Wiltshire Council

Health Select Committee
8 March 2016

Children's Select Committee
22 March 2016

Final Report of the Obesity and Child Poverty Task Group

Purpose

1. To present the conclusions and recommendations of the Obesity and Child Poverty Task Group for endorsement and referral to the relevant parties for response.

Background

2. In 2015 Children's Select Committee and Health Select Committee agreed to undertake a joint exercise looking at the links between child poverty and obesity.

3. The task group's terms of reference were:

   a) To explore and help develop the work already underway in Wiltshire communities to tackle obesity amongst children living in poverty and their families.
   b) To ensure that healthy lifestyle initiatives in Wiltshire are fully inclusive of children living in poverty and their families.
   c) To ensure that the Wiltshire Obesity Strategy includes an appropriate focus on children and families living in poverty.
   d) To explore how Wiltshire public services beyond health and leisure could contribute to tackling obesity amongst children in poverty and their parents.

4. The review linked with the following outcomes stated in the council's Business Plan 2013-17:

   - Outcome 4: Wiltshire has inclusive communities where everyone can achieve their potential
   - Outcome 5: People in Wiltshire have healthy, active and high-quality lives
   - Key action 10: Integrate public health at the heart of all public services
   - We will develop joint action plans with our partners and service plans for all council services that address key issues affecting all public services in Wiltshire, such as…obesity.
   - We will reduce inequalities between the most and least deprived communities

5. The review also linked with the following aim in the Wiltshire Health and Wellbeing Strategy:

   "Living fairly – reducing the higher levels of ill health faced by some less well-off communities."

6. The task group included the following members:

   Cllr Pat Aves (Chairman)
   Cllr John Knight
   Cllr David Jenkins
   Cllr Magnus MacDonald
   Cllr Bill Moss

7. The task group met with the following witnesses:

Cllr Laura Mayes	Cabinet Member for Children's Services
Kate Blackburn	Speciality Registrar – Public Health
Nick Bolton	Personal Development Education Adviser
Frances Chinemana	Associate Director for Public Health
Sarah Heathcote	Head of Service – Children's Health Improvement, Public Health
Phoebe Kalungi	Public Health Specialist
Rachel Kent	Public Health Specialist
Justine Womack	Public Health Consultant

8. The review was undertaken whilst the council and CCG were developing the joint Wiltshire Obesity Strategy, a draft of which was out for public consultation at the time of this report's publication. The task group held a special meeting to consider the Strategy with a specific focus on the links between obesity and child poverty.

9. Several members of the task group attended the Wiltshire Obesity Summit held in July 2015, which brought together members, professionals, academics and third sector organisations to identify the key priorities for tackling obesity in Wiltshire, informing the development of the Obesity Strategy.

Evidence

Childhood obesity

10. The recommended measure of obesity in adults is body mass index (BMI). For children BMI is adjusted for a child's age and gender against reference charts to give a BMI centile. This compares the child's BMI to other children of the same age and gender. A classification of obese for a child (for the purposes of population monitoring) is to be at or above the 95th BMI centile.

11. The World Health Organisation regards childhood obesity as one of the most serious global public health challenges of this century. Among children in

England, a quarter (23.4%) of 2 to 10 year olds and a third (35.2%) of 11 to 15 year olds are overweight or obese[1]. It is predicted that, without action, these figures will rise to almost nine in ten adults and two-thirds of children by 2050. If the proportion of obese children continued to rise, a whole generation could have a shorter average life expectancy than their parents.

12. The annual National Child Measurement Programme (NCMP) measures the height and weight of children in Reception Year, (aged 4 to 5 years) and Year 6 (aged 10 to 11 years). NCMP 2013/14 data estimates that 20.3% of Wiltshire children in Reception and 29.3% of Wiltshire children in Year 6 are overweight or obese[2].

13. The prevalence of excess weight in children in Reception Year in Wiltshire has fluctuated between 20-22% over the last five academic years, whilst nationally prevalence has plateaued at approximately 22%. Prevalence of excess weight in Year 6 children in Wiltshire schools has remained stable since 2011/12 (at approximately 29%) and has been lower than national levels over the same time frame.

