	**Responsibility**	**Completion Date**
R1:	A pan-Birmingham Children's Nutrition Task Force be established responsible to the Cabinet Member for Social Care and Health (in her capacity as Chair of the Children and Young Person's Strategic Partnership), to develop a City-wide action plan for responding to the growing problem of childhood obesity. The Task Force should be established along the lines of the proposed Terms of Reference attached at Appendix 8.	Cabinet Member for Social Care and Health	Task Force to be established by October 2004
R2	A dedicated lead officer, jointly funded by the City Council and the Primary Care Trusts and reporting to the Cabinet Member for Social Care and Health, be appointed in the first	Cabinet Member for Social Care and Health	December 2004

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	instance for a year, to ensure that real progress is made on this issue including the pursuit of interventions outlined in appendix 9.		
R3	An interim report be presented to the Birmingham Health Partnership before the end of the calendar year providing a fully costed action plan including detailed actions which have already been put in place.	Cabinet Member for Social Care and Health	December 2004
R4	All the PCTs in Birmingham • explore the feasibility of collecting: data on children's universal height, weight and BMI at reception year, year 7 and if possible year 11, or on a school population basis; • ensure that data generated by capturing children's universal height, weight and BMI is entered and fully utilised by the Child Health Surveillance System (CHSS); • ensure that BMI, height and weight information from the CHSS is made available to school nurses, head teachers and parents; • ensure that the health needs of obese children are identified and they and their families are offered appropriate help and support.	Chief Executives of the 4 Birmingham PCTs	December 2004
R5	The City Council works in conjunction with Birmingham's 4 Directors of Public Health to develop and disseminate to schools, advice and guidelines on • Food and drink in schools; • Commercial sponsorship; advertising and promotion in schools; • Physical activity in schools.	Cabinet Member for Education and Lifelong Learning	December 2004
R6	The City Council undertakes a review of the Health Education Unit, and works in conjunction with Birmingham's 4 Directors of Public Health, in examining the potential public health role of school nurses.	Cabinet Member for Education and Lifelong Learning	December 2004
R7	The City Council ensures that school governors receive training to better facilitate the effective execution of their governance function including • Proper consideration of how the school environment impacts on children's health and well-being; • The school's responsibilities for protecting the health of children; • Adopting a whole-school approach to combating obesity including issues as set out in section 4.5.4	Cabinet Member for Education and Lifelong Learning	December 2004

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	and 4.6.9 of this report.		
R8	Progress towards achievement of these recommendations be reported to the Health Overview and Scrutiny Committee by December 2004. Subsequent progress reports will be scheduled by the Committee thereafter, until all recommendations are implemented.	Cabinet Member for Social Care and Health	December 2004

6: Conclusions

6.1.1 Overall the Committee's conclusions are that current measures to tackle obesity in the City are failing. At present there is no coherent pan-Birmingham inter-agency approach to tackling obesity. Policy-making and strategic planning are not sufficiently integrated between the NHS and local government and a bold approach and strong leadership are required if the health of Birmingham's children is to be protected.

6.1.2 The evidence base of effective interventions for preventing and treating obesity in children is weak: many aspects of the management of childhood obesity have either not been subject to systematic evaluation or have limited robust evidence of support. Much research is needed to clarify what works for whom and in what circumstances, but currently there is sufficient guidance to permit the development of sensible service models.

6.1.3 Treating childhood obesity is difficult and services are not well developed. Current utilisation of the community nutrition and dietetic service for children is low in relation to need.

6.1.4 The current arrangements for surveillance monitoring of childhood obesity prevalence in Birmingham are unsatisfactory and urgent action is required to put in place information systems required to support needs-based planning and to monitor the impact of interventions.

6.1.5 Potentially, schools are both potent social as well as health promoting environments for children and young people. Schools should be part of the solution to control the childhood obesity epidemic: however, there is much research to suggest that many schools are also part of the problem.

