DRAFT 6 – 4/4/2016

Scrutiny
Improving Public Services

Obesity Issues in Essex

The Final Report of a review by a Task and Finish Group of the Health Overview and Scrutiny Committee

April 2016

Essex County Council

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Foreword

Since our Health Overview and Scrutiny Committee Task and Finish Group started our research on the Obesity crisis, there have been few weeks pass without attention being drawn to the problem of this “ticking time-bomb”. Prominent people and groups have been outspoken about the urgency of tackling it – The House of Commons Health Committee report **Childhood obesity – brave and bold action**, published in November 2015 and Jamie Oliver’s campaign to enforce the reduction of sugar in drinks and food.

As the subject is so large, we decided to concentrate our efforts on prevention – i.e. from pre-birth to age 11.

We had the full co-operation of all the agencies involved, who came to us and enthusiastically explained what they were trying to do and what the benefits of their services are. They are listed separately in this report and we thank them sincerely for their time and obvious dedication to helping to keep children healthy. Our recommendations are based on what we learned from them and perhaps the most important of these recommendations is that the County Council’s Public Health team are given the resources to help bring all the various agencies together for this important prevention.

I would like to close by thanking my colleagues for their ideas and attendance at meetings, and also to Graham Hughes, Scrutiny Officer, for arranging all our meetings and briefings and for getting the report together.

I commend it to you.

COUNCILLOR MARGARET FISHER
Lead Member of the Obesity Issues in Essex Task and Finish Group
April 2016

Executive Summary and conclusions

Background

A small Task and Finish Group established by the Essex Health Overview and Scrutiny Committee has been reviewing obesity issues in Essex with a specific focus on preventative measures for 0-11 year olds ('the Group').

The Group spoke to commissioners and providers of services aimed at pre-birth and early-years, pre-school, infant schools, and the promotion of sport and physical activity, changing fast food provision and the establishment of social prescribing. The Group have heard about some good existing practices already aimed at early years, pre-school and primary school children. There are also some promising new initiatives underway to encourage healthier lifestyles.

National evidence suggests that it is difficult to treat obesity once it is established and that it is highly likely that obese children will become obese adults. Therefore, it is essential that there is a strong focus on influencing lifestyles at an early age.

The scale of the problem

Nationally one fifth of children will be obese or overweight when they start school in Reception Class. By the time they leave primary school this figure will have increased to one third. Children from deprived backgrounds are twice as likely to be obese at both the start and finish of primary school which points to a significant health inequality issue resulting in an even greater need now for the targeting of services at areas with higher rates of deprivation. There are also specific areas in Essex such as Basildon, Castle Point, Harlow and Tendring where the prevalence of obesity at year 6 is noticeably higher than elsewhere in the county and higher than the regional average.

The trends are not improving and, to the contrary, highlight the numbers obese at Year 6 actually to be increasing so what is currently being targeted at children and young people is not enough. Urgent and bold action is required to address this. The most effective interventions will be those that focus on prevention and promoting a healthy lifestyle from an early age.

The cost of ineffective action is significant with the total cost of obesity to the health system currently estimated to exceed £5 billion per year. It is also one of the risk factors for Type 2 diabetes, which accounts for spending of £8.8 billion a year – almost 9% of the NHS budget. The wider costs of obesity to society will be significantly more than this.

How to stop the upward trend

The increasing trend of obesity has to stop as society cannot afford the financial, community and social costs of not doing so. There are no easy answers to solve what is now commonly being termed the obesity epidemic. Commentators will push

for either improved education and communication, greater exercise, the role of marketing and promotions, portion sizes or a role for sugar tax yet the solution will be a combination of all of these. There is no one factor that should be targeted alone. Our more sedate, inactive modern lifestyle needs to be tackled and *regular* physical activity and exercise needs to be built into everyone's lifestyle. However, changing the food environment and industry away from promoting high fat, salt and sugar ingredients would also be a significant contributor.

The nutritional ingredients of meals provided at schools is an important part of encouraging and ingraining healthy eating at an early age. The local take-up rates for Universal Infant Free School Meals generally seem to be good although they should be further improved and schools need to encourage parents to continue take-up of both Universal Infant Free School Meals at Key Stage 1 and the merits of continuing with school meals in Key Stage 2 and beyond whether or not they qualify for free school meals.

However, even once children have a healthy eating environment at school there is still the outside school environment. The economic and social environment can be such a large influence on lifestyles and increasing focus on approaching the obesity issue through an all-systems approach has to be encouraged. Therefore, the outcomes from the all-systems pilot in Braintree need to be monitored and, if there is improvement, then the approach must be extended elsewhere, concentrating initially on those other areas that have the highest rates of childhood obesity, namely Basildon, Castle Point and Tendring .

Co-ordination and leadership

The Group's conclusions and formal recommendations reflect that there is significant risk and opportunity around the format of future prevention services. The review has highlighted that the provision of some current services is fragmented yet there is likely to be further financial and resource pressures on all areas of local government in future and it is essential that greater co-ordination and joint working is undertaken to focus attention and resources more effectively and efficiently. Closer relationships with other stakeholders such as districts, community providers, and the private sector, will be important as part of encouraging greater focus on personal responsibility for healthy lifestyles and strengthening local communities to provide support for that.

With Public Health now integrated within the County Council, it provides the opportunity for stronger strategic leadership on prevention on a local level across the county. Strong and visible leadership is essential to take a whole-systems approach to tackling obesity. There is also now a greater opportunity to link up with local government to increase the influence on local planning, encouraging the development of walking and cycling routes, areas for sport and recreation as well as greater regulation of fast food outlets.

Recommendations

As a result of all the above the Group has made 21 recommendations on issues around interventions in early years, working with schools, sport and physical activity, regulation, planning and enforcement, integrated and joint working, and the role of the Public Health Team in Essex. The Group requests that these recommendations should be carefully considered for implementation.

Early Years provision

Recommendation 1 *(Page 19): That a breastfeeding support service should continue to be resourced to promote the benefits of breastfeeding either as a standalone service or as part of a more integrated 0-19 service offer.*

Owner: Cabinet Member for Health/ Director of Public Health
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 2 *(Page 20)**:** That Health Visitors should maximise their influence over behaviours and environment by taking every opportunity to signpost to other related prevention services.*

Owner: Cabinet Member for Health/ Director of Public Health
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 3 *(Page 21)**:** A wider and continual promotion of the Healthy Start programme should be established using supermarkets, pharmacists and other relevant retail outlets.*

Owner: Cabinet Member for Health/ Director of Public Health
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 4 *(Page 23): The focus by Children's Centres to increasingly target their services and use Outreach services to improve access to traditionally hard to reach groups should be encouraged and supported and that appropriate metrics assessing its success should be reported back to the Health Overview and Scrutiny Committee in a years' time.*

Owner: Cabinet Member for Health/ Director of Public Health
Implementation Review: April 2017
Impact Review Date: October 2017

Working with schools

Recommendation 5 *(Page 25)**:***

(i) *That efforts should continue to increase Universal Infant Free School Meals uptake and that the HOSC should receive an update on progress made in a year's time;*

(ii) *Schools should be encouraged to positively market Universal Infant Free School Meals all year round and not just at census time;*

(iii) *Any new pilots to improve uptake, promotion and/or delivery of Universal Infant Free School Meals should start in the most deprived areas which have the lowest uptake;*

Owner: Cabinet Member Education and Lifelong Learning/ School Meals Service Advisor
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 6 *(Page 26)**: The County Council's Schools Meals Support Service should encourage Local Education Authority maintained schools to further publicise the need for parents to still apply for Free School Meals so that the school receives Pupil Premium Funding for that child.*

Owner: Cabinet Member Education and Lifelong Learning/ School Meals Service Advisor
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 7 *(Page 26)**: That further influence needs to be exerted by schools and through the Healthy Schools Programme to encourage parents to include healthier choices in packed lunches.*

Owner: Cabinet Member Education and Lifelong Learning/ School Meals Service Advisor
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 8 *(Page 27)**: That Universal School Food Standards should apply to academies and free schools in addition to local authority controlled schools.*

Owner: Cabinet Member Education and Lifelong Learning/ School Meals Service Advisor
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 9 *(Page 27)**: That the School Meals Service Advisor should speak at local/regional School Governor conference(s) (i) to raise the profile of Universal Infant Free School Meals, (ii) encourage further improvement in uptake and (iii) encourage eligible parents still to formally*

register for entitlement to free school meals so that schools do not lose pupil premium funding.

Owner: Cabinet Member Education and Lifelong Learning/ School Meals Service Advisor
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 10 *(Page 28)**: That leverage should be exerted over those schools applying for, or maintaining, Healthy Schools' status to get them to promote Universal Infant Free School Meals and school meals in Key Stage 2 and beyond.*

Owner: Cabinet Member Education and Lifelong Learning/ School Meals Service Advisor
Implementation Review: April 2017
Impact Review Date: October 2017

Sport and physical activity

Recommendation 11 *(Page 30)**: There should be a stronger link between the activities supported in schools by Active Essex and the activities promoted under the Healthy Schools Programme.*

Owner: Cabinet Member Education and Lifelong Learning/Head of Active Essex
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 12 *(Page 30)**: That the role and expertise of Active Essex as an in-house resource for the County Council should be valued and protected as it provides the foundation for leading co-ordinated working with local partners.*

Owner: Cabinet Member Education and Lifelong Learning
Implementation Review: April 2017
Impact Review Date: October 2017

Regulation, planning and enforcement

Recommendation 13 *(Page 31)**: Further efforts to drive and expand the Tuck-in scheme should be encouraged with local Environmental Health Officers further incentivised to increase take-up.*

Owner: Cabinet Member for Health/Environmental Health
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 14 *(Page 31)**: That all planning areas and Public Health departments across Essex should promote low fat, sugar and salt in all takeaways.*

Owner: Cabinet Member for Health/Environmental Health
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 15 *(Page 32)**: That Public Health should be a material planning consideration for all business/commercial planning applications for food outlets lodged at each planning authority.*

Owner: Cabinet Member for Health/Environmental Health
Implementation Review: April 2017
Impact Review Date: October 2017

An All-Systems approach

Recommendation 16 *(Page 34)**: The outcomes from the Live Well Child Whole Community Approach pilot in Braintree need to be monitored and, if there is improvement, then it must be extended elsewhere, concentrating initially on those areas that have the highest rates of childhood obesity – namely Basildon, Castle Point, Harlow and Tendring.*

Owner: Cabinet Member for Health/Director of Public Health
Implementation Review: October 2016
Impact Review Date: April 2017

Integration and partnership working

Recommendation 17 *(Page 35)**: That the Group are encouraged by the potential of social prescriptions and request that its establishment pan Essex, albeit using different models, continues to be supported.*

Owner: Cabinet Member for Corporate, Communities and Customers/Director of Public Health
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 18 *(Page 35)**:*
That any commissioned projects to reduce or prevent obesity should make use of local social prescribing programmes, and that those local social prescribing programmes should support signposting and referral to local sources of help with obesity reducing behaviours - such as local walking, exercise, cooking, environmental and commercial weight loss groups.