14. The draft Obesity Strategy includes five strategic targets and three of these are directly relevant to obese children and children in poverty:

- To halt the rise of excess weight in children by 2020 (measure: PHOF 2.06i-ii excess weight in 4-5 and 10-11 year olds)

- To reduce the variation in excess weight in children between the least and most deprived areas by 2% by 2020 (measure: PHOF 2.06i-ii excess weight in 4-5 and 10-11 year olds).

- To aspire for a decrease of 1% the excess weight of children in each community area by 2020 (measure: PHOF 2.06i-ii excess weight in 4-5 and 10-11 year olds).

The financial cost of obesity

15. More details of the financial cost of obesity can be found in the Wiltshire Obesity Strategy, but the table below presents some key figures:

[1] For all the national statistics:
https://www.noo.org.uk/securefiles/150818_0833//Making_the_case_for_tackling_obesity_reference_sheet-230215%20factsheet.pdf (accessed 27th June 2015)
[2] National Child Measurement Programme 2014-15:
http://www.hscic.gov.uk/catalogue/PUB19109

Table 1. Financial cost of overweight and obesity (per year)	
To the NHS now	£5 billion
To the NHS in 2050	£10 billion
To the wider UK economy now	£27 billion
To social care, medication and reduced productivity now	£352 million
To NHS Wiltshire now[3]	£118 million
All of these costs are predicted to rise	

16. Preventing the prevalence of overweight and obesity has been predicted to generate the following savings:

Table 2. Potential savings to NHS Wiltshire through preventing overweight and obesity (per year)	
Reduction of 1%	£1.18 million
Reduction of 5%	£5.9 million
Reduction of 10%	£11.8 million

17. The savings shown in Table 2 apply to NHS Wiltshire only, but savings would also be reflected in local authority spend on social care. The groups most likely to require social care services align with those at considerably higher risk of developing obesity with over half (52%) of the expenditure on people aged 65 and over[4] and care of people with long term conditions accounting for 70% of total health and social care spend.[5]

The human cost of obesity

18. The impacts of obesity on people are wide ranging and are described in more detail in the draft Wiltshire Obesity Strategy. In summary, however, adults who are overweight and obese,

- Have an increased risk of developing a range of chronic health disorders
- Have lower quality of life and premature mortality

[3] For diseases related to overweight and obesity. £68.8 million is due to obesity alone. Foresight (2007) Tackling obesities: Future Choices- project report. Government Office for Science.
[4] NHS Information Centre (2012) Personal Social Services: Expenditure and Unit Costs, England Edition 2011-12
[5] Provisional release. Department of Health (2013) Improving quality of life for people with long term conditions. Public Health England. (2013d)

- For pregnant women, an increased risk of pregnancy complications and an increased risk of impaired foetal development
- Have 25% higher health expenditures than a person of normal weight in any given year
- Earn up to 18% less than non-obese people.

19. The consequences of unhealthy weight in children include:

    - emotional and behavioural problems
    - bullying, low self-esteem and school absence
    - bone and joint problems
    - breathing difficulties.

20. The longer term consequences include a very high likelihood of being overweight in adulthood with all of the associated impacts. 80% of children who are obese at age 10–14 will become obese adults, particularly if one of their parents is also obese. Current evidence suggests that around 97% of obese children come from families where at least one parent is obese or overweight.[6]

Childhood poverty

21. Children are said to be living in relative income poverty if their household's income is less than 60 per cent of the median national income. Nationally there has been a discussion of broadening the definition of poverty to include things like educational attainment, but this was met with opposition and dropped. The current measure is considered by some to be crude, but Wiltshire follows the national definition.

22. Children in poverty have a greater risk of having poor health, being exposed to crime and failing to reach their full potential creating a cycle of poverty in the future.

23. In the UK 17% of children, 2.3 million, live in poverty, which is one of the highest rates in the industrialised world. Overall child poverty in Wiltshire is low, but there are pockets of high deprivation. In 2011 11.4% (11,610) of Wiltshire children were living in poverty (source: HMRC). This was an increase of 0.4% (400) in Wiltshire since 2008, which compared well with other local authority areas in the South West of England. However, there is high variability across Wiltshire and significant deprivation across some vulnerable groups.

