



HEALTHY PATTERNS FOR HEALTHY FAMILIES: REMOVING THE HURDLES TO A HEALTHY FAMILY

A REPORT BY THE ALL-PARTY PARLIAMENTARY GROUP ON A FIT AND HEALTHY CHILDHOOD – Plain Text Version

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This report was prepared by a Working Group of the All-Party Group and we are proud to acknowledge the contributions of:

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With thanks also to Wendy Phillips for sharing her own experience of obesity with us.

We thank Slimming World for the financial support that made this report possible and make it clear that Slimming World neither requested nor received approval of its contents.

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THE ALL-PARTY PARLIAMENTARY GROUP AND THE WORKING GROUP

The Working Group that produced this report is a sub-group of the All-Party Parliamentary Group on a Fit and Healthy Childhood.

The purpose of the APPG is to develop practical policies to reduce the scale of childhood obesity and promote health and fitness by engaging with a wide variety of interests and experts in the sector and encouraging them to act together to find solutions. Group details are recorded on the Parliamentary website at:

<http://www.publications.parliament.uk/pa/cm/cmallparty/register/fit-and-healthy-childhood.htm>

The Officers of the APPG are:

Chair - Baroness (Floella) Benjamin of Beckenham OBE

Vice-Chairs - Lord McColl of Dulwich, Pauline Latham MP, Jim Fitzpatrick MP, Nic Dakin MP, Ian Austin MP, Diana Johnson MP

Hon Treasurer - Caroline Nokes MP

Hon Secretary - Julie Elliott MP

The Working Group is Chaired by Helen Clark, a member of the APPG Secretariat. Working Group members are volunteers from the APPG membership with an interest in this subject area. Those that have contributed to the work of the Working Group are listed on the front page.

The Report is divided into themed subject chapters with recommendations and an overall conclusion that we hope will influence political thinking in the lead up to the 2015 General Election and beyond.

EXECUTIVE SUMMARY

According to NICE (*May 2014*) obesity in the United Kingdom is rapidly becoming the norm. More than a quarter of adults are now defined as obese and an additional 42% are overweight.

Obesity is a family affair and it starts early.

The Early Bird Diabetes Trust survey of 300 Devon children (now in its 12th year) revealed that over 90% of excess weight gained by girls and over 70% gained by boys is acquired before school age.

These are shocking figures, but the Diet and Nutrition Survey of Infants and Young Children (*2013*) suggests that destructive patterns are established even earlier with 75% of babies between four and eighteen months receiving more calories than they need from solid food and formula milk.

The Early Bird study also claims that the parents of overweight or obese children were *'unaware and unconcerned. Today's parents are oblivious of their children's weight'* (*January 2013*).

It becomes difficult to ignore the findings of a Devon-based research programme, featuring 300 children, when they find an echo in a world-wide study, published in March 2013 by the University of Nebraska.

Devon's parents are not alone.

The Nebraska research found that:

- 51% of parents with an overweight or obese child considered that child to be of 'normal' weight
- About 14% of parents with normal-weight children thought their child was underweight
- Parents judged normal weight boys to be underweight, because of stereotyped preconceptions about what a boy should 'look like'.

What is now an 'obesity epidemic' comes with a high price tag; firstly to the Treasury and thence to the household budget of every family in the land. The Department of Health's policy module; 'Reducing obesity and improving diet' (*March 2013*) sets the cost to the NHS of being obese or overweight at more than £5 billion per annum.

The health costs of obesity to a child may include the following conditions in later life, with some developing in childhood:

- Liver disease
- Some cancers, specifically breast, bowel and endometrial
- High blood pressure
- High cholesterol levels
- Osteoarthritis
- Type two diabetes
- Sleep apnoea
- Cardiovascular diseases such as stroke and heart disease

- Depression/low self esteem
- Eating disorders such as bulimia

It is a formidable catalogue and the case-study below shows how behaviours encouraged in childhood and reinforced within the family establish patterns that the adult cannot break.

Wendy Phillips owns her own business, 'Sigma Accounting Solutions' and is a Fellow of the the Association of Chartered and Certified Accountants.

In her words:

'I am a 47 year old woman and for most of my life have been classed as morbidly obese. I often wonder why I am this way.'

I have come to my own conclusion that this condition I suffer from started to manifest in childhood and the way I was taught at school.

My parents, despite my father being a ship's cook and loving cooking, did not teach me about cooking as they were told by the school I attended that I was academically gifted and so they concentrated on encouraging me with academic things.

I went to an old grammar school that had recently been converted into a comprehensive school. Our school paid a lot of attention to academically gifted pupils and it was drummed into us all that our time should be spent on working hard at academic subjects. This was important and was the only way to be happy and successful and had to result in going to university and having a high level career.

Academically gifted pupils were steered away from subjects such as home economics.

My time at school resulted in me working very hard with little time for play. I concentrated upon getting a career and although I left my first university course due to stress, I felt such a failure afterwards that I worked hard and went back to university and studied every night while working full-time to allow me to do this.

I now run my own accounting practice and I have put everything I can into my career. This has also resulted in me not having children.

The pressure I put on myself has resulted in me not having time for myself. I work many hours and I am extremely tired after a stressful day. I do not have the energy to go shopping for fresh food or the energy to cook properly at night. I am not a keen cook, and I do not know how to cook many things, as this was not taught to me from an early age as academic work was the priority.

So as a result, I miss meals and eat 'takeaways' or unhealthy food.

In the past two years, with the help of my doctors and some counselling, I have tried to make more time for myself, and I have joined a gym. This has not worked well as work has interfered with my efforts and this comes first.

The recent economic downturn has not helped and although the staff that are employed by my company are paid more than the minimum wage, I often get paid less than half of this. This in turn puts pressure on, as I cannot afford to buy healthy food.

In summary, I think that what is taught at school and as a youngster has an impact that lasts a lifetime and it is hard to re-train coupled with the stresses of life, caused, for example, by working many hours for less than a minimum wage. Government and politicians fail to acknowledge that this affects how happy and healthy we are.’ (May 20014).

The causes of obesity are many, and as Professor Mike Kelly, Director of Public Health at NICE has said: *‘There is no ‘magic bullet’. It is about ensuring effective services are there to support people in the long term.’ (May 2014).*

The approach has been welcomed by Slimming World:

‘We’re delighted that the new NICE guidance recognises that being overweight or obese can have a serious effect on a person’s mental health as a result of stigma, bullying and discrimination.’ (Carolyn Pallister, Public Health Manager at Slimming World, May 2014).

This Report calls for a holistic approach to the obesity epidemic and for Government to support families to clear the hurdles to a fit and healthy childhood, thereby building the healthy nation of the future.

The family unit that can breed bad practice is itself best placed to learn and pioneer new and healthier ways of living:

‘Support occurs most readily in a social environment that facilitates healthy eating and health-promoting exercise. Many efforts that help people to achieve weight loss fail to establish the supportive social and interpersonal context that can reinforce and help maintain weight loss-related behaviour. Effective approaches should include these contextual influences and focus on making changes in the environment rather than in the individual. The social context most likely to support making healthy behaviour changes is the family.’ (Using the Family to Combat Childhood and Adult Obesity; Gruber and Haldeman, June 2009).

SUMMARY OF RECOMMENDATIONS

There are many recommendations flowing from this Report. This is a reflection of the massive amount of work required to address this issue and its dangerous consequences.

Whatever the result of the 2015 General Election, one thing is certain: the next Government will be faced with a child obesity epidemic of intractable nature and devastating effect unless a coherent, integrated strategy is adopted to address the issue and help families to overcome the multiple hurdles to health and fitness.

The recommendations also appear at the end of each relevant section.

Main recommendation

If there is one recommendation above all that the All Party Parliamentary Group on a Fit and Healthy Childhood would urge the incoming Government to adopt it is to appoint a Minister for Children to drive the policy and co-ordinate strategy across all Departments.

This should be a Cabinet post.