Owner: Cabinet Member for Corporate, Communities and Customers/Director of Public Health
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 19 *(Page 36)**:***

(i) *That common branding be developed to link all healthy living initiatives and related prevention programmes to make them highly visible and easily identifiable;*

(ii) *That learning from the Live Well Child Whole Community Approach pilot in Braintree (see Recommendation 16) be used to inform the convening of a multi-agency Obesity Summit for Essex as part of a co-ordinated and integrated drive to tackle obesity.*

(iii) *That, as part of (ii) above, the County Council reasserts its commitment to tackling obesity through a vision statement to which every council service and all public sector partners commit;*

(iv) *That, as part of (iii) above, this report and recommendations herein be included as part of a County Council Childhood Obesity Strategy to be developed by the Cabinet Member for Health.*

Owner: Cabinet Member for Health/Director of Public Health
Implementation Review: April 2017
Impact Review Date: October 2017

Recommendation 20 *(Page 37): (i) That Public Health explores opportunities for joint working with local celebrities to provide a high profile focal point for the promotion of future obesity campaigns and (ii) That Public Health explores the local opportunities for investing the proceeds from a Sugar Tax to encourage greater participation in sport and physical exercise.*

Owner: Cabinet Member for Health/Director of Public Health
Implementation Review Date: April 2017
Impact Review Date: October 2017

The Role of the Public Health Team

Recommendation 21 *(Page 38)**:***

(i) *Public Health programmes to encourage healthy lifestyles can save the NHS and Essex County Council significant sums of money by reducing avoidable health and social care costs and the Group requests that the Public Health Team continues to receive the resources necessary to further develop and expand their prevention programmes.*

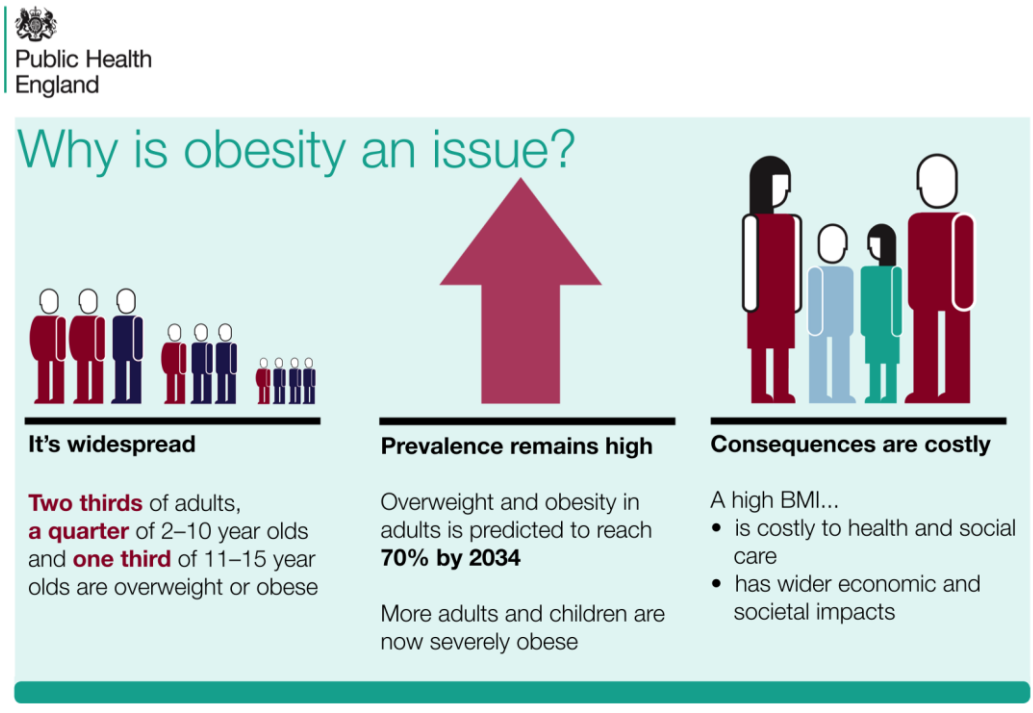
(ii) *The County Council should maximise the opportunity to fully utilise the potential of the in-house Public Health expertise and resource, increase its profile internally with employees encouraging them, for example, to become health champions, and transform the culture of the organisation so that the prevention agenda is incorporated into everyday considerations and decision-making.*

Owner: Cabinet Member for Health/Director of Public Health
Implementation Review Date: April 2017
Impact Review Date: October 2017

Background

The World Health Organisation has reported that childhood obesity is potentially one of the most serious global health challenges being faced. The House of Commons Health Select Committee has also now demanded bold and urgent action from Government. There is clinical evidence to support that being overweight or obese can lead to both chronic and severe medical conditions including Type 2 diabetes, cardiovascular disease and cancer. Whilst Type 2 diabetes has been more closely associated with adults, incidences in children are increasing. Obesity may also contribute to increased social care costs as well as having a significant impact on emotional health and wellbeing.

Treating obesity and its consequences is currently estimated to cost the NHS £5.1bn every year. It is one of the risk factors for type 2 diabetes, which accounts for spending of £8.8 billion a year, almost 9% of the NHS budget. The wider costs of obesity to society are estimated to be around three times this amount. By contrast, the UK spends only around £638 million on obesity prevention programmes. The numbers of adults in Essex diagnosed as overweight or obese is higher than the regional and national averages whilst the number of children similarly diagnosed is marginally below regional and national averages; however, there is an increasing trend of obesity in Year 6 children.



Source: Public Health England – Making the case for tackling obesity – why invest?

In view of the above trend and that two of Essex County Council's strategic outcomes are that 'Children in Essex [should] get the best start in life' and that 'People in Essex [should] enjoy good health and wellbeing', the Health Overview and Scrutiny Committee (HOSC) resolved to establish a Task and Finish Group to review obesity issues in Essex (the Group).

Membership

County Councillor Margaret Fisher (Lead Member),
Braintree District Councillor Joanne Beavis,
Castle Point District Councillor Bill Dick (served until June 2015)
County Councillor Ricki Gadsby,
County Councillor Keith Gibbs,
County Councillor Ian Grundy, (People and Families Scrutiny Committee)

Councillor Gadsby served as Deputy to the Cabinet Member for Communities and Healthy Living (who at the time had portfolio responsibility for Public Health) for a period during the review. Cllr Beavis was appointed as a Director of Active Essex after the review had started. In both cases it was agreed that both should declare their interest but continue as members of the Group.

Approach

The Group focussed its review on preventative measures aimed at pre-school and primary school aged children, so as to highlight the important role prevention can have in encouraging children, their parents and carers to take more personal responsibility for their health and wellbeing and general lifestyle.

The Scoping Document used by the Group for the review is attached as **Annex 1**.

Evidence base

Obesity issues remained topical throughout the duration of the review by the Group with significant publications and news commentary almost on a daily basis. This reconfirmed the Group's belief that obesity remains one of the most important challenges being faced in the health service today. A number of reports and publications were collected as part of developing a library of background material with which to guide members on some of the other reviews and commentary on the issue in the public domain and these have been listed in **Annex 2**.

Fourteen evidence sessions were held (the Group met on other occasions to discuss progress) and the Group also considered written evidence (listed in **Annex 3)**.

Limitations of the review

The Group is content that it has received a range of views and collected evidence from a number of key witnesses to fairly assess some of the current preventative measures in place, and being planned, to reduce the incidence of obesity which has enabled it to come to reasonable evidence-backed conclusions. However, the Group also acknowledge that there were further investigations that could have been made and other witnesses with whom the Group could have consulted. In particular, whilst members visited their local children's centre, they have not spoken directly with parents or service users.

The Group accepted the significant evidence available on the *causes* of obesity. It did not look at the links between obesity and other health issues (e.g. anxiety, bullying, depression) although there is significant evidence to indicate such links. The Group acknowledges that there is evidence to link deprivation with poor health outcomes and has offered some suggestions for this (particularly around the take-up of free school meals).

The Group notes that the development of a healthy school environment can improve educational attainment and performance and acknowledges the review undertaken by the People and Families Scrutiny Committee Task and Finish Group looking at the broader issue of educational attainment in schools.

The Group has not explored licensing, planning, transport or infrastructure issues in any detail although it has considered one particular local initiative around encouraging healthier preparation of food from fast food take-away outlets.

Acknowledgements

The Task and Finish Group wish to thank those contributors listed in Annex 3 for providing oral and written evidence.

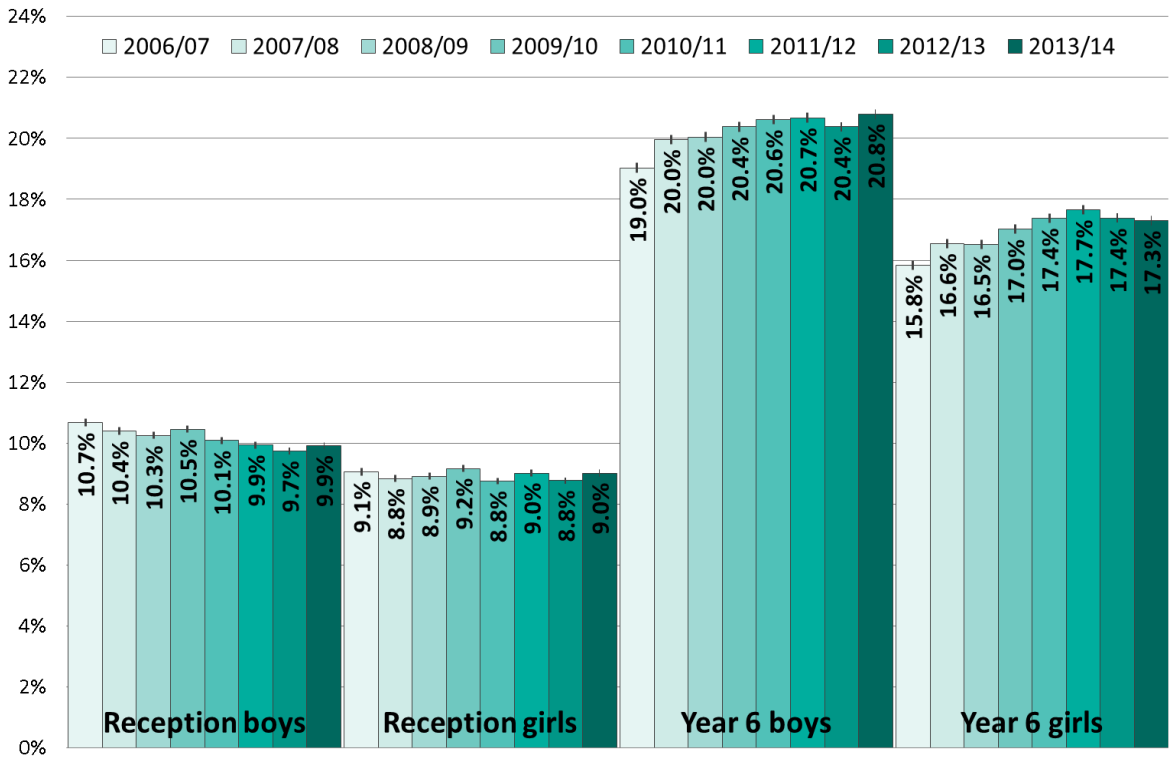
Findings and evidence

Context

The causes of childhood obesity can be complex and caused by a variety of factors including more sedate and less active modern lifestyles and unhealthy diets; the latter being compounded by greater use of convenience food, more food now being consumed outside the home with less food being prepared in the home, and a reduction in time and skills to prepare healthy meals.

The National Child Measurement Programme (NCMP) is a national programme for calculating the Body Mass Index of all children in maintained schools at Reception Year (age 4-5) and Year 6 (age 10-11 years). The NCMP probably provides the clearest indicator of obesity in children. The most recent data published by Public Health England in October 2015 indicates that, whilst there has been a slight downward trend in prevalence of obesity in reception age boys (and no significant trend for girls in the same age group), there is a significant upward trend of obesity prevalence among boys and girls in Year 6 (see chart below). This supports the Group's contention that a key component of preventative measures for obesity should concentrate on the pre-school and primary school age groups to encourage healthy living at an early stage in life and 'head-off' the trend towards obesity originating in those early years.

Obesity prevalence among boys and girls in Year 6 shows an upward trend
Prevalence of obesity 2006/07 to 2013/14 by school year and
sex

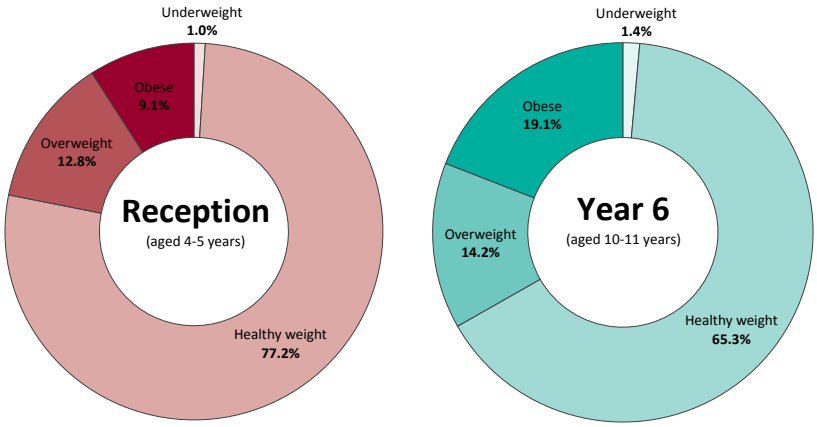


Source: National Child Measurement Programme as presented in the Public Health England Child Weight Data Factsheet (published October 2015)

When including those children who are considered overweight as well as the obese, the situation becomes even more startling with a third of children at Year 6 being considered obese or overweight.