6.1.6 Food manufacturers' marketing strategies include incentives for schools to promote their products by offering schools resources in the form of equipment, books, and income from vending machines. These products are often energy dense and high in fat, sugar and salt - for example, items such as crisps, confectionery, and fizzy drinks.

6.1.7 Currently the LEA has not issued policy guidance to help schools make a judgement on what are acceptable ways to generate income and what is expected of them as organisations responsible for protecting and promoting the health of children.

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6.1.8 Local school governance arrangements may fail children, as the quality of nutritional or physical activity opportunities locally provided is not scrutinised sufficiently by school governing bodies. Currently there is little school governor training to help governors examine how the school environment impacts on children's health and well being.

6.1.9 The importance of food poverty and its impact on rising obesity prevalence in those who are socio-economically disadvantaged cannot be underestimated. Of particular concern is the inability of some high-need groups to access affordable high quality fresh fruit and vegetables, and the transformation of neighbourhoods, where once a diversity of small retailers provided for local food needs, into areas characterised by food retail outlets selling takeaways, junk food, and long shelf-life energy-dense processed foods high in salt, fat or sugar. A joined-up approach is needed to develop local retailing strategies for tackling food poverty and lack of access to healthy eating opportunities.

6.1.10 Whilst the Committee has uncovered the depth of the problem and identified many of the issues that need to be tackled, there is much work that needs to be done to explore, negotiate and commission interventions for reducing obesity in the City. The Committee therefore recommends that:

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R8	Progress towards achievement of these recommendations be reported to the Health Overview and Scrutiny Committee by December 2004. Subsequent progress reports will be scheduled by the Committee thereafter, until all recommendations are implemented.	Cabinet Member for Social Care and Health	December 2004

South Tyneside Council

Cabinet

Date: 17 November 2004

Scrutiny Commission on Tackling Obesity in South Tyneside – Recommendations

Report of the Chair of the Social Care and Health Scrutiny Committee

Lead Member: Cllr Jim Foreman (Social Care & Health)

Summary

1. This report presents the findings from the Social Care & Health Scrutiny Committee and its Scrutiny Commission looking at Tacking Obesity in the Borough. The Commission's report makes 18 recommendations.

2. Cabinet is asked for their views on the report.

3. The relevant Executive Directors, in consultation with Lead Members will then prepare a detailed response to each of the Commission's recommendations, which takes Cabinet views into account.

4. This response, which will be presented to Cabinet, will outline the full financial, legal and risk implications of any recommendations.

Performing Together Reference: M5/1/1

Contact Officer: Paul Baldasera (Innovation Officer) 0191 424 7003

Recommendations from the Scrutiny Commission

27. From the detailed discussions members have had with a variety of witnesses they have questioned and the research that has been carried out, the Commission have been able to make a number of recommendations.

28. Appendix 1 shows where these discussions and evidence have led to these recommendations. The Commission are encouraged that a number of these recommendations are in line with the emerging obesity strategy being lead by South Tyneside PCT.

R1 The Local Authority and Primary Care Trust should introduce a "lifestyle Team" based on the smoking cessation model to which people can be referred for appropriate support from dieticians, nutritionists, fitness advisers, doctors etc (see appendix 4).

R2 South Tyneside should establish a plan on how to offer more healthy options through the school meals service and how to encourage children to make these choices. Initiatives could include:

- More curriculum based education about healthy food choices
- Healthy Tuck Shops and vending machines
- Reward schemes for making healthy choices
- Encouraging children to remain in school at lunchtimes
- Information on healthy packed lunches
- Working with local shops to provide healthy alternatives
- The School Meals Service working with the Primary Care Trust in analysing current menus for nutritional value and to make recommendations about how to improve them.
- A working party is set up to look at how food in schools can be improved. This could be done in conjunction with other local councils and could look at aspects such as
    - Providing better choices
    - Making healthy choices affordable to all children
    - Added value of increased food cost
    - Designing better catering facilities via *Building Schools for the Future.*

  This work could go back to the Scrutiny committee with a view to making further recommendations to cabinet.