Pregnancy

1. UK Government to provide and disseminate throughout the maternal care pathway, clear guidance on weight gain during pregnancy
2. Directed training support for GPs and midwives in body weight levels for pregnant women and revised guidance on the risks associated with smoking during pregnancy
3. GP practices/midwives to offer pregnant women funded referral to lifestyle weight management programmes
4. A national PHE campaign to inform pregnant women of the risk of vitamin D deficiency and the benefits of vitamin supplementation for mothers, infants and toddlers
5. UK Government to recognise the importance of health visitor involvement throughout pregnancy and post birth, up to and including the weaning period

Early Years

1. Government to embed early childhood nutrition indicators into the key developmental checks and frameworks that measure child poverty and health inequalities
2. The Department of Health/PHE should refresh its Start4life and Change4life strategies to develop clear messages on healthy eating and lifestyle for the toddler age group, currently dropping between initiatives
3. The Department of Health to work with all stakeholders to build consensus around guidelines on the earliest age at which parents can safely introduce solid food into their babies' diet and provide clear, consistent advice for universal use
4. The Department of Health, online parenting forums, 'early life' brands and retailers that parents trust, should work together to disseminate consistent advice on early life nutrition to families
5. The Department of Education and Department of Health should work with Children's Centres and nurseries to share good practice about establishing community hubs of expertise and support for families on early life nutrition and healthy lifestyles from pregnancy to preschool
6. The Department of Education should recognise the early years as a unique stage in its own right and not merely a preparation for school, reinstating the vital role of free

- play in establishing a healthy level of physical activity in young children. To this end, a new Level 3 award of Early Years Educator (EYE) and new graduate award of Early Years Teacher (0-5 years) should include play work as part of the foundation training
7. Health and wellbeing boards should be given a statutory duty to commission local services to provide consistent and clear advice for parents on breastfeeding, the introduction of solid foods and toddler feeding
 8. The Department of Health and Public Health England should build the evidence base on effective interventions to improve early life nutrition and provide information and guidance to health and wellbeing boards and other local commissioners

Play and Leisure

1. Government to follow the lead of the Welsh Assembly by introducing a ‘play duty’ as part of a new national Play Strategy, adopting a Whole Child approach, to promote healthy development through play and other activities and to encourage health and education professionals to signpost to such evidence-based organisations that can advise and support schools and families. Government to recognise the role that schools can assume in supporting children and families to adopt healthier lifestyles, including through an improved understanding and provision of outdoor play
2. Government to develop guidance to Local Authorities to include strategies for safer, child-friendly streets in residential areas, including new housing developments, within their Local Development plans, placing the child’s need to have safe, free access to suitable natural places to play before traffic issues and profit from development
3. Department for Education to introduce training and guidance in the enablement of free play for all professionals with responsibility for children, including Ofsted
4. Local Authorities to work with Primary Care providers, schools and others to offer guidance and support to families in facilitating freely chosen play
5. A new legal duty on public health bodies to work with schools and local government to ensure that all children have access to suitable play opportunities within close proximity to their home and at school
6. Public Health England to produce guidance to local Public Health commissioners on how projects and schemes that promote free play can be supported as part of local obesity prevention strategies and to work with Natural England to develop its *Natural Play* programme to extend opportunities for active outdoor play, partnering with Museum and Heritage organisations where appropriate

Nutrition and the school environment

1. Government to develop a cross-Departmental strategy co-ordinated by a Minister for Children at Cabinet level with the power of audit
2. A free, national, mandatory healthy schools programme including appropriate staff training to embed healthy eating, physical activity and body image education into the curriculum and to make sustainable changes to school food on a ‘whole school’ approach, with a possible starting point being The European Food Framework and its new subject specifications which outlines core skills for diet, active lifestyles and energy balance
3. Parents and pupils to be encouraged to collaborate with head teachers and chairs of governors to ensure that a school’s policies and ethos promote child fitness and wellbeing. Family Liaison Workers to be based in school to support parents in devising home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen-based pursuits

4. Extended schools and family learning to dovetail so that families and children can be educated together about food, nutrition, physical activity and health
5. New 'cooking programmes' within the school curriculum to combine nutritional education and elements from successful home economics syllabuses, rather than concentrating solely upon recipes

The effect of social and economic inequalities on child health and fitness

1. Implement Marmot's proposals for reducing health inequalities; specifically those linked to Policy Objective A: increased investment in early years, designing quality early years education and childcare and supporting families to develop children's skills. Build in a recognition that all parents are knowledgeable individuals who want the best for their children
2. Encourage breastfeeding by providing places for mothers to breastfeed at work and in shops/leisure outlets; presenting breastfeeding as a desirable *norm* (in Europe, television advertisements about breastfeeding are perfectly acceptable)
3. Follow the recommendations of the Healthy Child Programme, beginning in the antenatal period with visits from the Health Visitor
4. Government to extend the pupil premium to early years, thus committing additional investment to Children's Centre budgets. Children's Centres to remain a universal service, this being the most effective way of reaching disadvantaged families.
5. A new legislative requirement placed on local authorities which would prevent closure of Children's Centres without full, audited appraisal of the potential role for the voluntary sector to take over; and requiring the sharing of information between local authorities, agencies and Children's Centres
6. A national evaluation of the work done by Children's Centres including the development of a system of audit, so that Centres can carry out effective evaluation of their own services

The role of local government

1. Families and young people to be centrally involved in the design of public health programmes, commissioning decisions and interventions aimed at child health and fitness
2. The planning system to be used to encourage free play, walking and bicycling and accessibility to supermarkets via public transport and to discourage the proliferation and concentration of fast food outlets in specific neighbourhoods
3. Improved availability and identification of healthful food, calorie information and age-appropriate portion sizes in restaurants via recognition and endorsement schemes
4. Ensure that all Local Authority-run buildings and facilities implement strong nutritional standards for food and drink, provide free drinking water and are 'breast-feeding friendly'
5. Endorsement and recognition schemes to encourage local shops to improve their range of healthful foods
6. Promote partnership working on child and family fitness strategies via Local Authority-led services aligning with local schools, employers, the voluntary sector and NHS
7. Promote and facilitate Local Authority 'hubs' to share and transmit good practice
8. Encourage Local Authorities to undertake fitness assessments on the children in schools in their area

9. Government audit of Local Authorities across entire responsibility remit for strategies/policies to improve child health, wellbeing and reduce obesity with publication of annual outcomes

The role of lifestyle weight management programmes in helping families to become fit and healthy

1. Recognition by national and local government and professional bodies that those working in the health and education sectors have a duty of care to their patients, pupils and students who are at risk of suffering physical or psychological harm due to being overweight or obese
2. Government to develop and implement mandatory national training for all professionals who interact with families to equip them with the skills to raise the issue of obesity and weight management with sensitivity
3. Introduction of a specific 'training module' applicable to all undergraduate and professional studies, that addresses raising the issue with compassion, respect and sensitivity
4. Government to recognise the role that responsible commercial weight loss organisations can play in supporting families to adopt new healthy lifestyles and reduce the prevalence of obesity and to encourage health and education professionals to signpost to such organisations that are evidence-based
5. Local Authorities to raise awareness of lifestyle weight management programmes and providers amongst the public, and all professionals who work with families and children
6. Publicity material to raise awareness of lifestyle weight management programmes and providers to offer programmes that are culturally sensitive and available in a variety of languages and formats as appropriate to the community
7. Providers of lifestyle weight management programmes to monitor and evaluate their programmes and supply evidence-based data to commissioners and those responsible for referrals. All data to be published and readily accessible

PREGNANCY

'The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing' Marmot Review (2010).

The children of obese parents are likely to be obese themselves. Similarly, virtuous behaviours, learned within the family, can be instrumental in combating less benign pressure from outside when the child reaches school age and beyond.

'Supporting Families in the Foundation Years' (DfE 2011) acknowledges the importance of early life; for its own sake and as a determinant for quality of life in later years:

'The Government's aim is to put in place a coherent framework of services for families from pregnancy through to age 5, which focus on promoting children's development and help with all aspects of family life'. (DfE. 2011:11).

Access to excellent guidance on nutrition, play and exercise enables adults to give children the best start in life including being effective role models themselves; but the origins of obesity may be more deeply rooted than in learned behaviour.

Findings from a survey headed by Dr Haghghi (*Hospital for Sick Children, University of Toronto*) suggest that the babies of mothers who have smoked during pregnancy run an increased risk of becoming obese adolescents.

The adolescents studied had a higher body mass index and more total body fat and Haghghi claims that even smoking one cigarette per day can adversely trigger the reward centre of the brain in the foetus, thus stimulating future cravings for fat as well as other addictive substances such as alcohol (*Archives of General Psychiatry*,: 3.9. 12, online).

Another fallacy is that 'eating for two' during pregnancy will produce a fit and healthy child.