National Child Measurement Programme 2014/15

Body Mass Index status of children



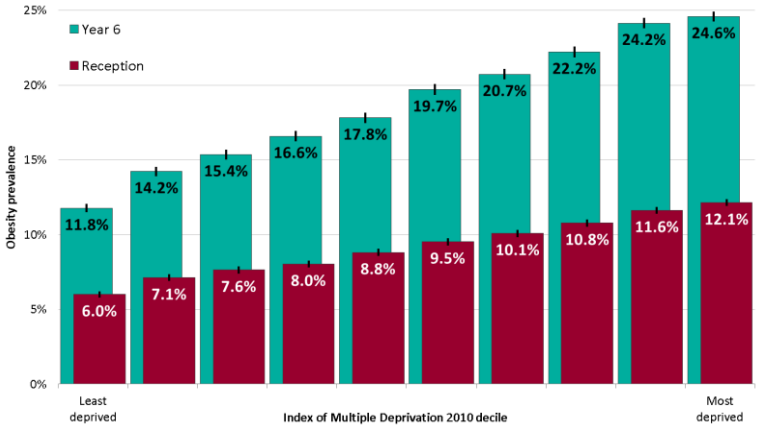
Source: Public Health England – Patterns and Trends in child obesity presentation (January 2016)

Parents and carers can play a large part in the weight of their children. Current evidence suggests that around 97% of obese children come from families where at least one parent is obese or overweight. (Strategic High Impact Changes: Childhood Obesity National support Team – Department of Health, March 2011 (p14)

Obesity and deprivation

Public Health England data suggests that the prevalence of obesity is strongly correlated with deprivation and is highest in the most deprived areas. The chart below shows a steady rise in obesity prevalence with increasing deprivation for both Reception and Year 6 children. Obesity prevalence of children in the most deprived decile is approximately twice that of children in the least deprived decile.

Prevalence of obesity by deprivation decile in Reception (aged 4–5 years) and Year 6 (aged 10–11 years) children, 2013/14

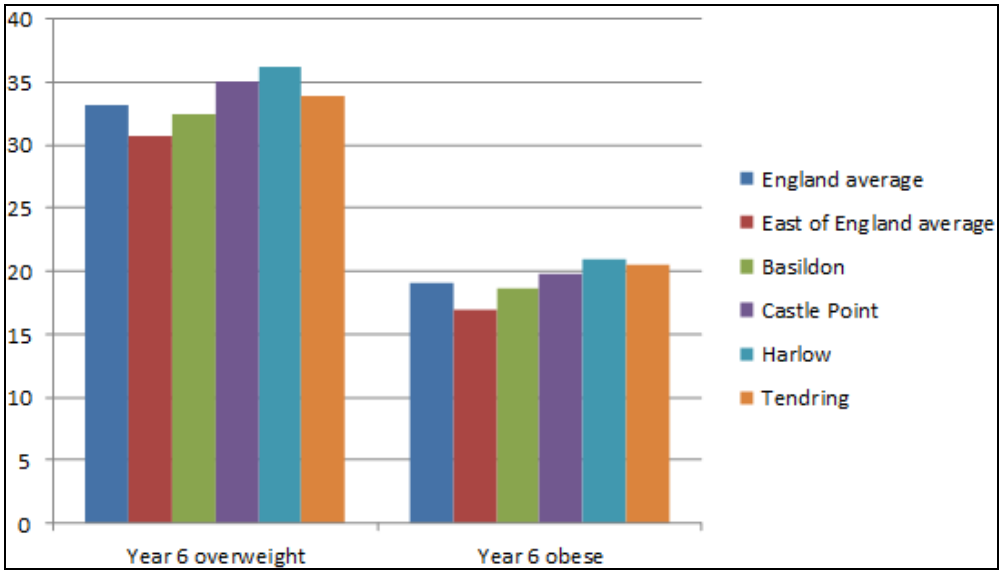


Source: National Child Measurement Programme

The Essex perspective

The latest National Child Measurement Programme data for Essex for 2014/15 reveals that, as with the national trend, the number of children considered obese or overweight significantly increases between measurement in Reception class and when children are measured again at Year 6.

The average rate of obesity prevalence in Essex compares favourably with both the England and the East of England Regional averages lying mid-range compared to all the upper tier local authorities in the region. However, analysis of Essex at district level reveals that the incidence of obesity varies significantly across the county: In particular, at Year 6 the Basildon, Castle Point, Harlow and Tendring areas have significantly higher rates of obesity ranging between 18.7% and 21%, compared to the East of England average of 16.9%. When including those considered overweight as well, those four areas continue to be outliers from the other areas in Essex ranging from 32.5% to 36.2% compared to the regional average of 30.7%.



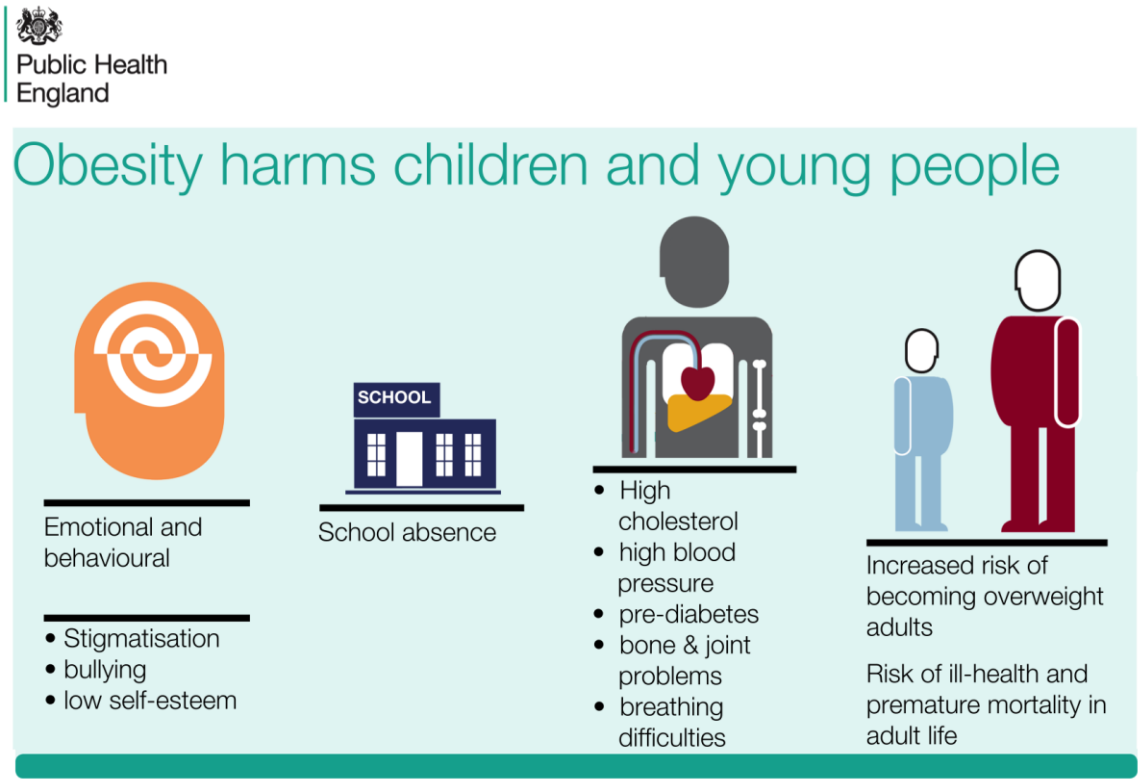
Above: Chart produced by extracting data taken from the National Child Measurement Programme 2014/15 highlighting, at Year 6, the incidences of obesity and of being overweight (which includes those considered obese) in the Basildon, Castle Point, Harlow and Tendring areas measured against the regional average.

Castle Point, Harlow and Tendring still significantly exceed the regional average for the prevalence of obesity among children in Year 6 when 5-years data is combined.

Health improvement has not been consistent across Essex, at least partially, due to varying levels of investment made at the time by Primary Care Trusts (the predecessors to Clinical Commissioning Groups) and Public Health are now playing ‘catch-up’ in some areas. In Castle Point, for example, there had been no public funded adult weight management service until August 2014.

Interventions in the Early Years

A child's formative years can ingrain an approach and attitude that will remain for the rest of their life. At such an early age a child is also going to be heavily influenced by parental and environmental influences. It is essential, therefore, that there are initiatives to encourage parents and carers to lead healthy lifestyles themselves as well as providing such a healthy environment for their child.



Source: Public Health England – Making the case for tackling obesity – why invest?

Family Nurse Partnership

The *Family Nurse Partnership* (FNP) is a preventative home visiting programme where specialist nurses give intensive one-to-one support to vulnerable first time mothers aged 20 and under at conception through to when the child is two years old. Schools, social workers, midwives, GPs can all refer someone to the FNP. However, the main on-going challenge for the FNP is that there needs to be clear maternity referral pathways in place to ensure that young women are referred to the service within the required timescales.

The Programme content includes guidance such as understanding nutrition, healthy diets and exercise for mother and child, cookery classes, and promotion of buggy strolling/baby yoga/keep fit classes.

The FNP has been reaching increasing numbers of young parents and been increasingly effective at supporting breastfeeding initiation and continuation. Substantial evidence exists confirming that breast fed babies have lower rates of obesity than bottle fed babies due to the formula in bottled milk. Therefore, the Group have been interested to hear about how breastfeeding is being encouraged and the differences in rates of breastfeeding across the county. Essex is above the national average of prevalence of breastfeeding of 47.3% except in the Basildon and Braintree areas. In particular, rates are lower in areas of the county where there has not been a dedicated breastfeeding support service. Basildon and Braintree are two of the four areas in Essex who have significantly higher rates of obesity at Year 6 ranging between 18.7% and 21%, compared to the East of England average of 16.9%.

Some of the reasons given for why mothers choose not to breastfeed are:

- Travellers do not culturally breast feed
- Young Parents often see breast feeding as a challenge to their sexuality and are not supported by their partners
- Women needing to return to work as essential wage earners may not be supported to continue breast feeding in the workplace
- Breast feeding in public is still open to challenge by members of society.
- Many parents do not access the antenatal classes provided during the day time by midwifery due to working patterns and priorities.
- Inconsistent messages are given to new parents causing them to give up or not try at all.

The Group has been cognisant of the cost pressures on the Public Health function as a result of the reduction in the ring-fenced Public Health grant provided by central Government announced in 2015 and that breastfeeding support services may not be delivered in the same way in future. However, as there is strong evidence to suggest that breast fed babies have lower rates of obesity than bottle fed babies the Group are keen to see this continue to be promoted.

> ***Recommendation 1: That a breastfeeding support service should continue to be resourced to promote the benefits of breastfeeding either as a standalone service or as part of a more integrated 0-19 service offer.***

Health Visitor role

It is important to give every child the best start in life and thereby help reduce current health inequalities. Every new mother and child has access to the universal *Healthy Child Programme* (HCP) through a health visitor, and will receive development checks and information on general parenting issues. The HCP specifically supports mothers to continue breastfeeding for as long as they choose and then provides information and advice on weaning and the introduction of a variety of nutritious foods (in addition to milk) to ensure the child is offered a progressively varied diet from 6 months. Health Visitors also encourage healthy weight pre-conception, during pregnancy and after birth as well as encouraging parents to monitor the growth and development of the baby (see Healthy Start overleaf). The only children who are not weighed and measured are in the independent school sector or in special needs facilities.