24. A Reducing Wiltshire Child Poverty Strategy 2014-20 was adopted by Council in 2015. This was a requirement of The Child Poverty Act, which commits this and future governments to eradicating child poverty by 2020. The Child Poverty Strategy has five key objectives:

    i. Provide effective support to vulnerable families with 0-5 year olds
    ii. Narrowing the Educational Attainment Gap

[6] Strategic High Impact Changes Childhood Obesity National Support Team, March 2011

iii. Develop an inclusive economy that will enable equality of economic opportunity for all
iv. Provide locally-focused support based on a thorough understanding of needs
v. Promote engagement with the Child Poverty Strategy and related implementation plan

The links between obesity and poverty

25. Though not exclusively, obesity is an inequalities issue, with excessive weight adversely affecting people from more deprived communities[7]. Nationally, there is an almost linear relationship between obesity prevalence in children and the Index of Multiple Deprivation score for the area they live in. Child obesity prevalence in the most deprived tenth of local areas (nationally) is almost double that in the least deprived tenth.

26. Nationally, socioeconomic inequalities appear to be widening in both reception and year 6[8]. This is particularly the case in year 6 where obesity prevalence is increasing in the most deprived areas.

27. The link between obesity and poverty amongst children in Wiltshire is clear, with a deprivation gradient across all years and measures of weight. Obesity is estimated to be over 8% higher for adults in the most deprived areas of Wiltshire compared to the least deprived. Those in low socioeconomic groups are two times more likely to become obese. Melksham, Westbury, Trowbridge, Warminster, Chippenham, Devizes and Salisbury have the highest levels of obesity and also come near the top of Wiltshire's Lower Super Output Areas.

28. In terms of children in poverty, aggregated NCMP data (2012/13 to 2013/14) found that:

- 24.1% of children resident in the most deprived areas of Wiltshire were of excess weight compared to 18.9% of children living in the least deprived areas

- The inequalities gap between the most and least deprived areas for excess weight in Reception Year stood at 5.2%.

- In Year 6, 34.3% of children living in the most deprived areas of Wiltshire were of excess weight, compared to 26.1% of children living in the least deprived areas.

- The inequalities gap between the most and least deprived areas for excess weight in Year 6 children stood at 8.2%.

[7] Marmot M. Fair Society, Healthy Lives: A Strategic Review of Inequalities in England. London: University College London, 2010
[8] National Obesity Observatory October 2010

Prevention and early intervention

29. Mary Rudolf, a leading Professor of Child Health, has stated that:

> "The case for intervening in the very early years to prevent obesity is compelling… [Evidence] highlights how lifestyle choices – both food preferences and physical activity – have their roots in the very early years. When we consider that young children themselves are likely to be more receptive at this age, it becomes clear that action is needed long before children reach school."[9]

30. Providing early help can narrow the gap for children who are at risk of poorer outcomes[10]. The Marmot Review is clear that "later interventions are considerably less effective if children have not had good foundations"[11].

31. The draft Wiltshire Obesity Strategy recognises this, stating that,

> "Preventing people from gaining weight in the first place is the most cost effective strategy for sustained reductions in obesity prevalence that will have the biggest impact on weight related health outcomes, over a lifetime[20]. Action will be taken through a universal approach to reduce inequalities across the life course[26]".
>
> "Our approach will be based on preventing obesity from occurring in the first place … and renewing preventative efforts in the early years."
>
> "[We will] Invest in preventative interventions in the early years (0-5 years old) to maximise the number of children starting school with a healthy weight."

Schools

32. Schools have a statutory duty to promote health and wellbeing. The Department for Education (DfE) require that all schools deliver a programme of Personal, Social and Health Education (PSHE), which includes a focus on healthy eating, and the current Ofsted Common Assessment Framework expects pupils to gain knowledge of how to "keep themselves healthy and make informed choices about healthy eating and fitness."

33. There is an evidenced link between pupil health and wellbeing and attainment and attendance (Public Health England, 2014).

34. The national School Food Plan includes actions and recommendations for schools that aim to improve the health and academic performance of children, by improving nutrition education and cooking skills.