Obese women have an increased likelihood of serious complications in pregnancy and a two fold risk of stillbirth (*Chu SY et al: Maternal obesity and the risk of gestational diabetes mellitus. Diabetes Care. 2007*) and neonatal death (*Kristensen et al: Pre-pregnancy weight and the risk of stillbirth and neonatal death. BJOG 2005*).

In July 2010, NICE guidance (*PH29 July 2010*) acknowledged that there is limited evidence on the content of effective interventions for pregnant women but stated the need for a sharper focus on diet, activity and behaviour change. The guidance also supported a clear identification process and referral of obese pregnant women to weight management services.

From April 2010, maternity service contracts require midwives to provide all pregnant women with a body mass index (BMI) assessment and to refer those with a BMI of <18.5 and >30 to weight management services.

The fact that an obese pregnant woman is still likely to be referred to as 'blooming' shows that the consequent adverse effects on the fitness and health of the child are still largely unknown or disregarded.

This will remain the case while there is a lack of consistent dietary information that is readily accessible from all the health/social care professionals that a woman will encounter during pregnancy.

RECOMMENDATIONS

- 1. UK Government to provide and disseminate throughout the maternal care pathway, clear guidance on weight gain during pregnancy**
- 2. Directed training support for GPs and midwives in body weight levels for pregnant women and revised guidance on the risks associated with smoking during pregnancy**
- 3. GP practices/midwives to offer pregnant women funded referral to lifestyle weight management programmes**
- 4. A national PHE campaign to inform pregnant women of the risk of vitamin D deficiency and the benefits of vitamin supplementation for mothers, infants and toddlers**
- 5. UK Government to recognise the importance of health visitor involvement throughout pregnancy and post birth, up to and including the weaning period**

EARLY YEARS

It could be argued that the growing burden of long term health conditions including diabetes and poor mental health have a substantial component of their origin in early life – and obesity deriving from lifestyle and feeding patterns established at that time.

Until relatively recently, little was known about the activity and dietary behaviour of the UK's pre-school 0-5 children and still less about their childcare environment.

'Every Child Matters' (2004), 'The National Service Framework for Children' (2004), and 'Supporting Families in the Foundation Years' (DfE 2011) brought a shift in emphasis as did a series of independent reviews commissioned by the Government, including those by Graham Allen MP, Frank Field MP and Dame Claire Tickell.

However, there is still an inadequate focus on the role of early nutrition and the part played by parents and families in feeding young children.

Parental influence is a critical determinant in children's food preferences (Benton D. 'Role of Parents in determining the food preferences of children and the development of obesity' 2004) and some food likings developed in early childhood will persist into adulthood. The idea that combating child obesity necessitates the creation of a family or home environment that promotes healthy family habits is gaining wider acceptance.

Young children require a varied and balanced diet to thrive and breastfeeding and good nutrition in preschool years have been found to be vital to their health outcomes. Many young children in the UK today are not receiving a diet rich in essential nutrients and become vulnerable to conditions affecting toddlers such as iron deficiency anaemia.

The pattern of modern life, with one or both parents working full or part time, means that responsibility for child care is frequently shared between extended family members, child-minders and early years educators in childcare centres, playgroups, and nurseries. Wherever children are fed, those involved should be aware of their responsibility to facilitate positive improvements in the child's diet and lifestyle.

Research also suggests that if sustained improvement in nutrition and physical activity within all child care settings is to be achieved, interventions should focus on role modelling by the child care staff and the consistent promotion of policies affecting child wellbeing.

Children learn behaviour through the adults supporting and teaching them and dietary choices are influenced through food availability and adult role models. Engaging and working with families is essential if children are to be fully supported and the collective well-being of all stakeholders must be addressed, involving all in training and development.

To date there is no statutory training available to support childcare settings wishing to improve the quality of the nutrition they provide, the physical activity environments they offer and the health promotion skills that can be cascaded to the family.

A well qualified, highly trained workforce is fundamental to improving health outcomes for children and families. 'More Great Childcare' (DfE 2013) proposes a new Level 3 award of Early Years Educator (EYE) and a new graduate award of Early Years Teacher (0-5 years) but takes a backward step in switching the emphasis from a play-based holistic child-

centred approach, towards formal teaching and learning. This limits its potential effect on the individual family.

A planned 4,200 extra Health Visitors ('Health Visitor Call to Action' 2011) by 2015, aims to extend the delivery of 'The Healthy Child Programme' 2009.

This public health promotion programme centres upon young children and families. It offers a framework of early intervention and its objectives include increased rates of breastfeeding, early recognition of growth factors and risk factors for obesity; healthy eating and increased activity levels, goals for child wellbeing and positive parenting, readiness for school and improved learning. The programme signposts early detection, focusing on developmental delay, patterns of ill health and abnormalities.

The proposed Two Year Review to be undertaken by Health Visitors and Early Years practitioners as part of the new Early Years Foundation Stage Curriculum stresses that partnership working between primary health care professionals (Health Visitors, midwives, School Nurses) and educationalists is essential to achieving the stated objectives.

RECOMMENDATIONS

- 1. Government to embed early childhood nutrition indicators into the key developmental checks and frameworks that measure child poverty and health inequalities**
- 2. The Department of Health/PHE should refresh its Start4life and Change4life strategies to develop clear messages on healthy eating and lifestyle for the toddler age group, currently dropping between initiatives**
- 3. The Department of Health to work with all stakeholders to build consensus around guidelines on the earliest age at which parents can safely introduce solid food into their babies' diet and provide clear, consistent advice for universal use**
- 4. The Department of Health, online parenting forums, 'early life' brands and retailers that parents trust, should work together to disseminate consistent advice on early life nutrition to families**
- 5. The Department of Education and Department of Health should work with Children's Centres and nurseries to share good practice about establishing community hubs of expertise and support for families on early life nutrition and healthy lifestyles from pregnancy to preschool**
- 6. The Department of Education should recognise the early years as a unique stage in its own right and not merely a preparation for school, reinstating the vital role of free play in establishing a healthy level of physical activity in young children. To this end, a new Level 3 award of Early Years Educator (EYE) and new graduate award of Early Years Teacher (0-5 years) should include play work as part of the foundation training**
- 7. Health and wellbeing boards should be given a statutory duty to commission local services to provide consistent and clear advice for parents on breastfeeding, the introduction of solid foods and toddler feeding**
- 8. The Department of Health and Public Health England should build the evidence base on effective interventions to improve early life nutrition and provide information and guidance to health and wellbeing boards and other local commissioners**

PLAY AND LEISURE

Article 31 of 'The UN Convention of the Rights of the Child' states:

'That every child has the right to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.'

'That member governments shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.'

In 2013, the UN issued a General Comment on Article 31 of the convention, clarifying that this means that governments have obligations to 'promote, protect and fulfil' children's right to play by means of appropriate 'legislation, planning and budgets'.

The benefit of play to the wellbeing of children, from better health outcomes to higher academic performance and improved social skills, is acknowledged by the UK Chief Medical Officer (Report 2013).

This is not a cry in the wilderness.

A growing body of research world-wide, acknowledges the benefit of play to the whole family; whether that involves simply visiting a playground together or engaging in schemes such as the USA-based 'Eat, Play, Grow' community curriculum and the Michelle Obama 'Let's Move' campaign.

Yet despite many exciting models and convincing and articulate champions (OPAL, Play England) there is no duty upon Government to provide good quality play space in England.

A time-honoured failure to address national Planning Guidance (PPG17 and associated training for Local Authorities and house builder companies) has meant that the built environment increasingly prohibits children's access to public space in their neighbourhood; depriving them of the free 'street play' of their forbears, and restricting them to the house and play station.

Heavy traffic is the main reason given by parents for a sharp decline in outdoor play. Every day in 2011, an average of 7 children between 0-15 were killed or seriously injured on the roads.

Yet intelligent planning (i.e. not building a major road between homes on one side and green spaces where children might play on the other) would reduce those figures.

Similarly housing development street layout; the police-initiated toolkit for architects and builders, 'Secured by Design' (concentrating on eliminating locations such as bushes/undergrowth perceived to be 'criminal friendly' rather than removing the *criminal*) and the 'stranger danger' fear, when most risks to children occur within the home, have combined to create a toxic climate for outdoor play.