The HCP encourages good eating habits with parents and carers asked to set a good example by the food choices they make for themselves and for family members to eat together. Mothers are taught how to read food labels, look at the nutritional balance of their family's diet, how to prepare home cooked healthy food free from additives and sugar and receive additional advice from a dietician, Health visitors and Children's Centre staff.

The Group heard about some innovative examples of community groups providing support to young mothers including the Harlow Essex Families Project which advised on basics such as learning how to go into a supermarket and do shopping. All HCP providers also promote physical activity and links with local schemes eg Buggy walks, Leisure Centre opportunities, Post-Natal exercise classes.

It is difficult to measure and evaluate an immediate short-term impact of Health Visitors - instead their benefit is likely to be seen more longer term (5-7 years). It was suggested to the Group that some of the consequences of a shortage of health visitors (up to a couple of years ago prior to the Call to Action that increased health Visitor numbers) were now being seen with the increase in obesity rates during primary school years.

The role of Health Visitors is integral to early prevention and child protection and can look across silos - they are really the only practitioner that is regularly welcomed into homes in deprived areas (no other practitioner sees everyone) so no stigma is attached to being visited by a Health Visitor. This wide acceptance provides the opportunity for Health Visitors to significantly influence behaviour and family environment and signpost services in the community such as Children's Centres and self-help groups.

> ***Recommendation 2: That Health Visitors should maximise their influence over behaviours and environment by taking every opportunity to signpost to other related prevention services.***

Healthy Start

The *Healthy Child Programme* promotes the uptake of Healthy Start vitamins and vouchers by young mothers and families on benefits and discusses the importance of vitamin supplements for all children under the age of 5. Healthy food vouchers are currently available to pregnant women and mothers of children under four on low incomes under the Healthy Start programme. The means-tested scheme gives one or two vouchers a week to use to buy healthy food or vitamins: Each Healthy Start voucher is currently worth £3.10 and issued depending on the age of the child,.

Parents are often not seen by Health Visitors at ante-natal stage until 28 weeks. The Group heard that there had been feedback from some clinicians that parents do not seem to know about Healthy Start and there may be incidences where midwives are not giving out information on the programme. The Group recognises that, in reality, health promotion effectively sits with Health Visitors rather than midwives but that every possible avenue for promotion should be grasped. With that in mind, the Group would like to see wider and continual promotion of the programme through all possible outlets such as at supermarkets and pharmacists. In particular, the Group felt that the Healthy Start Programme needed to be promoted beyond just those clients already entitled to free vouchers for vitamins. It is also acknowledged that GPs may not be promoting Healthy Start as a result of them not seeing young parents until some considerable time after birth of the child.

> ***Recommendation 3: That a wider and continual promotion of the Healthy Start Programme be established using supermarkets, pharmacists and other relevant retail outlets.***

The Group received some data on the numbers of Healthy Start Vitamin vouchers handed-out over the past year across some parts of Essex – figures for some areas were not available. Whilst it is difficult to extrapolate across areas, there did seem to be a higher number handed-out in the north east of the county. However, it was pointed out that dispensing rates could be affected by the number of local reception areas that were available for clients and could spike after advertising campaigns.

The Group noted the call from the Royal Society of Public Health (RSPH) in November 2015 to provide healthy food vouchers to parents of primary schoolchildren who are overweight to encourage the eating of more fruit and vegetables. This would be a similar system to the Healthy Start Programme (above). At the moment parents of children identified as overweight through the national child measurement programme received a letter to prompt them to seek assistance but often there was no other follow-up or links to other services. The RSPH recommend that vouchers should supplement the letter.

Children's centres

Children's Centres have the opportunity to engage at an early stage with families and children to start to build healthy lifestyles. There is no defined list of defined activities that a children's centre must offer as the expectation is for them to understand the communities they serve and base and target their services on those local needs. However, the services will include support on breastfeeding and weaning and nutrition and cooking skills. Children's centres will use Change4Life publications to support work on healthy eating and active lifestyles.

Referrals to Children's Centres can come from a variety of sources including Family Nurse, Health Visitors, GP, families, childcare provider, social worker, Job Centre Plus etc. Referrals will tend to be for specific targeted services but sometimes access to a supportive universal service is part of putting parents and children in touch with a peer group and building confidence. Similarly, the Children's Centre can refer children to local Health Improvement Teams, Child Health Improvement Sessions, GP and/or Community Paediatric Dieticians. Both the HENRY (health, exercise, nutrition for the really young) and MEND programmes can be offered in Children's Centres and provide 1:1 interventions for families with babies, preschool and primary school aged children to help develop the skills required for a healthier family lifestyle.

> *In one case on a HENRY course a parent started the course with a 4 year old who predominantly only drank milk and ate chicken nuggets. By the end of the programme he was trying new foods and Mum had cut his milk down to 1 pint per day instead of 4 pints per day and he was having 3 meals and 2 snacks.*

An engagement activity undertaken by the County Council in the fourth quarter of 2015 suggests that there is good awareness of the centres and services. However, providers acknowledge that there are challenges in engaging with harder to reach groups such as traveller communities and other ethnic groups: For example, there can often be cultural differences with some ethnic groups just not expecting their children to go to any early years' provision. The Group heard of one example of innovative practice whereby members of staff from a Children's Centre have made friends with a local Polish shop owner who acts as a liaison/translator for them to engage with the local Polish community.

Other Groups that can be difficult to engage are workless households, single parents, and some groups with physical or mental disabilities: For example, children with special needs can also be difficult to access as they often will have so many other types of educational and care appointments that it is difficult to fit in another commitment to a children's centre as well. In addition, parents often can be very protective of the child and not want to expose their own child's behaviour publicly.

Children's centres are responding to the challenge of reaching hard-to-reach groups with greater outreach services, increasingly going out to meet families rather than a family having to come to the Children's Centre: By doing this, targeted work also can often be done in the home which is sometimes necessary to build the confidence of

the family. This may mean reconfiguring services away from solely being located at fixed sites (i.e. at Children's centres). The potential for using some libraries as a possible alternative site for some services was highlighted to the Group.

However, it is important that future service delivery strikes a balance between providing some universal healthy eating and exercise programmes with the need to deliver some innovative initiatives to engage those families who otherwise would be less likely to attend mainstream groups. It is this latter group who are likely to be in most need of early help to make fundamental changes to their eating habits and lifestyle choices.

Providers have also highlighted the role of social media in becoming increasingly important in raising the profile of children's centres.

***Recommendation 4**:*

The focus by Children's Centres to increasingly target their services and use Outreach services to improve access to traditionally hard to reach groups should be encouraged and supported and that appropriate metrics assessing its success should be reported back to the HOSC in a years' time.

Working with Schools

Schools can be a key environment for children to learn about healthy behaviours and lifestyles and change habits and promote healthy lifestyles. In particular, activities in schools will give children the opportunities to develop life-long healthy eating habits and healthy physical activity levels.

Universal Infant Free School Meals

The Government introduced the funding for mandatory Universal Infant Free School Meals (UIFSM) from September 2014 for every child in Reception, Year 1 and Year 2 in state funded schools (maintained schools, academies and free schools). The UIFSM scheme seeks to provide every infant school aged child with a healthy nutritious lunch. Evidence suggests that packed lunches prepared by parents and carers generally are not as healthy tending towards more sugary and fatty ingredients. Therefore the Group wanted to see the current take-up rates for UIFSM, what could be done to further increase take-up rates and issues being faced that might prevent that or challenge the viability of the service.

The Government pays £2.30 for each meal provided under UIFSM based on how many pupils eat school lunches on a given "census" day held twice a year. Therefore, the Group heard that getting as many pupils as possible in front of plates on that date matters financially to a school. There is the suggestion that in order to maximise school income, any meal is put on the menu on census day to make sure that almost everyone has a dinner and gets counted – ironically this could be chips, fish fingers and pizza when one of the main drivers behind UIFSM is to provide a healthy nutritious meal for all children in Key Stage 1!!

There is no legal requirement on schools to provide regular uptake data to the County Council. The Group discussed whether there could be more transparency in providing data to determine funding: census figures could then more closely reflect everyday use and the funding for UIFSM would more closely align with day to day usage and encourage schools to be more proactive in driving a higher uptake throughout the year.

> *85% of Essex Schools (87% of primary schools) now operate an in-house school meal provision compared to just 18% in 2004/5.*

There are variable take-up rates for UIFSM across the county. Some areas such as Benfleet can be as low as 57% whilst other areas can be around 90%. The overall trend for Essex is around 76% uptake which is 3% ahead of East Anglia but 5% behind national –however the national figure includes London where, historically, Free School Meals has been universal in a number of boroughs for some time, and they also have higher levels of uptake historically than other parts of the country.

Surprisingly, some of the most deprived schools/areas in Essex have some of the lowest overall UIFSM take up. Basildon, Benfleet, Canvey, Clacton and Harlow overall tend to be lower than the rest of the county – although there are some

schools in those areas who do not reflect this and will have higher uptake. The Group has heard that some of the reasons for low uptake may be due to:

- Lack of marketing/publicity
- No particular minimum publicity standards to be met
- Lack of understanding by parents
- Parents believe that their children won't eat the food being offered
- Parents thinking that as they eat together at home/have a hot meal in the evening that they shouldn't have a second hot meal.

Uptake of Universal Infant Free School Meals in Essex is 83% (ahead of national figure). Schools with no former provision prior to the introduction of Universal Infant Free School Meals have an average uptake of 88-95% uptake

By and large the Group considers that UIFSM uptake is reasonably good at local level. However, there are issues to be addressed around maximising the numbers of children having UIFSM locally and greater targeting of effort in lower uptake areas. Uptake of school meals in at Key Stage 2 has grown on the back of UIFSM and Essex has a combined 65% uptake across the county.

Recommendation 5:

(i) That efforts should continue to increase Universal Infant Free School Meals uptake and that the Health Overview and Scrutiny Committee should receive an update on progress made in a years' time;

(ii) Schools should be encouraged to positively market Universal Infant Free School Meals all year round and not just at census time;

(iii) Any new pilots to improve uptake, promotion and/or delivery of Universal Infant Free School Meals should start in the most deprived areas which have the lowest uptake;

The School Meals Support Service

The Essex County Council School Meals Support Service (SMSS) provides support to schools ranging from finance and operational through to source and supply and menu development. The SMSS also supports other strands within the curriculum around health and wellbeing and healthy schools.

The SMSS works with schools to develop menus and an appropriate menu cycle with flexibility to allow variation from school to school and area to area so as to base it upon what local children would like. If a menu is not working for a school then the SMSS will work with the pupil body and teachers to see what needs to change. The SMSS work with school kitchen staff to prepare good quality "home-cooked' fresh

and wholesome meals and encourage schools to prepare food in different ways. e.g. steaming. Vegetarian and faith based food choices are now offered.

Finances

It seems that one indirect consequence UIFSM is that some schools are missing out on Pupil Premium funding as it is triggered by applications by eligible parents and carers for Free School Meals for their children. As all pupils in Key Stage 1 now are automatically eligible there has been a decline in parents actually registering for Free School Meals.

> ***Recommendation 6: That the County Council's Schools Meals Support Service should encourage Local Education Authority maintained schools to further publicise the need for parents still to apply for Free School Meals so that the school receives Pupil Premium funding for that child.***

The Group also heard that small and rural schools can struggle to avoid making a loss in providing dinners. The Group saw some sample business plans for a few Essex schools that illustrated the challenge and heard that the SMSS offered support to try and find an appropriate operating model for schools. The SMSS usually encouraged kitchens to be on site to prepare meals. However, in a small number of cases an appropriate operating model might mean meals not actually being prepared on site but being sourced from neighbouring facilities.

Most primary schools are working to an 85-90 pence actual plate cost (not including other costs). If the SMSS can represent a group of schools in an area then it can benefit from bulk purchase efficiencies which can be passed onto the schools.

There was significant media speculation in the late summer of 2015 concerning the future of UIFSM and that the budget for the provision was not ring-fenced. However, the continued central government funding of a UIFSM has now been confirmed.