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[9] 'Tackling obesity through the Healthy Child Programme: a framework for action' Professor Mary Rudolf, November 2009 (p.7) http://www.noo.org.uk/uploads/doc/vid_4865_rudolf_TacklingObesity1_210110.pdf
[10] Waldman, J (2008) *Narrowing the gap – summary of research messages,* NFER: Slough.
[11] Marmot M. Fair Society, Healthy Lives: A Strategic Review of Inequalities in England. London: University College London, 2010

35. The council's Joint Commissioning Team offers a Wiltshire Healthy Schools (WHS) Programme, which helps schools to implement a whole school, evidence-based approach to health and wellbeing, focussing on local priorities including obesity. There is evidence from a range of sources that shows that Healthy Schools programmes are effective in promoting healthy lifestyles, especially healthy eating, and ensuring that PSHE matches pupil's needs (Ofsted, 2010).

36. Following reductions in local authority funding Wiltshire's health schools programme transitioned from providing a free and fully-funded programme, to becoming financially self-supporting by trading support with schools. Although the previous approaches were successful, they are not sustainable within current budgets and a number of posts that provided specific support to schools to reduce obesity were reduced to a single post over the past five years. Much of the support now offered is through the use of web-based tools. The current Wiltshire Healthy Schools offer includes:

- a one-day course, focussing on addressing local health priorities
- a half-day workshop session to enable completion of the online audit
- access to the online audit and action planning tools
- telephone and email support

School meals

37. Nationally 48% of pupils access school meals and children of school age eat an average of 200 meals at school per year. This represents around 1/5th of all of the meals they consume.

38. All maintained schools, and academies founded before 2010 and after June 2014, have to provide meals that meet nutritional standards set out in full in the national School Food Plan. However, there is no mechanism in place to ensure that schools are meeting these nutritional standards.

39. In 2014 central government introduced universal free schools meals for all Key Stage 1 pupils (ages 5 to 7). Beyond Key Stage 1, all pupils in state-funded schools are entitled to receive free schools meals if they or their parents are eligible for certain benefits. To claim them families who meet the criteria have to register via schools or the local authority. The council website includes online forms and paper forms are also available at council hubs.

40. All schools should have mechanisms in place whereby pupils accessing free school meals do so anonymously (often through the use of pre-paid electronic cards), decreasing the risk of embarrassment and stigmatization.

41. Benefits data from Her Majesty's Revenue and Customs (HMRC) suggests that around 1.4 million (21%) of children aged 4-15 in England are entitled to receive FSM. School Census data shows that around 1.2 million (18%) of 4-15 year old pupils in maintained schools are registered to claim FSM. Therefore around 200,000 pupils (3% of all pupils aged 4-15) appear to be entitled but are

not claiming FSM. This means that nationally 14% of pupils entitled to FSM are not claiming them.

42. In the South West region, 17% of pupils entitled to free schools meals are thought to be not claiming them. At the time of publication, the task group had not sourced data establishing what the precise take-up of free school meals in Wiltshire is. However, the map at Appendix 1 gives a graphical representation of Wiltshire's under-registration compared with other local authority areas.

43. A cross-sectional study from 2009 carried out a survey of children's packed lunches at school, and assessed their nutritional value. The study found that only 1% of packed lunches meet the new standards for school meals proposed by the School Meals Review Panel (SMRP), formed in 2005.

Wiltshire Food in School Project

44. The council's Public Health team, in partnership with Soil Association's Food For Life, developed a 9 month pilot project to support schools, the wider school community, and caterers to have the opportunity, confidence, and ability to access healthy and sustainable food. The pilot's overall objective was to support 25 target primary schools to improve the health and wellbeing of their school community by making improvements to the school food agenda. This was to be achieved by:

    a) Providing the skills and knowledge for the school communities to make informed food choices leading to healthy and sustainable food behaviours
    b) Enabling change in food culture within the settings engaged through a whole setting approach
    c) Supporting schools to implement and meet the recommendations of the School Food Plan

45. An extension of the project is now being considered for commencement in September and could include:

    - Training packages for school staff – nutrition education; cooking and growing in the curriculum; improving dining room environment; food safety
    - Food safety and food standards audits
    - Targeted healthy cooking classes for parent and children
    - Targeted support to implement breakfast/afterschool clubs, amongst other support.