For today's children, this is likely to take place in a designated playground with ever-increasing maintenance costs for Local Authorities and a deficit for children in unfettered opportunities to explore the urban and rural environment and thereby gain confidence and resilience whilst developing team working and leadership skills.

Extending a traditional school day for childcare purposes and the extra curricular educational agenda has also adversely impacted upon play. Growing concern about child obesity has led to an increased role for sport in the structured 'wrap around care' activities in after-school schemes and holiday clubs, but the physical activity and other play needs of the majority of children remain unmet.

Funding such as the Primary Sport Premium only benefits those children who are already active and it is likely that overweight children may seek out opportunities to *avoid* involvement in sporting activities.

Birmingham, for example, reports that around 40% of children living in the city are now presenting as overweight so it is reasonable to assume that the sport initiative is missing its target audience.

Periods of the day traditionally available for children's free play and the benefits of essential regular exercise, but also opportunities to experience risk and danger evaluation and decision – making are now largely lost. In their place is supervised 'activity time' which is unlikely to facilitate robust free play as recent changes to childcare regulation will mean that larger numbers of children will be supervised by under-qualified staff (Children and Families Act 2014).

In addition, play opportunities on offer within the school environment are frequently assessed by means of geographical space. Does the school have a playing field? Whilst the practice of building on these to accommodate an influx of children from neighbouring failed and closed schools is not ideal, OPAL argues that a school's cultural attitude to play is of equal importance:

At OPAL, we audit (on 18 essential criteria) every school we visit, and we regularly see schools blessed with huge fields, but most of the space totally wasted as a play/learning asset. I've even seen schools chop down their trees and bushes to build what they erroneously call an 'outdoor classroom'. They already had the perfect outdoor classroom but not anymore!

Some schools have lunchtime staff who demonstrate very restrictive behaviour towards children without realising it, limiting the children's ability to accrue vital social, emotional, cognitive, creative and physical skills. Schools often allow access to their playing fields only in the summertime, limiting the play space to tiny, fenced tarmac areas for the rest of the year.

We also come across inner-city schools with little or no grass to play on, and we can show them just how little that matters to a successful, positive play culture. At Victoria Park Primary School in Bristol, 470 children have perhaps two tennis court-sized spaces to all play together in, yet the playtimes are amazingly positive.'
(Neil Coleman 2014)

This approach finds echo in a Skills Active Memorandum submission to an Education Select Committee enquiry, 'The role and performance of Ofsted'.

'Ofsted should also be looking at how the school provides for the wellbeing of its pupils as regards attitudes towards play and break-time. Evidence has shown the importance of freely-chosen play to children and recent projects in schools have demonstrated the practical benefits of freely – chosen play to the wellbeing and behaviour of children.'
(2011).

The Memorandum credits outcomes for primary school-aged children in South Gloucestershire, following the appointment of a 'Learning and School Effectiveness Play Adviser' and notes that OPAL (Outdoor Play and Learning) programmes have been developed and delivered to 30 schools.

It criticises Ofsted inspections for failure to recognise the importance of excellent play opportunities to children's learning and wellbeing, and the freedom to *'take appropriate levels of risk'* and *'playfully and independently explore the relationship between themselves and the physical and social environments around them'* is cited as an essential prerequisite *'without which play cannot take place.'*

Article 31 of 'The UN Convention on the Rights of the Child' asserts a child's right to recreational, cultural and leisure activities and as with play, offers scope for the family unit to develop healthy patterns of activity.

The development of outdoor heritage sites can offer active engagement for families and although there remains work to be done in specifically targeting communities experiencing the highest levels of deprivation, examples of good practice here and in the USA include:

- John Clare Cottage (Peterborough) : heritage and gardening skills programme for SEN pupils and those from pupil referral units; engaging them in active physical skills that do not need agility in academia or sport
- English Heritage : links to local archaeological societies encouraging families to get practically involved with digs
- The Association of Children's Museums (USA) , Good to Grow: 'Going Wild in Children's Museums' in partnership with the National Wildlife Federation, piloting sites that create outdoor spaces to connect children and families to natural outdoor settings
- The Children's Museum of Pittsburgh (USA) : envisions creating a new kind of 'town square' for children and families

In terms of Government action, The Welsh Assembly has introduced section 11(3) of the Children and Families (Wales) Measure 2010, widely known as the 'play duty', requiring Local Authorities to secure sufficient play opportunities for children in their areas and addressing gaps in provision as far as is reasonably practical. They must publish details about where facilities are located and what they offer.

It is a significant step – but no reason for complacency and more remains to be done:

Wales is leading the way globally in terms of legislating for children's play. However, we need to recognise that we have some considerable way to go to improve the environment for children.' (Mike Greenaway, Director Play for Wales, Issue 42, Spring 2014).

An essential part of the 'way to go' will involve the engagement of and support for the family unit:

'The family provides the primary social learning environment for children and the primary setting for ... involvement in opportunities for play and other physical activity. Parental health behaviour guides the development of health practices in children and children can influence these same behaviours of their parents and siblings.' (Using the Family to Combat Childhood and Adult Obesity: Gruber and Haldeman, online June 15, 2009).

RECOMMENDATIONS

1. Government to follow the lead of the Welsh Assembly by introducing a ‘play duty’ as part of a new national Play Strategy, adopting a Whole Child approach, to promote healthy development through play and other activities and to encourage health and education professionals to signpost to such evidence-based organisations that can advise and support schools and families. Government to recognise the role that schools can assume in supporting children and families to adopt healthier lifestyles, including through an improved understanding and provision of outdoor play
2. Government to develop guidance to Local Authorities to include strategies for safer, child-friendly streets in residential areas, including new housing developments, within their Local Development plans, placing the child’s need to have safe, free access to suitable natural places to play before traffic issues and profit from development
3. Department for Education to introduce training and guidance in the enablement of free play for all professionals with responsibility for children, including Ofsted
4. Local Authorities to work with Primary Care providers, schools and others to offer guidance and support to families in facilitating freely chosen play
5. A new legal duty on public health bodies to work with schools and local government to ensure that all children have access to suitable play opportunities within close proximity to their home and at school
6. Public Health England to produce guidance to local Public Health commissioners on how projects and schemes that promote free play can be supported as part of local obesity prevention strategies and to work with Natural England to develop its *Natural Play* programme to extend opportunities for active outdoor play, partnering with Museum and Heritage organisations where appropriate.

NUTRITION AND THE SCHOOL ENVIRONMENT

'During school years, children and young people develop life-long patterns of behaviour that can affect their ability to eat a healthy diet, maintain a healthy weight and be more physically active. Schools, led by head teachers and chairs of governors, have an important role to play by providing opportunities for children and young people to be physically more active, develop healthy eating habits, and also by providing role models. A school's approach to assessing the environment and developing its policies will be more effective if the whole school community is involved, for example, by encouraging collaboration between head teachers, governors, school council members, pupils and parents. Involvement from pupils and their parents may produce more effective outcomes.' (*'Obesity: prevention and lifestyle weight management in children and young people.'* NICE quality standard draft. July 2014).

The NICE statement highlights the crucial role of schools in promoting the health and fitness of children.

It suggests that the best outcomes will be achieved by adopting a holistic approach involving the family and may be set against figures from the National Child Measurement Programme (2011/12) showing 32.4% of girls and 35.4% of boys aged 10 – 11 to be overweight.

Of that number, 17.1% of girls and 20.7% of boys were categorised as obese and the Programme in 2012/13 charts an upward trend, with one in three of the children measured in Year 6 presenting as overweight or obese.

'The National Diet and Nutrition Survey' (Results from Years 1-4 (combined) of the Rolling Programme 2008/9–2011/12: Executive Summary) cites poor diet as a significant factor in the childhood overweight epidemic.

Whilst just 10% of boys and 7% of girls met the 'at least five a day' recommendation of fresh fruits and vegetables, and consumption of oily fish was well below an advocated one portion per week, the Survey reveals that intake of added sugars or NMES (non – milk extrinsic sugars) exceeded the daily recommended value for all children, peaking in the 4–10 and 11-18 age groups.

Main sources of NMES are predictably; cakes, biscuits, breakfast cereals, fruit juices and sugary soft drinks.