Nutritional standards

The Group heard that the contents of packed lunches taken to school by pupils did not have to meet any particular nutritional standards at present. If there were clear nutritional guidelines in place that set out the standards for the food in lunchboxes, similar to those regulating meals provided by the school, it could present the opportunity for further discussion on nutrition with parents and carers.

> ***Recommendation 7: That further influence needs to be exerted by schools and through the Healthy Schools Programme to encourage parents to include healthier choices in packed lunches.***

Providing UIFSM for the first three years of a child's formal education is a significant opportunity for a school to 'sell' their meals to parents and emphasise their good

quality and nutritional value, so that parents are persuaded to continue with them once the child moves into Key Stage 2. This should be part of educating junior school aged pupils to make better and informed healthy food choices which will also carry forward into Key Stage 3 (secondary schools). Access to home-cooked foods at primary school can prepare children to look for more traditional healthier foods beyond primary school and the Group were heard that there was an important role to be played by governors and school leaders to give greater emphasis to this.

Whilst the SMSS does offer some support to academies, the Group noted that academies are not regulated in the same way and that future funding agreements will require that they have to comply with basic school meal standards. In focussing on preventative measures in schools that promoted nutrition, cooking skills, healthy eating, and levels of activity, the Group acknowledge that there may be less influence on those schools that are not under Local Education Authority control.

> ***Recommendation 8: That Universal School Food Standards should apply to academies and free schools in addition to Local Education Authority controlled schools.***

New national food standards are aimed at primary school aged children and stipulate appropriate portion sizes. This does not stipulate differentiating smaller portion sizes for younger children but some local discretion is being exercised in Essex to make meals appropriate for pupils' individual needs.

Role of School Governors

Whilst the SMSS does sometimes speak to School Governors particularly when moving contracts, it does not do so on other matters. The Group were mindful of the role of the County Council as Corporate parents and the need for improved links with the network of school governors.

> ***Recommendation 9: That the School Meals Service Advisor should speak at local/regional School Governor conference(s)***
> ***(i) to raise the profile of Universal Infant Free School Meals;***
> ***(ii) encourage further improvement in uptake; and***
> ***(iii) encourage eligible parents still to formally register for free school meals so that schools do not lose pupil premium funding.***

Health and wellbeing

It is too early for there to be any clear evidence to indicate improved health and wellbeing as a result of a full year of UIFSM having been run. It is likely that the benefits from the higher nutritional value of school meals will be seen over a longer period of time. However, the Group has concluded that UIFSM gives the opportunity to introduce a wider variety of foods to pupils and provide further interventions and guidance for healthy eating. It should promote a better food culture, assisting pupils in developing social skills (particularly around the eating environment where there should be a dedicated and focussed time for eating) and develop life-long healthy eating habits. Therefore, every effort should be made to encourage further take-up of UIFSM.

Healthy Schools Programme

The Essex Healthy Schools Programme (HSP) goes beyond just the formal learning and teaching on health and wellbeing and includes culture, ethos and environment, values and attitudes, and the social and physical environment. The programme links with the work of Active Essex and the Essex School Meals Service.

Under the HSP pupils and parents are taught that their food choices are influenced by food labels and advertising, portion sizes, and the importance of balanced diets and healthy snacking. Schools are required to encourage a positive dining experience at mealtimes. The Schools also have a duty to encourage a healthy eating programme throughout the day so it must include Breakfast Clubs and packed lunches. During separate discussions on the Universal Infant Free School Meals Service the Group had already concluded that more influence needed to be exerted on the contents of packed lunches **(see Recommendation 7 – page 25)**. Most schools have a healthy snack provision and, whilst schools do not tend to strictly police it, they do have some influence on what children choose to eat. Again, the degree of influence exerted can vary between schools.

There are also staff workshops to encourage the setting up and maintaining of a school garden and encouraging gardening clubs.

> *The Healthy Schools Programme is engaged with 98% of Essex Schools (excluding the private sector) representing 540 schools (majority of academies and all primary schools) with them having either achieved Foundation Status or above (i.e. working towards enhanced status).*

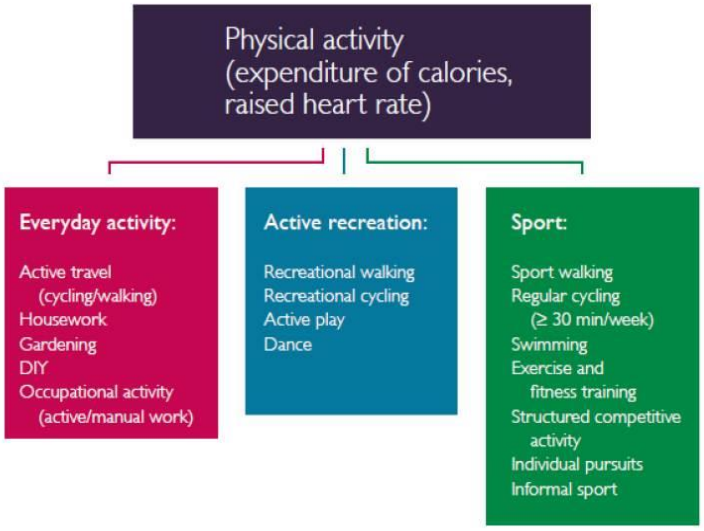
The County Council supports schools to become accredited under the programme and the current take-up rates are very encouraging. Schools are keen to obtain Healthy School Status as it helps them to meet their statutory duty to promote health and wellbeing and reinforces their links with Public Health via the School Health Improvement Teams. If a school is seeking or maintaining Healthy School status then it gives the School Meals Service more influence and leverage in getting the school to improve its school lunch provision. Private schools can also join the HSP but they will not be directly eligible for any Public Health interventions that may be required. ECC also work with special schools and children in other special educational settings.

Recommendation 10: That leverage should be exerted over those schools applying for or maintaining Healthy Schools' status to get them to promote Universal Infant Free School Meals and school meals in Key Stage 2 and beyond.

Sport and physical activity

> *"Physical activity includes all forms of activity, such as everyday walking or cycling to get from A to B, active play, work-related activity, active recreation (such as working out in a gym), dancing, gardening or playing active games, as well as organised and competitive sport."*
> The Government Chief Medical Officer

There is increasing evidence to suggest that being physically active can contribute to leading healthier lives. To encourage greater participation in sport and physical exercise, it needs to be made easily available, enjoyable and appealing. Physical activity should be a core part of tackling childhood obesity and will also improve general fitness and health. With children influenced by their parents and wider environment it is important that active lifestyles are encouraged throughout the family and local community.



Source: Active Essex?

According to recent Schools and Students Health Education Unit (SHEU) Surveys the proportion of primary and secondary pupils in Essex saying they have exercised five times or more in the last week has declined in recent years. Now 35% of primary pupils say that in the last week they have exercised enough that they had to breathe harder and faster five or more times, and the figures are significantly lower for secondary pupils (see Glossary for more explanation about the survey). Physical activity is extremely important for young people and children as it not only has an impact on their health and general wellbeing but has been shown to have an impact on education and academic attainment.

> *57% of primary school pupils in Essex walk to school*
>
> *(Schools and Students Health Education Unit survey)*

There is also evidence to suggest that areas that have higher physical activity levels are likely to have a lower level of overweight or obese people. Basildon, Castle

Point, Harlow and Tendring have some of the highest rates of childhood obesity in the county and some of the lowest levels of physical activity. By contrast Uttlesford, Epping Forest and Chelmsford have lower childhood obesity levels and higher physical activity levels. There is evidence demonstrating the significant effect that physical inactivity can have on health and hence the cost to the NHS and social care of inactivity is also significant. Therefore, physical activity levels need to increase.

Active Essex

Active Essex is a County Sports Partnership (largely funded by Sports England) which networks local agencies to increase participation in sport and physical activity: These agencies include national governing bodies, school sport partnerships, local authorities, sport and leisure facilities, health commissioners and other sport and non-sporting organisations. Active Essex co-ordinates the work of 14 devolved Active networks who deliver activity programmes and these link into each of the 14 Essex Local Authorities and the Health and Wellbeing Boards. Projects such as Live Well in Braintree and Let's Get Moving in the west of the county are encouraging greater participation in sports and recreational activities.

Active Essex has Early Years practitioners qualified in outdoor physical play training. A grant is available to schools to fund projects aimed at promoting a healthy lifestyle (e.g. dance classes and cycling activities) and the Group heard specifically about Early Movers, Born to Move and Keeping Dance Alive – a county wide mass participation dance programme involving 70 schools and 600 young performers.

Active Essex has trained teachers

from over 200 schools since September 2015

The Group also heard about the "Daily Mile scheme" run by a Scottish primary school which involved all pupils walking 5 laps of their school field each day: This fitted into the school day with little reported disruption to their curriculum objectives and saw significant health and wellbeing benefits. Active Essex is discussing with partners similar schemes to promote physical activity levels among young people and families (Beat the Street and the Golden Mile).

Active Essex also co-ordinates the work of 14 School Sports Partnerships which engages all primary, secondary and special schools in sport and which delivers the Schools Games programme. In addition, Active Essex works closely with the County Council's Schools Education Service in advertising and promoting activity programmes. The Group heard that there was some uncertainty around the central funding of some of the partnership networks and Active Essex are exploring alternative funding sources. As part of this, Active Essex have been considering an application for Foundation Trust status and the Group welcomed this innovative thinking as a step towards greater financial independence.

> *Active Essex currently works with [all] 428 primary schools in Essex*

Active Essex are trying new ways to further encourage partnership working and intend to establish a physical activity forum for the County to bring together all the key partners within the area. Closer working with local councils is essential as they have responsibility for parks and recreation facilities in each district. Active Essex will be looking to explore opportunities to devolve some funding down to district level where it can be shown to be more effective and produce improved local outcomes. However, whilst there are some good examples of improved partnership working there are also some linkages that still need improvement, particularly with the community providers of the Healthy Schools Programme for example.

Recommendation 11: There should be a stronger link between the activities supported in schools by Active Essex and the activities promoted under the Healthy Schools Programme.

School Sport Premium Funding is ring-fenced for 'improving PE and School Sport provision' but schools have the freedom to choose how they do this and Active Essex can offer support and guidance on this. Schools are currently spending their money on additional coaches, extending competition, health enhancing activities and extra-curricular clubs as well as the costs of transport to and from sports facilities and to up-skill teachers to also be able to deliver better outcomes. It is an OFSTED requirement that schools provide information on how Sports Premium funding is being spent on school websites. The Government has confirmed that Sports Premium funding will continue to at least 2020.

Whilst Active Essex promotes sport and physical exercise with local partners it is acknowledged that its profile and impact can be increased with regular use of a common branding and consistent straightforward message.

Recommendation12: That the role and expertise of Active Essex as an in-house resource for the County Council should be valued and protected as it provides the foundation for leading co-ordinated working with local partners.

Regulation, planning and enforcement

A major part of an obesogenic environment is having access to unhealthy food and fast food outlets are a significant contributor to this. There have been suggestions that local authorities should use their limited planning powers to restrict the opening of new fast food outlets in local neighbourhoods. However, this would not have any impact on local fast food outlets already in existence and, instead, those outlets need to be encouraged to adapt their 'offer' with local councils communicating a clearer message about the dangers of selling food that is high in fat, salt and sugar. Therefore, the Group were particularly enthused by the Tuck-In service (funded by the County Council's Public Health Team) coordinated by Tendring District Council in partnership with the borough and district council Environmental Health teams across the County (see below).