Targeting local priorities

46. Following the creation of the Wiltshire Child Poverty Strategy, the council's Public Health team has developed child poverty profiles for each of Wiltshire's 20 community areas. These present a breakdown of each areas' child poverty statistics against other localised data on vectors like employment, educational attainment, gender, housing and health outcomes like obesity. The breakdowns

illustrate where issues lie in each area and in some cases highlight significant correlations or patterns.

47. Using the child poverty profiles effectively could help target local priorities and the allocation of resources to address the factors driving issues like obesity and child poverty.

Obesogenic environments

48. The draft Obesity Strategy includes the following strategic priority,

> "6.4 Strategic priority 4: Take steps towards reversing the 'obesity promoting' environment where people live, play, learn, work and retire.
>
> We will do this by providing information, advice, services and behaviour change support and influencing the quality of the environment in which people live."

49. The task group received evidence of how Public Health has begun work across the council to support other services to reduce the prevalence of obesity across Wiltshire. A joint event was held with Spatial Planning, Development Control and Sustainable Transport with lecturers from the Centre for Urban Environment and the University of the West of England (UWE) facilitating the discussions.

50. This cross-team work is at an early stage, but an objective moving forward is to explore how the council and partners can influence the creation of 'non-obesogenic environments'. Recent evidence shows that children living near green spaces are less likely to experience an increase in BMI over time[5]. The Government's Foresight obesity report, states that "the top five policy responses assessed as having the greatest average impact on levels of obesity [include] increasing walkability / cyclability of the built environment"[12].

<u>Prevalence of fast food outlets</u>

51. The draft Obesity Strategy states that,

> "We will take action to help people in Wiltshire make better choices for themselves and their families and ensure healthy food and activity choices are the easy and preferred choice."
>
> "[We will] Engage and work with local food producers and retailers to encourage an environment that promotes healthy food choices".

52. One of the dietary trends in recent years has been an increase in the proportion of food eaten outside the home, which is more likely to be high in calories.[4] Hot food takeaways, in particular, tend to sell food that is high in fat and salt, and low in fibre, fruit and vegetables.[13]

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[12] Government Office for Science (2007) Foresight: Tackling obesity – Future Choices

53. Research into the link between food availability and obesity is still quite undeveloped[14] but a US study found evidence of higher levels of obesity in communities with high concentrations of fast food outlets.[15] Data compiled by Public Health England shows a strong association between deprivation and the density of fast food outlets, with more deprived areas having a higher proportion of fast food outlets per head of population than others.

54. The task group therefore wished to explore what powers local authorities have to restrict the proliferation of fast food outlets through the planning and licensing processes, should they wish to:

55. Under the Licensing Act 2003 responsible authorities can only raise valid objections relating to one of the four objectives in the Act:

1. Prevention of crime & disorder
2. Public safety
3. Prevention of public nuisance
4. Protection of children from harm

56. Objective 4: "Protection of children from harm" could theoretically be used to justify refusal of licenses on health grounds but in reality there is no known incidence of this being done. Placing conditions on an individual application or refusing it all together without robust evidence can lead to the decision being successfully challenged in court, with the associated resource and cost implications for the licensing authority.

57. In a recent Association of Directors of Public Health (ADPH) survey[13] on action to improve the public's health, protect children and young people and reduce health inequalities, 81% of responding highly prioritised the need to amend licensing legislation to empower local authorities to control the total availability of junk food, alcohol, and gambling outlets.

58. In terms of planning, a 2014 study by Public Health England[14] reports that:

i. The government's public health strategy 'Healthy lives, healthy people', recognises that "health considerations are an important part of planning policy",[1] and the Department of the Environment 2011 white paper made many connections between planning and health.[9]

ii. NICE public health guidance, 'Prevention of Cardiovascular Disease', [20] recommends encouraging planning authorities "to restrict planning permission for takeaways and other food retail outlets in specific areas (for example, within walking distance of schools)".

iii. The National Planning Policy Framework (NPPF) requires that "Local plans should "take account of and support local strategies to improve health, social and cultural wellbeing for all".[8]

[13] Association of Directors of Public Health (ADPH) survey
[14] 'Obesity and the environment: regulating the growth of fast food outlets', Public Health England

iv. The National Planning Practice Guidance (NPPG) refers to promoting access to healthier food and that a health impact assessment may be a useful tool where significant impact is expected.

v. A number of local authorities have drawn up supplementary planning documents (SPDs) to restrict the development of new fast food premises near schools, though there are limitations to these.

vi. It is only in recent years that local authorities have started to use the legal and planning systems to regulate the growth of fast food restaurants, including those near schools, so there is some lack of evidence of their impact. [21]

vii. A number of authorities have had planning decisions, based partly on health impacts, challenged through the appeals process, but not all have been successful. Healthy eating and proximity to a school have been given substantial weight when there is an adopted local plan policy or SPD in place, local evidence on childhood obesity and healthy eating initiatives, and representations from the relevant school.