In recent years, there has been a concerted effort to improve the quality of school food and worthwhile initiatives include:

- The School Food Plan: supported by The Secretary of State for Education and a range of organisations designed to help head teachers improve school food. A website offers case studies of proven success stories
- Food for Life Partnership: contains dedicated schools programmes with nearly 5,000 schools enrolled, using a 'whole settings' approach to renovating the food culture-making lunchtimes fun; enriching learning with practical activities such as food growing, farm visiting and cooking
- The School Fruit and Vegetable Scheme: funded by the Department of Health and entitling every child aged 4-6 in fully state-funded schools to a piece of fruit or vegetable each day and equating to approximately 2.2m children in approximately 16,500 schools

- School milk: subsidised by the European Union under the European school milk scheme and funded by the Department of Health for children aged under five
- Revised standards for food served in schools, (available from September 2014 and in regulatory force in January 2015) giving clearer food-based standards with practical guidance for the creation of nutritionally balanced meals and cheaper, less burdensome operational costs, allowing for increased flexibility
- A free school lunch offered to all pupils in reception, year 1 and year 2 from September 2014; mandatory in all state-funded schools in England including academies and free schools (Children and Families Act 2014).

Welcome curricular changes to the teaching of food in schools from September 2014, will see cooking and nutrition becoming a compulsory addition to the Design and Technology specification (key stages 1-3 –up to age 14 years).

Pupils will be taught how to cook applying principles of nutrition and healthy eating and syllabuses will include sections on seasonality, sourcing and the characteristics of a range of ingredients.

However, tangible progress here is countermanded by the Ofqual recommendation that current Home Economics (Food and nutrition), Catering and Design and Technology (Food) A level subjects will cease to be available from 2016.

The NICE quality standard ('Obesity: prevention and lifestyle weight management in children and young people': draft 2014) states:

'It is well recognised that children who are obese are likely to have obese parents. Many cases in which obesity runs in families may be due to environmental factors, such as poor eating habits learned in childhood, or due to relational and behavioural factors such as poor boundary setting. Therefore, family involvement in interventions is important to ensure improvements in outcomes are maintained.'

The Government-backed Change4Life Healthy Lifestyle Delivery Programmes are family-centred approaches within the community and are rolled out to families with children aged between 0-19 years via NHS Trusts.

Attractive programmes range from messy play with foodie fun and games in children's centres for the under-fives, PHSE programmes of physical activity, games, health messages and weekly challenges aimed at years 5 and 6, and programmes where parents/carers participate in games, healthy eating, cooking and physical activity with their children who have been referred via the National Child Measurement Programme.

NICE recommends a similar strategy in education; urging head teachers and governors to assess the school environment in collaboration with parents and pupils so that there is a greater likelihood of achieving consensus around feasible policies to promote physical activity and a healthy weight and lifestyle.

It is an aim as yet awaiting practical definition.

Olivier de Schutter, UN Special Rapporteur on The Right to Food (Briefing Note 09 - April 2014) makes a case for Government use of public procurement policy as a tool to '*set a positive trend and accelerate a transition towards sustainable food systems that respect the rights of vulnerable groups, including small-scale food producers.*'

Ideally such schemes should:

- 1) *source preferentially from small-scale food producers and actively empower them to access tenders; 2) guarantee living wages as well as fair and remunerative prices along the food supply chain; 3) set specific requirements for adequate food diets; 4) source locally and demand from their suppliers that they produce food according to sustainable methods; and 5) increase participation and accountability in the food system.'*

Schutter argues that *'the effectiveness of such public procurement policies and programmes would be maximised by fully integrating them under right to food national strategies and framework laws, and by co-ordinating them with other food security policies'*.

The Government press release, announcing the introduction of new school food standards for England, makes reference to the Soil Association's Food For Life Catering Mark, noting that many academy caterers hold this independent endorsement and are taking steps to improve the food they serve by using ingredients which are fresh, free from trans fats and undesirable additives, better for animal welfare and comply with national nutrition standards.

The Government's new Plan for Procurement also welcomes the Mark as a *'well established best practice tool.'*

However, there is no governance in this area and the evidence base around specific criteria for being awarded the Quality Mark is reliant upon the values of the organisation delivering.

There remains no mandatory scheme. Many initiatives nationwide have gone some way to change the school food culture with positive effect yet to date **NUTRITION AND THE SCHOOL ENVIRONMENT** remains very much a 'work in progress'.

There is a need for a coherent, evidence-based national strategy, drawing together examples of best practice and aligning the school setting with the family in the community so that strategies to promote a fit and healthy childhood are not circumscribed by the given hours of a school day.

RECOMMENDATIONS

1. **Government to develop a cross-Departmental strategy co-ordinated by a Minister for Children at Cabinet level with the power of audit**
2. **A free, national, mandatory healthy schools programme including appropriate staff training to embed healthy eating, physical activity and body image education into the curriculum and to make sustainable changes to school food on a 'whole school' approach, with a possible starting point being The European Food Framework and its new subject specifications which outlines core skills for diet, active lifestyles and energy balance**
3. **Parents and pupils to be encouraged to collaborate with head teachers and chairs of governors to ensure that a school's policies and ethos promote child fitness and wellbeing. Family Liaison Workers to be based in school to support parents in devising home activities that encourage children to be**

more active, eat more nutritious foods and spend less time in screen-based pursuits

- 4. Extended schools and family learning to dovetail so that families and children can be educated together about food, nutrition, physical activity and health**
- 5. New 'cooking programmes' within the school curriculum to combine nutritional education and elements from successful home economics syllabuses, rather than concentrating solely upon recipes**

THE EFFECT OF SOCIAL AND ECONOMIC INEQUALITIES ON CHILD HEALTH AND FITNESS

In January 2013, the then Public Health Minister, Anna Soubry placed the obesity epidemic in a socioeconomic context, telling The Daily Telegraph:

'When I go to my constituency, in fact, when I walk around, you can almost now tell somebody's background by their weight. Obviously, not everybody who is overweight comes from deprived backgrounds but that's where the propensity lies. It is heartbreaking that people who are some of the most deprived in our society are living on an inadequate diet.'

Ms Soubry, (who also flagged up adverse family eating habits and the prevalence of fast food in the diet of children from disadvantaged backgrounds) was accused of fuelling a 'blame' culture, but research findings are kinder to her.

The Nice quality standard ('Obesity: prevention and lifestyle weight management in children and young people' draft July 2014) states:

'A strong positive relationship exists between deprivation (as measured by the 2010 Index of Multiple Deprivation (IMD) score) and obesity prevalence for children in each age group. In the least deprived decile, the obesity prevalence was 6.4% among Reception children compared with 12.1% among those in the most deprived decile. Similarly, obesity prevalence among Year 6 children schools in the least deprived decile was 13.0% compared with 24.2% among those in the most deprived decile.'

The correlation of socioeconomic factors and body weight is not a new concept.

In April 1997, The International Journal of Obesity published a paper entitled 'Does area of residence affect body size and shape?' (A Ellaway, A Anderson and S Macintyre); a study of 691 people aged 40 and 60 from four socially diverse urban neighbourhoods in Glasgow. People living in 'the most deprived neighbourhood' were found to be 'significantly shorter, and had bigger waist circumferences, waist-hip ratios and BMIs'

It would therefore be likely that the children (who were not part of the study) would also be overweight:

'Many cases in which obesity runs in families may be due to environmental factors, such as poor eating habits learned in childhood'(NICE quality standard draft: July 2014).

In conclusion, the Glasgow study suggests that:

'If Health of the Nation targets on reducing the proportion of overweight individuals in the population are to be met, public health policy should focus on places as well as people.'
(Ellaway, Anderson, Macintyre, 1997)

and is corroborated fifteen years later by National Child Measurement Programme (2012-13) data showing that children from deprived areas are likelier to be obese than those living in more affluent areas. However, there remains a need for definitive Government strategy to address the adverse effects of social and economic inequalities on the health of the child.

The furore occasioned by Anna Soubry's observations exposes the fact that to date, despite the presence of evidence-based research, such strategy has not made the transition into mainstream policy.

There is a wealth of persuasive material:

'Child Obesity and Socioeconomic Status' (National Obesity Observatory *October 2010*) further develops the connection between a child's weight, and household and neighbourhood deprivation.

Collating research findings from the National Child Measurement Programme, Health Survey for England and the Millennium Cohort Study, the paper contends that:

- Areas with the highest level of income deprivation have a child obesity prevalence almost double that of areas with the lowest level (Income Deprivation Affecting Children Index)
- Child obesity prevalence rises as household income drops and is markedly higher in the lowest income group than the highest (Health Survey for England; Millennium Cohort Survey)
- Children in households where the main earner works in a professional occupation have lower rates of obesity than those where the main income-earner works in a manual job (Health Survey for England).