Through the Public Health function and local district councils, initiatives to prevent obesity can be focussed at a local level. However, there are some aspects that need a stronger national approach such as bringing pressure upon the food industry and food producers to reduce fat, salt and sugar in their ingredients and extending school food standards to free schools and academies. Notwithstanding this, some local action can also be taken to promote low fat, sugar and salt in all takeaways, for instance. The Tuck-In Scheme is intended to encourage better options primarily around the preparation of fast food and persuade vendors to make small changes such as Low Salt option, putting out sachets rather than bowls so customers will probably use less, encourage cooking in vegetable oil, cook at right (lower) temperatures, and offering smaller portions. Vendors are also encouraged to offer grilled as well as fried food and increase the amount of vegetables and fruit available on the menu. Some of the tips can save the vendor money. Each district/borough has discretion in how exactly to implement the scheme and how to promote it. Environmental Health officers routinely conduct food hygiene inspections at fast food vendors and will be observing food and cooking methods as part of that and so are in a position to give immediate advice on healthier food preparation. However, it will be necessary to change the Environmental Health Officer mind-set away from an 'inspection and regulatory' one to a positive 'giving advice and help' one. The Tuck-In scheme is promoted by the use of a logo being displayed at the trading premises demonstrating that the business cares about its customers by making a continuous effort to reduce salt, sugar and fat content of the food it serves.

> ***Recommendation 13: Further efforts to drive and expand the Tuck-in scheme should be encouraged with local Environmental Health Officers further incentivised to increase take-up.***
>
> ***Recommendation 14: That all planning areas and Public Health departments across Essex should promote low fat, sugar and salt in all takeaways.***

Planning policies should be more sympathetic to local strategies aimed at reducing childhood obesity. When local plans are reviewed, councils should specifically consider how tackling obesity or promoting greater physical activity can be incorporated. As part of this, the Group discussed ways to limit the proliferation of fast food outlets. Public Health teams are not 'statutory consultees' in the planning

application process and so do not have to be consulted. There are instances where they may be consulted as non-statutory consultees. However, there should be a formal process that enables Public Health Teams to comment on relevant planning applications at an appropriate point in the planning management process. A similar process could also be agreed for the local plan-making process to consider issues around open space, play and leisure provision, good design and access to healthy food outlets.

> ***Recommendation 15: That Public Health should be a material planning consideration for all business/commercial planning applications for food outlets lodged at each planning authority.***

During the latter stages of the Group's review there has been considerable national media coverage calling for the introduction of a sugar tax on full sugar soft drinks as part of a general reduction in sugar in everyday food and drink. The Group's review has not specifically looked at this issue but such a tax would seem consistent with the Group's aspiration to encourage healthier lifestyles including diets with lower fat, salt and sugar. Revenue from a sugar tax could be ring-fenced and spent on further preventative measures. The food industry can play a significant part in reducing the incidence of childhood obesity by reducing the fat, sugar and salt content of processed foods, ensuring that healthy and nutritious choices are widely available and affordable and practicing responsible marketing for those foods aimed at children.

An all systems approach

Wider determinants of obesity

Whilst the cause of obesity may seem straightforward and is often cited as simply lack of exercise and excess and/or high calorie food consumption the issues are more complex than that. The 'Foresight' report on tackling obesity, first published in October 2007 (Foresight – Tackling Obesities: Future Choices – Government Office for Science, p5) noted that:

> *"People in the UK today don't have less willpower and are not more gluttonous than previous generations. Nor is their biology significantly different to that of their forefathers. Society, however, has radically altered over the past five decades, with major changes in work patterns, transport, food production and food sales. These changes have exposed an underlying biological tendency, possessed by many people, to both put on weight and retain it."*

A complicated Foresight map pictorially demonstrating the complex nature of the causes of obesity was seen by the Group and demonstrated that there is no one intervention that can make significant impact on its own. Additionally, it is not easy to show cause and effect of a particular measure or lifestyle choice when so many other factors may also influence any evaluation of that measure or choice. This supports the increasingly prominent view that a 'whole system' approach, which looks at everything from the promotion of healthy diets and activity to the redesigning of the built environment as well as wider cultural and societal values is important. In the case of childhood obesity, children's lifestyles and behaviour choices are not of their own making, and are often formed as a result of their interaction with their parents/carers and other environmental influences.

Source: Public Health England – Making the case for tackling obesity – why invest?

This approach is supported in Professor Sir Michael Marmot's 'Fair Society, Healthy Lives', where he states that the crucial determinants of health are: "…the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces, economics, social policies, and politics." He also suggested that poverty and low living standards are powerful causes of poor health and health inequalities with action on health inequalities requiring action across all social determinants of health including the affordability of healthy food, the availability of safe play areas for children, and the accessibility and affordability of exercise.

Source: Public Health England – Making the case for tackling obesity – why invest?

A whole systems approach in Essex

There are areas in Essex where obesity is more pronounced, such as in Basildon, Castle Point, Harlow and Tendring, which might suggest a local link between obesity and deprivation as each of these areas have significant pockets of deprivation.

Braintree now has a dedicated team to look at obesity and it also has a 'Live Well' campaign which has been adopted by the Mid Essex CCG which is looking to embed it across the rest of Mid Essex. Partnership working in localities and collaboration with CCGs will be critically important to drive improved health prevention and relieve pressure on NHS budgets.

A 'Live Well Child' pilot incorporating a Whole Community Approach to try and reduce obesity and the numbers of overweight children has started in Braintree and will look at community, home and business environments. Some of its focus could be on schools (behavioural interventions with classes and teachers) and also look at actions already happening such as Walking Buses and cycling proficiency.

Recommendation 16: The outcomes from the Live Well Child Whole Community Approach pilot in Braintree need to be monitored and, if there is improvement, then it must be extended elsewhere, concentrating initially on those areas that have the highest rates of childhood obesity – namely Basildon, Castle Point, Harlow and Tendring.

Integration and partnership working

Prevention should not be seen as solely an add-on and needs to be embedded in planning, commissioning and delivery and local clinical commissioning groups should be one of the main drivers of this. Front-line public sector staff should be able to identify and undertake opportunistic interventions and quick automatic referrals for service users ('Making Every Contact Count').

Social prescriptions

Social Prescribing is about linking people, through early signposting, to activities and non-medical sources of support in the community from which they might benefit: in the case of preventative measures for obesity this could include walking groups and gardening groups and exercise classes. In Basildon & Brentwood, Castle Point and Rochford and West Essex Clinical Commissioning Group areas a GP hub model is being developed where a GP/health practitioner refers to a social prescriber who carry out an assessment and recommend an appropriate route often supported by trained volunteers; In North East and Mid Essex the service is accessed by using the on-line Connect Well Essex website. In North East Essex prescribers and trained volunteers, sometimes situated in GPS and community settings identify early intervention opportunities and act as the connector and facilitator to them; In Mid Essex social prescribing champions, e.g. within council offices, GP practices, pharmacies, and local community facilities give people information using Connect well and, for complex cases, health trainers act as social prescribers.

Members considered that a fully developed social prescription system in the county could provide a crucial early signposting service to leading healthier lifestyles as part of a prevention strategy.

> ***Recommendation 17: That the Group are encouraged by the development and potential of social prescriptions and request that its establishment pan Essex, albeit using different models, continues to be supported.***

A key issue around further developing social prescribing is how to build and extend it into the existing community provision. It will only be constrained by the number of organisations who are willing to receive referrals from it.

> ***Recommendation 18: That any commissioned projects to reduce or prevent obesity should make use of local social prescribing programmes, and those local social prescribing programmes should support signposting and referral to local sources of help with obesity reducing behaviours, such as local walking, exercise, cooking, environmental and weight loss groups.***

Source: Public Health England – Making the case for tackling obesity – why invest?

A common theme throughout the review has been that there are many interventions that the Public Health function at the County Council and its partners can implement. However, these often seem separate and unconnected interventions. During the review the Group heard about a number of different initiatives and programmes that all aimed to be part of a preventative approach towards childhood obesity.

The Group noted the pan-Essex remit of Active Essex and believe that there could be significant synergies to link all the activities in Essex under a common brand which is instantly identifiable with generic messaging across all services - it also needs to emphasise the importance of taking individual responsibility. The Group believes that it may be cost effective, as well as increase recognition, by adopting a widely known brand for local use. The Group has not received any evidence to suggest a particular brand but notes that Active Essex and Living Well brands are already reaching across Essex and adapting one of those may offer the most cost effectiveness solution. In view of the responsibility of the Health and Wellbeing Board (HWB) to co-ordinate and integrate local services, such branding should, probably be approved by the HWB.

Recommendation 19:

(i) That common branding be developed to link all healthy living initiatives and related prevention programmes to make them highly visible and easily identifiable;

(ii) That learning from the Live Well Child Whole Community Approach pilot in Braintree (see Recommendation 16) be used to inform the convening of a multi-agency Obesity Summit for Essex as part of a co-ordinated and integrated drive to tackle obesity.

(iii) That, as part of (ii) above, the County Council reasserts its commitment to tackling obesity through a vision statement to

which every council service and all public sector partners commit;

(iv) That, as part of (iii) above, this report and recommendations herein be included as part of a County Council Childhood Obesity Strategy to be developed by the Cabinet Member for Health.

Higher profile campaigns

Essex has local celebrities extolling the virtues of healthy food and healthy living and that, as part of raising the profile of Public Health programmes confronting the obesity challenge, there is an opportunity for joint working with these celebrities to provide a high profile focal point. In particular, Jamie Oliver has campaigned in the past to improve the nutrition of school meals and challenged the junk-food culture by showing schools they could serve healthy, cost-efficient meals that children enjoyed eating. More recently he has been highlighting the dangers of added sugar in our diet which he blames for the rising epidemic of bad teeth and type-2 diabetes and has advocated taxing sugary drinks and, during the preparation of this report, the Government has confirmed its intention to introduce such a Sugar Tax. The introduction of such a measure should prompt further conversations as to what local interventions can be considered to encourage the provision of low sugar and low fat options in food outlets.

Recommendation 20**: **(i) That Public Health explores opportunities for joint working with local celebrities to provide a high profile focal point for the promotion of future healthy lifestyle campaigns and (ii) That Public Health explores the local opportunities for investing the proceeds from a Sugar Tax to encourage greater participation in sport and physical exercise.

The role of the Public Health Team

The Group believes that, with Public Health now integrated within the County Council, it provides the opportunity for stronger strategic leadership on prevention across the county.

With in-house Public Health expertise, the County Council now has the opportunity to co-ordinate and drive the prevention agenda using and exploiting contacts with local partners. In particular, it is essential that Public Health further develops its links with borough and district councils to maximise the potential for a co-ordinated local approach (see All Systems Approach on page 31) which includes local recreation and leisure services and environmental health.

There should be greater consideration of the impact of the Council's and Public Health decisions, and how they are co-ordinated and impact on the health of the local community. It is also vital that all services across the council and partners are aware of their potential impact.

The Public Health Team has the opportunity to change the culture of the County Council and other strategic partners so that the prevention agenda is incorporated into everyday considerations and decision-making. In particular, there should be a corporate approach towards health and wellbeing for all, which could, for instance, encourage staff to 'buy-in' to being health champions and social prescribers. Therefore, the Group were encouraged by the recent launch of a pledge campaign that has also been targeted at employees and members (as well as the wider public) to raise awareness of weight management and physical activity. The Essex Weighs-In campaign aims to be conversational, giving people the tools, advice, support and encouragement to refocus health habits and connect with each other. A website has recipes and exercise advice with a community focus encouraging participation in blogs to share experiences. This campaign should be the start of this culture change.

The Group have been cognisant of the severe financial pressures on local government and, specifically, on the Public Health function through the recent reduction in the ring-fenced national grant for Public Health. It would be counterproductive to reduce resourcing the prevention services being commissioned by the Public Health Team at a time when obesity rates are increasing.