Conclusions

General

59. The factors behind obesity are extremely complex, involving physical, social, emotional, biological and environmental factors. Not all of these factors are within the gift of the local authority, partners and the task group to influence directly or as directly as we might like. The current national debate about the merits of introducing a sugar tax is one example of a potentially important influencing factor, not to mention the freedom of individuals to make their own healthy or unhealthy choices.

60. However, meaningful collaboration between local partners and the targeting of resources at the right areas can make a difference to the prevalence of obesity amongst the Wiltshire population. The task group supports the joint development of the first Wiltshire Obesity Strategy by the council and Wiltshire CCG as the first step in doing this. A strong commitment to the delivery of the Strategy, which includes overview and scrutiny's role in ensuring this, is the next step. (**Recommendation 1**)

61. The task group therefore strongly supports the ambitious targets set out in the draft Obesity Strategy to:

- Halt the rise of excess weight in children by 2020
- Reduce the variation in excess weight in children between the least and most deprived areas by 2% by 2020
- Aspire for a decrease of 1% the excess weight of children in each community area by 2020

62. The delivery of these targets will be crucial to the future health and wellbeing of county and indeed the financial health of the council, CCG and other partners. (**Recommendation 2**)

The cost of obesity

63. The cost of obesity to the public purse is huge and growing quickly. It is the task group's view that the scale of the problem and its trajectory in the coming decades has not been fully grasped by society. While levels of child obesity are lower in Wiltshire than the national average it is a concern that its prevalence in the county appears to be increasing while nationally it has plateaued. Approximately 1 in 5 4-5year olds start school already overweight/obese and 1 in 3 of our 10-11 year olds leave primary school overweight or obese.

64. The draft Wiltshire Obesity Strategy sets out the projected financial impact of overweight and obesity on the NHS in Wiltshire were it to go unchecked. However, the real costs go far beyond the NHS, falling across many services such as social care, as well as VCS organisations addressing the more tangential impacts of obesity such as social isolation. The financial cost of obesity means of course that there is the opportunity for significant savings to be made if partners' collaborative efforts are targeted in the right ways. (**Recommendation 3**)

The case for prevention and early intervention

65. Regarding obesity, the case for prevention and early intervention is clear and directing resources at the early life stages should therefore be prioritised. As the draft Wiltshire Obesity Strategy says,

    "Preventing people from gaining weight in the first place is the most cost effective strategy for sustained reductions in obesity prevalence that will have the biggest impact on weight related health outcomes, over a lifetime[20]."

    "In order to give children the best start in life we need to focus on pre pregnancy, pregnancy, infancy, early childhood to age 5 and families as critical stages for interventions to prevent obesity and weight related health inequalities." [26, 29]

66. Decisions about the funding levels for preventative and early intervention programmes should be considered in light of the longer term savings that can and must be achieved. The financial benefit to Wiltshire may not be seen immediately, but a long-term perspective is needed, where all partners consider the impacts of obesity in their full breadth rather than on individual organisations in the short or medium term. For the Obesity Strategy to achieve its potential both the council and Wiltshire CCG will need to prioritise prevention and early intervention and interventions targeted at younger life stages. Some examples of preventative healthy lifestyle initiatives and the value-for-money demonstrated is provided at Appendix 2. (**Recommendation 4**)

Obesity and child poverty

67. Children, particularly children living in poverty, are demonstrably vulnerable to obesity and all of the associated impacts on their health and ability to achieve their potential. The task group strongly supports the target set out in the draft Obesity Strategy to:

    - Reduce the variation in excess weight in children between the least and most deprived areas by 2% by 2020

68. The draft Obesity Strategy recognises that some sectors of the population are at particularly high risk of developing obesity and these include 'Children' and 'People living on a low income'. The task group supports the commitment in the Strategy to making "targeted preventative interventions" and ensuring "targeted action at key points in the life course, addressing variation in access to services".