Economic disadvantage is a demonstrable barrier to healthy eating.

Low income and debt make nutritious meals less affordable because healthy foods such as fruit and vegetables are expensive.

Supermarkets are beginning to extend their 'budget lines' of low cost brands to fresh food ranges, but 'out of town' locations may mean that families who cannot afford to run a car are reliant upon the more expensive, lower quality food that can be readily obtained from a local corner shop.

Anna Soubry claimed that people from deprived backgrounds were likely to eat '*an abundance of bad food*' such as 'breakfast buns' from fast food outlets, but for families on restricted income, the appeal is economic.

Processed foods and foods with high fat and sugar content are cheaper than healthy alternatives and children enjoy them, so there will be no waste.

Food preparation is also impacted by financial matters such as exorbitant fuel costs. Households using gas and electricity meters cannot afford to use energy on long, slow, cooking processes – and deprived areas have a higher number and greater concentration of inexpensive, fast food outlets. The food they supply is energy-dense and palatable – although not necessarily nutritious - and it is unsurprising that it tempting to use them.

The physical nature of the deprived *neighbourhood* united with poor planning practice, creates its own barrier to child health and fitness.

In areas that combine deprivation with high crime rates, children's outdoor play spaces, both natural (foliage, dens etc) and man-made (play parks) have either been removed or are widely perceived as being too dangerous for children to be allowed to use.

Similarly, high levels of crime and disorder will make it unlikely that parents will encourage their children to take exercise by walking to school or playing out of doors. For a fuller discussion on the importance of play, see the PLAY AND LEISURE section of this report.

In addition, the election of a Conservative/Liberal Democrat Coalition Government in 2010 brought in its wake, a shift of emphasis from a drive to reduce social exclusion and poverty, to a concentration upon *the individual* with parental and family influence replacing the prime responsibility of the community in addressing inequalities.

Community initiatives like Sure Start Centres (now Children's Centres) are the most visible casualty of the change in direction.

Originally introduced as a universal provision; designed to strengthen communities and encourage active participation by focusing on the promotion of the health and wellbeing of children, they are increasingly seen today as vehicles for targeted provision, aimed to offer support to families in the greatest need.

The change in role has made it easier for local authorities, (under increasing budget pressure), to close Centres in more affluent areas. To date, funding has been cut by a third, over 60 Centres have closed and there is a danger of the former Sure Starts being commonly perceived as providers of services specifically tailored for 'failing' families, thus impairing their ability to reach those who need them most.

For remaining Centres, the change of emphasis has meant a corresponding dilution of the services on offer, with less emphasis on the proven benefits of children learning through play.

'For Children's Centres to continue to work successfully as community hubs, excellent working partnerships with local services are crucial. They must remain a national priority for central government if it is to achieve its ambitions to improve educational outcomes, increase social mobility, reduce poverty, help troubled families turnaround and improve child health outcomes.' Anne Longfield OBE: Chief Executive, 4Children (Children's Centres Census 2013). 2010 saw the publication of The Marmot Review; 'Fair Society, Healthy Lives'.

The report of the Commission, chaired by Michael Marmot is described as a 'Strategic Review of Health Inequalities in England post-2010' and the Chair's Note encapsulates its findings – and the ethos governing the recommendations:

'People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviour – it should become the main focus.' (Michael Marmot, 2010).

Policy Objective A 'Give every child the best start in life' provides detailed recommendations designed to reduce inequalities in the early development of children, support parents via high quality maternity services, parenting programmes and early years education and promote *'the resilience and well being of young children across the social gradient.'*(Marmot: 2010).

Practical recommendations directly address the inequalities that provide seemingly insuperable barriers to well being and fitness for the children of families circumscribed by socioeconomic disadvantage – but just as important is the intellectual underpinning without which progress will be piecemeal:

Health inequalities that could be avoided by reasonable means are unfair. Putting them right is a matter of social justice. But the evidence matters. Good intentions are not enough'. (Marmot: 201).

Or, in Marmot's own use of the words of Pablo Nerunda: *'Rise up with me against the organisation of misery.'*

RECOMMENDATIONS

- 1. Implement Marmot's proposals for reducing health inequalities; specifically those linked to Policy Objective A: increased investment in early years, designing quality early years education and childcare and supporting families to develop children's skills. Build in a recognition that all parents are knowledgeable individuals who want the best for their children**
- 2. Encourage breastfeeding by providing places for mothers to breastfeed at work and in shops/leisure outlets; presenting breastfeeding as a desirable *norm* (in Europe, television advertisements about breastfeeding are perfectly acceptable)**
- 3. Follow the recommendations of the Healthy Child Programme, beginning in the antenatal period with visits from the Health Visitor**
- 4. Government to extend the pupil premium to early years, thus committing additional investment to Children's Centre budgets. Children's Centres to remain a universal service, this being the most effective way of reaching disadvantaged families**
- 5. A new legislative requirement placed on local authorities which would prevent closure of Children's Centres without full, audited appraisal of the potential role for the voluntary sector to take over; and requiring the sharing of information between local authorities, agencies and Children's Centres**
- 6. A national evaluation of the work done by Children's Centres including the development of a system of audit, so that Centres can carry out effective evaluation of their own services**

THE ROLE OF LOCAL GOVERNMENT

In 'Healthy Lives, Healthy People: A call to action on obesity in England' 2011, the Government argued that strategies to combat obesity should be designed and led by local government 'as each community had different characteristics and problems(which) were best addressed at a local level' (*Tackling obesity: Local government's new public health role*' Local Government Association, 2013).

The Health and Social Care Act (2012) made the recommendations statutory from April 2013; via ring-fenced public health grants for Local Authorities and a requirement for them to appoint a Director of Public Health to lead a public health team.

Post 2013, Local Authorities must deliver the National Child Measurement Programme (formerly the remit of PCTs); advise clinical commissioning groups on public health matters and set up a Health and Wellbeing Board to monitor performance and influence commissioning strategy.

'Obesity: prevention and lifestyle weight management in children and young people' (Nice quality standard draft: July 2014) provides further clarification, stating that Local Authorities should work with community partners to:

- Provide and promote healthier food and drink choices at Local Authority venues used by children and young people
- Develop a co-ordinated local physical activity strategy to promote the benefits of physical activity, highlight the risk of sedentary behaviour and increase the opportunities for children and young people (and their families and/or carers, as appropriate) to be physically active
- Raise awareness of lifestyle weight management programmes among the public, healthcare professionals and other professionals who work with children and young people

These are new requirements and Local Authorities are to some extent, still feeling their way – but examples of good practice are already emerging as listed by the Local Government Association (*Tackling obesity: Local government's new public health role*, 2013).

Many Local Authorities have already devised and are working to, comprehensive programmes.

In Birmingham, the Health and Wellbeing Board is rolling out its Childhood Obesity Strategy 2013/14, having calculated that 40% of the city's children will be obese by the time they leave primary school and that:

'the financial cost of obesity to our city amounts to £2.6 billion per year, including costs to the NHS, social care and the wider costs to the economy.' (*Fit for the Future: Birmingham's Childhood Obesity Strategy*).

The public document identifies the three determinants of an obesity crisis as Environment, Behaviour and Opportunity, listing desired outcomes, courses of action and targets to be achieved by 2016/17 in each category.

The attractive tabular format is accessible and the recommended actions and target time lines credible e.g. the desired Outcome of **Fewer environmental factors which are known**

to contribute to obesity is listed as achievable by practical steps such as changing Unitary Development Plans to encourage walking and cycling with the target of including healthy food choices in inspections of early years settings, children's homes, hostels and other LA regulated premises by 2016/17.

Similarly, the Outcome of children accessing physical activity is accompanied by realistic Actions of ensuring that local play facilities are safe, with access to *'low cost, high excitement activities in settings used by and appealing to children and their families.'*

The 2016/17 target sets a *'50% increase in children accessing Be Active compared to 2012/13 baseline'* and a 2% rise in child take-up of school meals.

Derby City Council has been recognised nationally by the LGA for its adoption of a 'Livewell' service.

The programme is described by the Authority as:

'a person-centred, twelve month behavioural change programme, based around the individual's priorities and aspirations for improving their own health.'