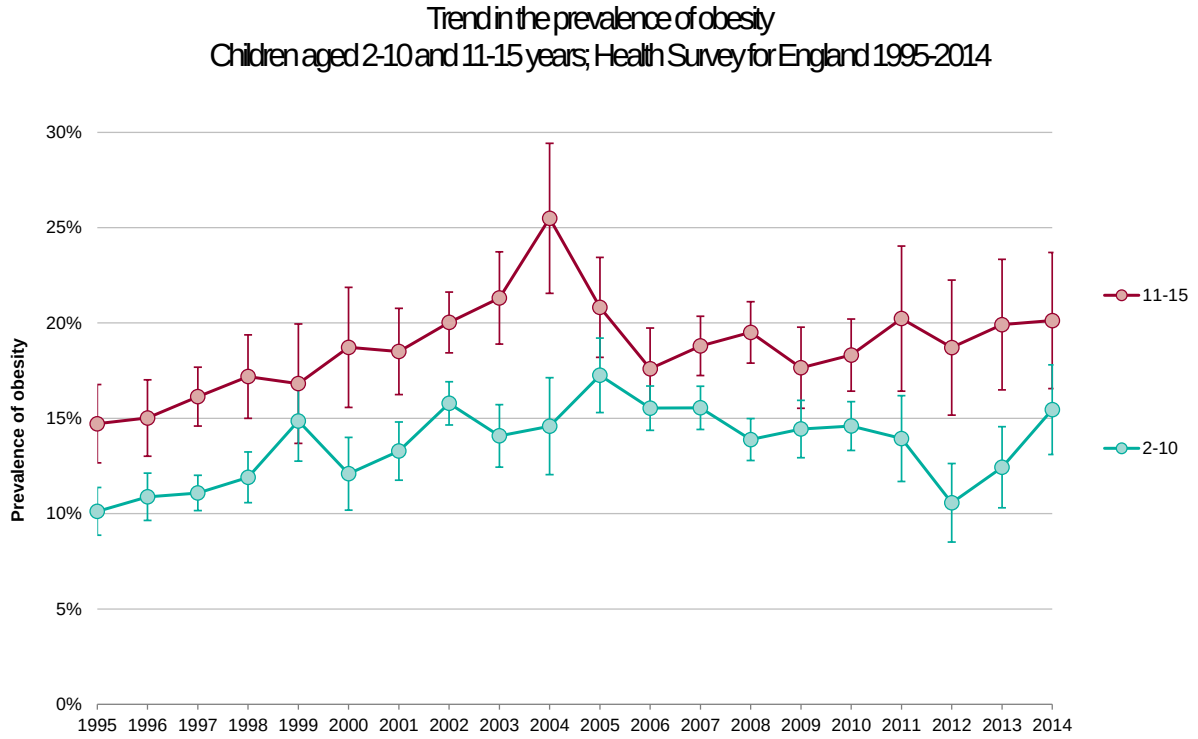
Recommendation 21:

(i) Effective Public Health prevention programmes to encourage healthy Lifestyles can save the NHS and Essex County Council significant sums of money in reducing avoidable health and social care costs and the Group requests that the Public Health Team continues to receive the resources necessary to further develop and expand their prevention programmes;

(ii) The County Council should maximise the opportunity to fully utilise the potential of the in-house Public Health expertise and resource, increase its profile internally with employees encouraging them, for example, to become health champions, and transform the culture of the organisation so that the prevention agenda is incorporated into everyday considerations and decision-making.

Risks and opportunities

The prevalence of obesity is trending upwards. Past efforts to reverse the trend would appear to have failed. With increasingly inactive sedate lifestyles and increased demand for, and availability of, fast convenient food, there is a significant risk that the prevalence of obesity will further increase leading to more obesity related poor health conditions and consequential greater demands on the health service and social care, at a time when there are already severe demand pressures.



Source: Public Health England: Patterns and trends in child obesity presentation (January 2016)

Communication and reach

The risk of obesity can be mitigated by communicating a clear message to everyone about the benefits of leading a healthy lifestyle. However, it is possible that information campaigns to promote healthier living and more active lifestyles may only actually help those people who have already engaged with health bodies or who already have an awareness of the issues. Therefore, health promotions could actually increase existing health inequalities. It is important that the focus of promotions has an outreach element to maximise the impact.

Plans should consider the motivations and characteristics of target groups in relation to obesity otherwise the message will be lost. Therefore it is important to tailor the language and media used for the intended audience. E.g. for some audiences it may be better to refer to healthier weight and taking healthy choices. In relation to encouraging sport and physical activity, for example, are the messages only appealing to those already interested in sport and do the activities need to be organised in a less formalised way so that they are not seen as organised sport and are less competitive?

Furthermore, one of the fundamental risks in developing an obesity strategy is that it will omit those in greatest need. Providers know who are the hard to reach groups and have to overcome the cultural, personal and social obstacles to engage with these groups and convince them that preventative services can still benefit their overall wellbeing. Sometimes the temptation can also be to launch new initiatives in areas or for certain demographic groups that will provide quick momentum and progress and only specifically target hard-to-reach groups over the longer term. The Group has heard about specific hard to reach groups such as the traveller community, some larger park-homes, children who are home educated, single parents and working families. Better identification and support for these Groups may be needed, possibly through a specialised service – it has been suggested that GPs may be able to assist in identifying some of these Groups (e.g. those being home educated).

Funding

Further funding pressure on local government and, in particular, central government funding of Public Health, could risk health prevention not being as effective in confronting obesity as it needs to be and may dilute the impact of some of the key messages. Funding of prevention services is essential in relieving the pressure on health and social care. In particular, the Group heard concerns about the uncertainty around the continued role of some services in their current format (e.g. Health Visitors).

Regulation and planning

Unless processes are established to give Public Health a more prominent role in local planning, social and economic environments could increasingly become obesogenic as our demand for instant and convenient services outweigh developing healthier physical environments and infrastructure. The planning system has a vital role in helping to deliver objectives aimed at reducing obesity. Local councils, throughout their organisations and not just their planning and public health departments, should be championing a whole-systems approach.

Integrated services

There is also a risk that prevention initiatives to reduce the incidence of obesity in future could be compromised by the interventions being delivered separately and in an unconnected way. In particular, Children's services have various complementary services being delivered by a number of providers. The Group heard that the fragmentation of these services across multiple contracts and providers may mean that parents and children may find it difficult to navigate between services and resources are not being targeted in the most efficient manner.

However, significant changes are expected in children's services in Essex in future. Commissioning responsibility for the Family Nurse Partnership and the 0-5 Healthy

Child Programme (incorporating the health visiting services) transferred from NHS England to upper tier local authorities in October 2015. As a result, providers have had to establish new relationships with local authorities and this has created its own challenges. However, it does also provide the opportunity to develop a comprehensive pre-birth -19 health, wellbeing and family support service instead to include those 0-5 services (Family Nurse Partnership and 0-5 Healthy Child Programme) and 5-19 services (essentially the school nurse service) together with the County Council's existing commissioning of services through Children's centres with linkages also to other related services. The Group welcomes the move towards an integrated 0 to 19 service if it means that it is easier for parents and children to identify and access services and link to and move between different services.

Next steps

The Obesity crisis is a "ticking time-bomb". Transformational change, new models of commissioning services and local partnerships should be at the heart of a new integrated approach putting 'Health Prevention' firmly on the agenda of Public Health in Essex.

Models of Local Devolution will need to be further explored and expanded across Essex in a targeted approach to meet need and reduce inequalities in Essex. Local Government is the "Sleeping Giant" of Public Health and needs to be fully awake across Essex. Implementation, driven by examples of best practice across Essex, will need to be strongly led and supported.

There is a risk if transformational change, local partnership working and integrating services is not successfully implemented. The risk is reduced if implementation is embedded, through partnership, at a local level (the level closest to people). Strong local leadership and support of community partnerships is key (refer Sir Thomas Hughes-Hallett '*Who Will Care?*' *Commission's* report into health and social care for Essex). Good community wellbeing is dependent on the effectiveness of joined up Public Health collaborative networks and is best coordinated, through local devolution, at a local level. Outcomes and examples of best practice must be captured and measured to demonstrate success.

Glossary

Academy/academies	State-funded schools in England which are directly funded by the Department for Education and independent of local authority control.
Borough/District Councils	A second-tier local authority providing local public services such as cemeteries, planning, licensing, social housing and waste collection.
Change4Life	A public health programme run by the Department of Health to help families make improvements to their diet, activity levels and alcohol consumption. It uses the slogan "eat well, move more, live longer". http://www.nhs.uk/Change4Life
Clinical Commissioning Group	Clinically-led groups of GP Practices responsible for commissioning most health and care services in an area for patients. They work with local councils on health and adult social care, early-years services, and public health issues etc.
County Council	An upper tier local authority which will provide county wide services such as education, social services, transport, strategic planning, police, fire services and, since, 2013, Public Health.
County Sports Partnerships	They are networks of local agencies promoting participation in sport and physical activity. They deliver Sport England programmes such as Sportivate on a local level.
Department of Health	The Ministerial Department of the United Kingdom Government responsible for government policy on health and adult social care matters in England. It oversees the English National Health Service.
Health Overview and Scrutiny Committee (HOSC)	Specific legislation requires upper tier councils to have a committee that reviews and scrutinises the planning and provision of local health services.
HENRY	'Health, Exercise, and Nutrition for the Really Young'. It is a charity that advises families on changes to lifestyle to help prevent childhood obesity. http://www.henry.org.uk/homepage/
House of Commons Health Select Committee	Appointed by the House of Commons to examine the work of the Department of Health. The Committee has a high public profile and its reports often generate national media coverage.
Health and Wellbeing Board	A committee of an upper-tier local authority which oversees the integration of health and social care services so that they are more "joined up". It assesses local health and wellbeing needs and agrees a joint health and wellbeing strategy.
Local Education Authority	Has responsibility for all state schools in their area including the distribution and monitoring of funding for the schools, co-ordination of the

	admissions process for schools, and they directly employ school staff.
MEND	Mind, Exercise, Nutrition… Do it! A social enterprise that designs programmes and services, to help people improve their health, fitness, and self-esteem. http://www.mendcentral.org
Obesogenic	An environment that supports being obese and discourages healthy food intake and/or physical activity: for example, prohibitive distances to a grocery store, parks and recreation facilities.
OFSTED	The Office for Standards in Education, Children's Services and Skills. It is a non-ministerial Government department. It inspects and regulates services that care for and educate children and young people.
Primary Care Trusts	They were responsible for commissioning of most local health services for an area. In 2013 they were replaced by clinical commissioning groups.
Public Health Team	The Team within Essex County Council which commissions preventative health services such as health checks, weight management programmes, Family Nurse and Healthy Child programmes and other healthy lifestyle programmes.
Public Health England	An executive agency of the Department of Health responsible for promoting good health, sharing information and expertise with councils, industry and the NHS, and providing data to improve the understanding of health issues.
Pupil Premium	Extra funding given to a school for each child who is either looked after by the local authority, eligible for Free School Meals or whose parents are currently serving in the armed forces which should be used to improve the educational attainment of those pupils.
Schools Health Education Unit (SHEU) survey	Measures key indicators of wellbeing of children and young people in Essex during January and February each year and participating schools ask pupils from Year 4 and up to take part.
School Health Improvement Team	These work in close partnership with Essex County Council and other partners to promote a healthy educational environment in schools.
Sport England	Decides how to invest government and National Lottery funding to encourage participation in sport. They also fund an England wide network of county sports partnerships.
Sports Premium	Ring-fenced Government funding for maintained primary schools and academies to improve the provision of physical education and sport. As part of their inspection regime, OFSTED will hold schools to account as to how the funds are spent.

ANNEX 1

Essex County Council
Overview and Scrutiny Committee
Review Scoping Document
CURRENT - AS AT 29 SEPTEMBER 2014

This form is a tool that should be compiled at the start of each inquiry to set out clearly the aims and objectives of the committee's involvement in a particular matter, and will be completed at the end of the inquiry to confirm what has been achieved. The form also provides an audit trail for a review.