R3 A screening programme should be developed for preschool children to monitor weight gains and to initiate early action with families.

R4 We should implement a range of interventions in schools to prevent obesity and promote healthy lifestyles. These should include:

- More physical education (ensuring at least 2 hrs per week)
- More teaching of cooking skills
- Primary school projects
- Awareness training for headteachers
- Systems for weighing and measuring children throughout their school career (BMI not always best measurement) to trigger interventions for children who are overweight, working with families
- Health promotion messages to children/promotion of less sedentary behaviour
- After school clubs/camps

The Department for Education and Skills *Health Blueprint for Schools* provides a template for how we can achieve this

R5 As well as the young people we serve now, we should target the variety of youth activities we provide to include those young people who would not normally volunteer for such schemes and children with physical and learning disability.

R6 We should equip people with more cooking skills through the appointment of community nutritionists.

R7 We need to engage the community to encourage them to take up healthy choices. Initiatives could include:

- Health promotion campaigns (On View, Gazette etc)
- Engaging community groups
- Outreach initiatives in CAF areas
- Lifestyle questions in the residents survey
- Pedometer initiatives

R8 We should look at more ways to make sport and exercise available to all through community associations, healthy living centre network and schools. This should include the provision of free junior membership and discounted activities where this is possible. We should also ensure convenient, affordable transport links and car parking to encourage people to take up these activities.

R9 Promoting healthy lifestyles should be a factor that is taken into account when the council and its partners undertake any policy initiative i.e. the policy should explain how it is going to effect/promote the healthy lifestyle choices of the residents.

R10 The developing Local Development Framework and the Open/Green Spaces Strategy, which contributes to it, should state explicitly how they will create activity friendly localities and how planning policy will guard against contributing to the "obesogenic" environment. This will include:

- Accessible leisure facilities
- Better/safe play spaces
- Bike paths and cycle lanes
- Safe areas for walking
- Access to local shopping
- Traffic calming and traffic free schemes
- Neighbourhoods where people value children playing

An officer steering group should establish a brief for consultants to prepare an Open/Green Spaces Strategy which will fully recognise these issues.

R11 We should work with local supermarkets and shops to encourage people to make healthy choices when shopping.

R12 The PCT should establish support mechanisms (through the proposed lifestyle teams) for people who need to lose weight. This will include consideration of working with commercial diet clubs as the Obesity Strategy develops and is implemented.

R13 We need to develop work with farmers markets and food co-ops to make affordable healthy food available to deprived areas of the borough.

R14 GPs need a range of support and training to assist people who have problems with weight. These would include

- Wider awareness and usage of the exercise on referral scheme
- More guidance as to where to refer patients who have problems with weight
- Taking opportunistic opportunities for health promotion (e.g. whilst weighing a patient)
- Distributing standard leaflets for distribution in GP surgeries
- More information about drug therapies that are proven to work
- Promotion of proactive area wide schemes engaging a number of GP practices.
- More awareness of the effectiveness of surgical procedures in certain cases

R15 *Building Schools for the Future* must show explicitly how new schools will provide healthy eating opportunities and sufficient, thoughtfully designed space and facilities for physical activity.

R16 As a major employer and a "champion" organisation, we should provide a healthy environment for employees that encourages healthy lifestyles. This could include: -

(in the short term)

- Access to regular health checks
- Health Bus tour to work places
- Annual health promotion days
- Healthy eating options in the canteen
- Lunchtime information sessions on healthy eating and exercise
- Access to shower and changing facilities
- Greater promotion about what is currently available

(in the long term)

- Sign up to PCT healthy workplace scheme
- Healthy workplace issues embedded into policies and strategies
- Free/discounted use of council run leisure facilities for employees

R17 The recommendations of this commission should be taken into account when developing the local multi-agency strategy to tackle obesity.

R18 This report should be sent to government with a request for

- The production of a national obesity strategy
- Tighter guidelines on food advertising, particularly those adverts aimed at children