Livewell was launched in April 2013 and is designed to work specifically with *'three thousand index clients and their families per year, incorporating a variety of healthy programmes including weight management, healthy pregnancy, stop smoking, child weight management, men's health and Liveability, a weight management programme for adults with learning disabilities.'*

After a twelve month roll-out, the council's statistics show:

- A 90.5% retention rate for the service
- A minimum of 5% weight loss for users
- A 74.5% increase of self-reported physical activity
- A 78.93% increase in fruit and vegetable intake

This promising 'bill of health' for Derby is due in part to the fact that prior to 2013 the City Council had been pro-active in the field of public health and could therefore hit the ground running when statutory obligations were introduced.

In 2006 it became the first Local Authority in the country to have a Local Public Service Agreement reward target to increase children's physical activity levels, adopting a partnership approached called 'b active'.

A link with the Carnegie Physical Activity Research Institute at Leeds Metropolitan University led to further collaboration between Derby City Council and Derby County Community Trust to develop 'The Movement', described as:

'An innovative targeted programme to 11-16 year old girls that would increase physical activity levels, improve health outcomes and increase the self-esteem and confidence of sedentary young females living in the city.'

In 2014, a City Council evaluation of The Movement cites amongst other positive outcomes:

- 1480 girls taking part in targeted activities
- 115 workshops delivered to raise awareness around physical activity, health and self-esteem in 5 secondary schools across the city
- Derby City Council policy change within Leisure Facilities, providing allotted times for young people to access facilities at affordable prices and offering specialist staff to support them
- Shortlisted for the Sports Industry awards 2011

The initiatives taking place in Birmingham and Derby show ways in which local councils can work in partnership with their communities to increase levels of fitness, health and wellbeing.

Government should now audit Local Authorities across their entire responsibility remit for annual outcomes in the area of child health and fitness levels and publish the results with recommended examples of good practice.

All Local Authority tools for self-audit should include a demonstrable requirement to include collaboration and co-operation with the family in all initiatives to improve child health and wellbeing and reduce levels of obesity.

RECOMMENDATIONS

- 1. Families and young people to be centrally involved in the design of public health programmes, commissioning decisions and interventions aimed at child health and fitness**
- 2. The planning system to be used to encourage free play, walking and bicycling and accessibility to supermarkets via public transport and to discourage the proliferation and concentration of fast food outlets in specific neighbourhoods**
- 3. Improved availability and identification of healthful food, calorie information and age-appropriate portion sizes in restaurants via recognition and endorsement schemes**
- 4. Ensure that all Local Authority-run buildings and facilities implement strong nutritional standards for food and drink, provide free drinking water and are 'breast-feeding friendly'**
- 5. Endorsement and recognition schemes to encourage local shops to improve their range of healthful foods**
- 6. Promote partnership working on child and family fitness strategies via Local Authority-led services aligning with local schools, employers, the voluntary sector and NHS**
- 7. Promote and facilitate Local Authority 'hubs' to share and transmit good practice**
- 8. Encourage Local Authorities to undertake fitness assessments on the children in schools in their area**
- 9. Government audit of Local Authorities across entire responsibility remit for strategies/policies to improve child health, wellbeing and reduce obesity with publication of annual outcomes**

THE ROLE OF LIFESTYLE WEIGHT MANAGEMENT PROGRAMMES IN HELPING FAMILIES TO BECOME FIT AND HEALTHY

'Obese mother—of two turns down gastric surgery to drop ELEVEN STONE naturally – and inspires her overweight family to lose 18st between them.'(Katy Winter, MAIL ONLINE 25th April 2014).

The 'Mail' feature concerning Lisa Robinson and her family appeared just over a month before a NICE press release advocated referrals (some funded) by 'GP practices and other health and social care professionals' of 'overweight and obese adults' to lifestyle weight management programmes (Wed 28th May 2014).

A NICE draft quality statement ('Family involvement in lifestyle weight management programmes' July 2014) states that such programmes are more likely to succeed in enabling children and young people to achieve a healthy weight if the whole family is involved:

'Lifestyle weight management programme providers encourage family members to be involved.

Family involvement in the programmes is important to ensure that children and young people receive positive reinforcement and support away from the programme. Involving the family may also make the programme more successful, change behaviour and improve BMI over time in children and young people. It may also benefit family members because they may have the same genetic and/or lifestyle risk factors for weight as their child.'

The experience of Lisa Robinson and her family is testament to the effect of involving the family unit in an effective, evidence-based lifestyle weight management programme.

Ms Robinson, from Blyth Northumberland, chose to decline her GP's offer of 'taxpayer-funded bariatric surgery' (MAIL ONLINE) in favour of embarking on a commercial lifestyle weight management programme with 'Slimming World'. She lost over eleven stones in weight and felt so empowered and supported by the programme that she encouraged her family to join her.

The initiative was a striking success (*'together, the fabulous fat-fighting family has lost nearly 30st in weight.'* MAIL ONLINE), but the benefits to the Robinson family surpass a reading of the scales.

As Lisa put it:

'All our lives have been transformed – even my children's. Dylan once battled with ADHD but since I removed the additives and junk food from our family diet, he's so much better.

I've had to get used to the new person I see in the mirror....I feel just wonderful.' (MAIL ONLINE).

Effective lifestyle weight management programmes, as the Robinson family discovered, address the whole person/family's diet, physical activity and behaviour patterns, working *with* the family rather than providing clinical 'instruction' that might appear to be intimidating or judgemental.

Carol Weir, (Head of Service for Nutrition and Dietetics at Leeds Community Healthcare NHS Trust) who was part of the NICE guidance development team states:

'We need to focus on more than just diet and being more active. Using tools such as weight monitoring and settling realistic personal goals are really important. We also found that a lot of overweight or obese people were put off seeking help because they felt that they were being blamed for being unable to lose weight and the position they have found themselves in.' (20th May 2014).

NICE recommends that health professionals should ensure that all communication with people who need help to address weight problems is respectful and non-judgemental; an approach welcomed by 'Slimming World'.

Slimming World was started 45 years ago from a conviction that the burden carried by overweight people is two-fold. There is the burden of excess weight itself and there is often a far heavier burden: that of shame, self criticism and poor self esteem...

For many overweight people, successful long-term weight loss can only be achieved by tackling deep-seated emotional issues and support is most effective when it is delivered with genuine warmth, compassion, empathy, respect and understanding.' (Carolyn Pallister; Public Health Manager at Slimming World: 27th May 2014).

Responsible weight loss organisations provide regular and consistent weight management support to diverse communities throughout the UK; with high take-up in low income areas, especially those pursuing a model of established support groups at the heart of communities.

The Robinsons discovered that participating together in a responsible, evidence-based lifestyle weight management programme increased self worth in adult members, and equipped them to make beneficial changes to their children's diet and activity patterns.

NICE recommends that that:

'Providers of lifestyle weight management programmes ensure that they encourage family members to be involved in the programme and provide services that include the appropriate core components (July 2014).

Families should ideally be able to access training to support changes in behaviour *as a family* to improve their children's health and fitness levels. 'Support' should include positive parenting strategy and help in devising plans tailored to meet:

'A child or young person's age, gender, ethnicity, cultural background, economic and family circumstances, any special need and how obese or overweight they are. This should include helping them and their family to set goals, monitor progress against them and provide feedback.' (NICE draft: July 2014)

The approach might combine practical education in nutritional labelling with strategies to ensure that cultural needs are met and advice about promoting increased physical activity levels for the whole family.

A confidence-boosting programme to encourage all family members to be physically active and eat healthily will set patterns for adults to adopt and children to follow.

Such thinking must be welcomed - but as yet there is a training shortfall for education and health professionals, many of whom will have unique and long standing relationships with families at different stages of their lives and are ideally placed to refer those in need of help to responsible weight loss organisations.

Mentioning sensitive issues of overweight and obesity requires skill, delicacy and empathy - and those who raise the issue with people in need of help will need specific, dedicated training to ensure that advice given is at all times respectful, non-judgemental and free from blame and stigma.

Engaging with a responsible weight loss organisation should be a positive step - and one in which learning to create and follow new patterns of health and fitness can strengthen and energise the family unit.