Review Topic	**Obesity measures in Essex**
Committee	Health Overview and Scrutiny Committee
Terms of Reference	(i) To provide Members with an improved understanding of issues and trends arising from obesity and their applicability to Essex; (ii) To review preventative measures aimed at pre-school and primary school aged children to include looking at nutrition, cooking skills and healthy eating, healthy lifestyles and levels of activity. If appropriate to review the effectiveness of their implementation; (iii) To consider appropriate related reports that may influence and/or impact on the issue.
Lead Member, and membership of Task and Finish Group	County Councillor Margaret Fisher (Lead Member) District Councillor J Beavis District Councillor B Dick County Councillor R Gadsby County Councillor K Gibbs Nominee from the People and Families Policy and Scrutiny Committee
Key Officers / Departments	Public Health Officers including: Jane Richards, Head of Commissioning – Public Health and Wellbeing and Jason Fergus, Head of Active Essex, Schools Improvement Management Team Active Essex Chairman Councillor Gooding, Cabinet Member for Education and Lifelong Learning Education Department within Essex County Council/ Schools Clinical Commissioning Groups Public Health England
Lead Scrutiny Officer	Graham Hughes
Relevant Portfolio Holder(s)	Councillor Anne Brown

Relevant Corporate Links	Corporate Outcomes Framework - People in Essex enjoy good health and wellbeing Agreed corporate indicators: The most applicable being: People in Essex have a healthy life expectancy. Reduced differential in life expectancy across different areas of Essex. Prevalence of healthy lifestyles. Percentage of Essex residents who consider themselves to be in good health. Life satisfaction rates (ONS condition of wellbeing) However, good health and wellbeing can also impact on other agreed indicators.
Type of Review	Full Committee (for initial briefing) Thereafter Task and Finish Group
Timescales	TBA
Rationale for the Review	One of Essex County Council's desired Corporate Outcomes is that People in Essex enjoy good health and wellbeing Obesity can cause an increased likelihood of contracting a number of severe and debilitating conditions, such as cancer, diabetes, heart attacks, respiratory problems, ulcers, circulatory problems etc. These conditions can be expensive to treat and can impact directly and indirectly on Essex County Council as well as the NHS. Essex County Council is now responsible for Public Health and scrutiny of this service falls within the remit of the HOSC. Minimising obesity and encouraging healthy lifestyles could also improve other corporate outcomes. E.g. promoting a fit and able workforce of Essex to stimulate economic growth.
Scope of the Topic	Included in the review: Initially to receive an overview via a briefing on all main issues and trends. Subsequent agreed focus to review preventative measures aimed at pre-school and primary school aged children to include looking at nutrition, cooking skills and healthy eating, healthy lifestyles and levels of activity. If appropriate to review the effectiveness of their implementation.
Key Lines of Enquiry	Initial key lines of enquiry so as to understand the issue- (i) The incidence of obesity in pre-school and primary school aged children; (ii) levels of physical activity in pre-school and primary school aged children; (iii) identify trends, outlyers and issues (iv) the role and commissioning obligations and responsibilities of Essex County Council, the Clinical Commissioning Groups, Public Health England and NHS England Area Team. [consider current educational campaigns to promote healthy living by Essex County Council, the clinical commissioning groups, Public Health England and NHS England Area Team;
Other Work Being Undertaken	Public Health England national briefings Reviews and monitoring by Public Health Team in Essex. Scrutiny work either completed by or underway by other local district/borough councils Other work TBA.

What primary / new evidence is needed for the scrutiny?	Baseline statistics on obesity, nationally and locally Identify any concentrations of the issue in particular groups and/or locations Impact of unhealthy weight on health Essex County Council's plans (linked to Public Health) CCG's plans/ responsibilities NHS England involvement and responsibilities Public Health England involvement and responsibilities Healthy Schools Programmes Ofsted requirements for physical activity Active Essex and other organisations responsible for promoting healthy active lifestyles Access to healthy food Food labelling Regulation of fast food outlets Other information as identified during the scrutiny
What secondary / existing information will be needed?	To be determined
What briefings and site visits will be relevant to the review?	To be determined
Who are the witnesses who should be invited to provide evidence for the review?	Portfolio Holder Public Health Officers Education department within Essex County Council Schools CCG's NHS England Area Team Public Health England Health and Wellbeing Board Current service providers Adult/child representative Groups Health visitors Charitable/community support groups Food Standards Agency Environmental Health Active Essex Recreation and Leisure
Implications	In terms of topic, have the following matters been taken into consideration in the planning of this review: Legal implications ……Yes/ no Financial implications ……..Yes/ no Equality and diversity issues….. Yes/ no Other critical implications……
What resources are required for this review?	At present it is difficult to quantify the additional resources required to undertake this review. Given that the resource available is finite, it will be necessary to consider carefully the timing of the review within the Committee's overall work programme.
Indicators of Success	TBA – could include: Improvements to services if/where needed Increased education/publicity
Provisional Timetable	To be determined

Annex 2

Library of background report and publications

During the course of the scrutiny a virtual library of supporting documents and reports, news articles, was established and maintained.

1. Position statement from Royal College of Paediatric and Child Health
http://www.rcpch.ac.uk/sites/default/files/page/obesitypositionstatement.pdf

2. Royal College of General Practitioners Guidelines

http://www.rcgp.org.uk/clinical-and-research/clinical-resources/nutrition/obesity.aspx

3. Public Health England – Child obesity

http://www.noo.org.uk/NOO_about_obesity/child_obesity

4. Government Policy document – Giving all children a healthy start in life

https://www.gov.uk/government/policies/giving-all-children-a-healthy-start-in-life

5. Government guidance on commissioning of public health services for children

https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children?utm_medium=email&utm_source=The+King%27s+Fund+newsletters&utm_campaign=4363533_HMP+2014-07-04&dm_i=21A8,2LIX9,FLWQKF,9HQXZ,1

6. House of Commons Library – School meals and nutritional standards – Briefing Paper No. 04194, 13 October 2015.

7. Nursing Times Article (11 May 2015) Health Visitors tackle childhood obesity.

8. East Anglian Daily Times article – 1 May 2015 – Governor says schools are missing out on Pupil Premium funding after free meal policy introduced.

9. Public Health England – child weight data factsheet – PHE publications gateway number 2015432 – published October 2015.
10. Public Health England updated analysis of the National Child Measurement Programme (January 2016)
http://fingertips.phe.org.uk/profile/national-child-measurement-programme/data#page/0/gid/8000011/pat/6/par/E12000006/ati/102/are/E10000012/iid/20602/age/201/sex/4

11. Why social prescriptions are just what the doctor ordered
Social prescriptions, from fishing to knitting groups, are helping patients back on to the road to recovery: Rachel Williams – The Guardian Tuesday 5 November 2013

12. Extract article from NESTA website dated 5 November 2013 – Social prescriptions should be available from GP surgeries, say four in five GPs.

13. The Guardian - Tuesday 10 November 2015 - Parents of obese children should get healthy food vouchers, experts say **(**Royal Society for Public Health report recommends similar system to Healthy Start programme to halt rise in overweight primary school children);

14. Royal Society for Public Health report recommends similar system to Healthy Start programme to halt rise in overweight primary school children Denis Campbell Health policy editor - The Guardian - Tuesday 10 November 2015;

15. Leicester City Council – webpage on promotion of outdoor gyms in parks;

16. House of Commons Health Committee – Childhood Obesity – brave and bold action – First report of Session 2015-16 – 30 November 2015;

17. foresight obesity system map encompassing psychological, Behaviour, environment, economy etc published by Government Office for Science (First published: 17 October 2007);

18. The Guardian – Tuesday 24 November 2015 – Family Nurse Partnership: helping young families or a waste of money? Commentary on the results of an evaluation published in The Lancet;

19. Public Health England – Power Point presentations – Patterns and Trends in Child Obesity (January 2016), Patterns and Trends in child physical activity – www.noo.org.uk/slide_sets/activity

20. Politics Home – 21 January 2016 – Sarah Wollaston MP (Parliamentary Health Committee Chair): It's time for a bold and brave strategy on childhood obesity:
21. Press releases from West Essex CCG regarding a new Sugar Smart App (January 2016)

22. Public Sector Executive website – 22 March 2016 - LGA study - "Nearly 2,500 academies have failed to adopt healthy school meal standards"

Annex 3

Main evidence base of the Scrutiny

Fifteen formal oral evidence sessions were held where the following witnesses (in the order of appearance) have been able to provide evidence:

- Jane Richards, Head of Commissioning, Public Health and Wellbeing, Essex County Council (ECC).
- Jason Fergus, Head of Active Essex.
- Carol Partington, Commissioning Support Manager, ECC.
- Jason Walmsley, School Meals Service Advisor, ECC *(twice)*
- Carolyn Terry, EYCC Commissioner for Sufficiency and Sustainability, ECC Education and Lifelong Learning - People Commissioning, ECC (2 sessions)
- Debbie Healy, NHS England (Commissioner of both Family Nurse Partnership and Health Child Programme services in Essex).
- Deborah Delacey, South Essex Partnership Trust (provider of Family Nurse Partnership across the County).
- Judy Hurry – South Essex Partnership Trust (provider of Healthy Child Programme in Castle Point & Rochford and West Essex);
- Carrie MacGregor – Provide, (provider of Healthy Child Programme in Mid Essex);
- Carol Archibald,Team Leader, Food,Health & Safety,Tendring District Council;
- Elaine Hanlon, Principal Environmental Health Officer, Brentwood Borough Council;
- Adrian Coggins, Head of Public Health & Well Being Commissioning *(twice)*;
- Helen Lax, Strengthening Communities Project Lead, ECC;
- Louise Wilshire from Colchester CVS;
- Jane Hanvey, Director of Transformation, Mid Essex CCG;
- Stephanie Farr, South Essex Partnership Trust;
- Rosie McHerne of ACE, Anglian Community Enterprise.
- County Councillor Anne Brown, Cabinet Member for Communities and Healthy Living (now Cabinet Member, Corporate, Communities and Customers) *(twice)*
- Brian Shaw, Strategic Lead Education and Skills, Active Essex
- County Councillor Graham Butland, Cabinet Member for Health
- County Councillor Ray Gooding, Cabinet Member for Education and Lifelong Learning

Unfortunately, North East London Foundation Trust (provider of the Healthy Child programme in Basildon and Brentwood) was unable to send a representative to attend either of the sessions arranged with community providers to discuss the Healthy Child Programme and Family Nurse Partnership or provide briefing material.

<u>Written evidence</u>:

Power point presentations delivered by contributors during the review on national, regional and local incidence of obesity, Active Essex, Healthy Schools Programme, School Meals Service, Healthy Child Programme, Family Nursing Partnership, Social Prescriptions.

Encouraging Healthier Takeaways in Low-income Communities Report (based on research by the Cities Institute, London Metropolitan University, October 2014).
Tuck-in brochure and flyers.

Extract pages taken from Healthy Start Programme website.

Free School Meals Take-up analysis for Essex by district (trend September 2014 – April 2015 and subsequent update).

Sample School Business Plans for the provision of School Meals

Updated overview of Active Essex data and impact statements 2014-15
Essex and district schools exercise data.

Data graphs on district breakdown of Healthy Schools rates and activity participation rates.

Charts showing the percentage of Essex Primary School students who said they had exercised 5+ times in the last week. Essex Health & Wellbeing of pupils 2014 - Schools Health Education Unit Survey

Draft Cabinet Member Decision document on the Final Award of Breastfeeding Support Service contract in Basildon and Brentwood

Essex County Council Press release dated 28 October 2015: explaining the reasons behind changes to a breast feeding support service

Data provided on dispensing of Healthy Start Vitamins

Essex Weighs-in campaign briefing note (December 2015).

Miscellaneous emails from contributors providing further information and clarification after witness sessions (notably on Universal Infant free School Meals).

Site visits:

Members of the Group have individually visited local primary schools and Children's Centres to speak to staff and assess the eating environment. The Schools and Children's centres visited were:
Berechurch Children's Centre (Cllr Margaret Fisher) – summer 2015
Children's Centres Visits by Cllr Jo Beavis – summer 2015
Chetwood Children's Centre (Cllr Ian Grundy) – 4 August 2015
Little Handprints Children's Centre (Cllr Bill Dick) – 4 June 2015
De Vere Primary School - Castle Hedingham (Cllr Jo Beavis) – March 2015
Gosfield County Primary (Cllr Jo Beavis) – March 2015
Waltham Holy Cross Infant School (Cllr Ricki Gadsby)–19 March 2015
Stock Primary School (Cllr Ian Grundy) – 18 March 2015
Kendal C of E School, Colchester (Cllr Margaret Fisher) – 9 March 2015
St George's Infant School and Nursery (Cllr Margaret Fisher) – 17 November 2014

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