RECOMMENDATIONS

- 1. Recognition by national and local government and professional bodies that those working in the health and education sectors have a duty of care to their patients, pupils and students who are at risk of suffering physical or psychological harms due to being overweight or obese**
- 2. Government to develop and implement mandatory national training for all professionals who interact with families to equip them with the skills to raise the issue of obesity and weight management with sensitivity**
- 3. Introduction of a specific 'training module' applicable to all undergraduate and professional studies, that addresses raising the issue with compassion, respect and sensitivity**
- 4. Government to recognise the role that responsible commercial weight loss organisations can play in supporting families to adopt new healthy lifestyles and reduce the prevalence of obesity and to encourage health and education professionals to signpost to such organisations that are evidence-based**
- 5. Local Authorities to raise awareness of lifestyle weight management programmes and providers amongst the public, and all professionals who work with families and children**
- 6. Publicity material to raise awareness of lifestyle weight management programmes and providers to offer programmes that are culturally sensitive and available in a variety of languages and formats as appropriate to the community**
- 7. Providers of lifestyle weight management programmes to monitor and evaluate their programmes and supply evidence-based data to commissioners and those responsible for referrals. All data to be published and readily accessible**

THE USE OF LEGISLATION

'Sugar has become the new tobacco in terms of public health' (Francesco Branca, Director for Nutrition, Health and Development. WHO 'Sugars intake for adults and children', March 2014).

'I call on manufacturers to ramp up reformulation of products to use less added sugar. If voluntary efforts fail to deliver, then we as a society may need to consider the public health benefits that could be derived from a regulation such as a 'sugar tax.' (Dr Sally Davies, Chief Medical Officer, Annual Report March 2014).

'Brains becoming dependant on sugar.'(US film 'Fed Up', produced by Laurie David – release date 2014)

The adverse effect of sugar on the health and fitness of the nation – and the nation's children is now widely accepted.

However, there is no consensus around what to do about it.

The advisory group, 'Action on Sugar' takes the view that food manufacturers should be encouraged to make gradual incremental reductions in the amount of sugar added to food - a process of *dehabituation*.

Another other school of thought is that voluntary 'self regulation' has failed and that the UK should follow the lead of the USA, Ireland, France, Hungary and Finland and institute a sugar tax.

Neither 'solution' has won widespread acceptance.

New forms of taxation are politically difficult (as seen by the notorious 'pasty tax' of 2012) now that food regulation is familiarly regarded as a 'burden on industry' rather than 'consumer protection'.

In 2014, a report in 'The Mail on Sunday' (May 4th 2014) containing the suggestion that the Labour Party was considering proposing a cap on sugar in cereals was greeted by Paul Wheeler from Kellogg's as might be expected:

'Frosties has been on sale for more than 60 years and by now we think people know there's sugar in them – we're not hiding it.

The problem with ideas like this is they want an easy, silver bullet solution to what is a very difficult issue. It all boils down to the fact we believe parents, and not the government, should choose what their kids eat.'

Labour argues that public opinion about the health of children is different, citing the recent consensus around a ban on smoking in cars when children are passengers.

It is considering the viability of recommending maximum levels of fat, salt and sugar in children's foods and maximum ingredient levels, on top of a statutory labelling scheme. The measures would be complemented by an ambition for levels of physical activity to reach 50% by 2025 with school sport at the centre of activities for children.

From an industry perspective, some progress has been made without resorting to the tax system, as can be demonstrated by the reduction in sugar content of the breakfast cereal,

'Sugar Puffs', from 49% in the early '90s to 31% today (representing a 37% cut). A further line of argument is that instead of taxing 'offending' products, 'virtuous' foods should be made cheaper, thus increasing their appeal to families and individuals on tight budgets.

Whilst debate on the desirability of deploying the tax system as a weapon in the war on obesity seems certain to continue, there is general agreement that more focus is needed on educating the public about the health and fitness of children.

In a letter to the Chief Medical Officer, the Royal College of General Practitioners called for 'a COBRA-style emergency taskforce to be set up to tackle the rising epidemic of childhood obesity.' (*'Health leaders declare 'State of Emergency' on childhood obesity' RCGP 31st August 2014*).

The RCGP and 11 partner organisations called for the creation of a national Child Obesity Action Group 'as a matter of urgency' calling amongst other measures for:

- Increased support for the National Child Measurement Programme
- Improved investment in data-gathering IT programmes of weight measurement
- More training in malnutrition and obesity for GPs and other health professionals
- Outreach projects to educate families about the dangers of obesity.

There is little to disagree with here, but devising ways in which to educate the public and benefit the family are not guaranteed to be easy and there is no 'quick fix'.

The so-called 'traffic-lights' system of food labelling, for example, is considered to have been insufficiently effective in helping people to make informed food purchasing choices and assess foods such as yoghurt (high in sugar, low in fat). 'Education' in its best sense will of necessity entail a properly multi-agency approach, involving community-based interventions, child health professionals, early years practitioners, engagement with multiple sectors; housing, health, education, transport - and be driven by national and local government.

Another contention would be that education programmes, especially those involving children and sugar, are likely to be of limited success and should be complemented by improving the nutrient content of foods by replacing sugar with sweeteners such as aspartame or more natural forms such as stevia.

However, despite the fact that these products have been repeatedly tested and found safe, the reasoning in favour of sweeteners remains largely unheard. This is unlikely to remain the case.

At a time in our history when according to Richard Roope, RCGP, Clinical Lead for Cancer:

'For the first time, we have a generation of patients who may predecease their parents. Only 3% of the public associate weight with cancer, yet after smoking, obesity is the biggest reversible factor in cancers'

It is neither feasible nor desirable that **any** potential method of addressing child obesity should remain unexplored.

CONCLUSION

Writing in the TES (29th August 2014), chef Jamie Oliver (whose widely admired campaign to improve school dinners in 2004 resulted in the Labour Government investing £280m in school kitchens and training) lambasted political parties for failing to attack the child obesity epidemic.

He claimed that the health service was ‘*buckling under the strain*’ of disease precipitated by obesity, stating:

‘With the general election coming up next year, I find it shocking that no party is showing leadership in trying to reduce childhood obesity and improve public health. It’s a shameful state of affairs and we’re all suffering as a result. The reality is that diet-related diseases are shortening our lives and costing us a fortune.’

The political parties in their turn might feel justified in baulking at the criticism.

Since 2010, the Conservative/Liberal Democrat Government has introduced a number of measures that have enjoyed widespread approval, such as reformation of the food standards and including cooking in the national curriculum. It has increased the potential for communities to work together by making Public Health the responsibility of local government and the introduction of a free school meal for infant school pupils could be the cornerstone of an entire re-positioning of policy on the role of nutrition in child health.

The previous Labour Government (1997- 2010) introduced strategies that have been welcomed by practitioners, including ‘Every Child Matters’, Change4Life’ and the school/sport partnership. The School Fruit and Vegetable scheme and investment in school kitchens and training triggered new and positive attitudes towards school food.

Yet despite this progress, Jamie Oliver’s words strike a chord as child obesity levels continue to soar. What then, is the answer?

The answer is that there is no single solution - no ‘magic bullet’ in the form of a tax or amount of money to cure the entrenched problem of child obesity now commonly referred to as an *epidemic*.

This Report, compiled from research papers submitted by members of the All-Party Parliamentary Group on a Fit and Healthy Childhood does not claim to provide **the answer** either.

What it aims to do is to consider the ways in which various matters such as early years practice, nutrition in school, facilitating children’s play and others can promote best practice for child health and fitness, with specific recommendations appertaining to each.

The report recognises that policy in each area must be centred upon a whole family approach with collaboration and consensual working between all agencies, sectors, and interests involving practitioners from industry as well as the professions and co-operation between the voluntary sector, local, national and international government as appropriate.

Dr Richard Roope, RCGP Clinical Lead for Cancer believes that taking collective responsibility for the crisis must entail collective action as of urgency:

'We are in denial. Our children are currently amongst the most overweight in Europe. This statistic is something that we should all be extremely ashamed of and we all have a responsibility to take action and reverse the trend.' (31st August 2014).

Whatever the result of the 2015 General Election, one thing is certain: the next Government will be faced with a child obesity epidemic of intractable nature and devastating effect unless a coherent, integrated strategy is adopted to address the issue and help families to overcome the multiple hurdles to health and fitness.

If there is one recommendation above all that the All-Party Parliamentary Group on a Fit and Healthy Childhood would urge the incoming Government to adopt it is to appoint a Minister for Children to drive the policy and co-ordinate strategy across all Departments.

This should be a Cabinet post.