69. It will be important that the implementation plan behind the Strategy reflects the importance that those living on low incomes, particularly children, face additional challenges in terms of achieving good health outcomes such as issues with access to activities and facilities due to unaffordable costs, a lack of transport or simply not being aware of the opportunities available. (**Recommendations 5 and 6**)

Schools

70. Schools have almost unique access to hard to reach groups of children, including those who are vulnerable to poor health outcomes due to factors such as living in poverty. Engagement with schools should therefore be given greater emphasis in the Wiltshire Obesity Strategy and the associated implementation plan. (**Recommendation 7**)

71. Access to school meals can ensure that children eat at least one nutritious meal per day and therefore act as a safety net for those who are vulnerable to health inequalities, including those living in poverty. The task group was concerned at the percentage take-up of free school meals amongst eligible pupils in Wiltshire. Eligible pupils who do not access free school meals are presumably either eating,

    a) nothing for lunch;
    b) a packed lunch, only 1% of which have been shown to meet nutritional guidelines;
    c) food bought from outside the school, not subject to nutritional guidelines and potentially high-calorie 'fast food';
    d) paid-for school meals, thereby not accessing their entitlement to free meals, with the associated financial impact on their families.

72. Working with schools to increase the take-up of free school meals amongst eligible families would be a targeted way of supporting families on low incomes, which have been shown to have on average a higher incidence of obesity. It

would also improve those families' financial situation by saving them the cost of a paid-for school lunch. (**Recommendation 8**).

73. The task group welcomes the work undertaken through the Wiltshire Food in School project run by the council's Public Health team, which is helping 25 primary schools improve the health and wellbeing of their school community. The task group particularly supports the approach of targeting schools located in deprived areas as this reflects the strong evidence linking poverty and obesity.

74. The outcomes of the work will need to be analysed, but schools' almost universal access to children and the demonstrable need for early intervention when it comes to obesity suggest that initiatives supporting schools in deprived areas to improve health outcomes of pupils should be sustained and possibly expanded. (**Recommendation 9**)

75. Due to a changed educational landscape local authorities' have a reduced ability to influence schools directly. Reducing resources have also meant that the support for schools to improve pupils' health and wellbeing has been streamlined.

76. The draft Wiltshire Obesity Strategy states that partners will work,

    "collaboratively across health services, Council services, **schools**, workplaces, communities and with individuals to maximise opportunities to be physically active and eat a healthy diet."

    "Work collaboratively with children's centres and other early years settings, **schools**, libraries, the local media, professionals and voluntary organisations to actively promote and raise awareness of current programmes for children, young people and their families. This will include providing advice to families on healthy eating and cooking low cost healthy food."

77. Schools are a vital conduit to children and families because they have access to hard to reach groups such as those living in poverty and because healthy lifestyle messages have been shown to travel home with children. Changes in the educational landscape over the past decade mean local authorities have little direct influence over schools and the priority they give to encouraging healthy lifestyles, the latter likely to be more influenced by its prominence in Ofsted's common assessment framework.

Targeting Local Priorities

78. Every area board has now been presented with their community area's child poverty profiles, but key to delivering actual outcomes will be how area boards are supported to address the issues the identified. The commitment to delivering the Obesity Strategy (**Recommendation 10**).

Obesogenic environments

Cross-team working

79. There is clear evidence of a link between the prevalence of obesity and environments that discourage people from taking part in healthy activities and making healthy food choices. The task group supports the initial collaborative work being led by Public Health with teams across the council to look at innovative ways of addressing this. Many different services will have a tangential impact on encouraging or discouraging health behaviours. Though small in isolation it is the combination of all services considering what measures they can take to make a difference.

80. A small but telling example of this is a recent amendment to the council's school admissions pack through which parents are asked to indicate their preferred choice of school for their child. Following conversations between Public Health, the Safe Active Travel working group and School Admissions team the application form now asks parents to consider how the child will get to school and the potential financial impact of a commute; a nudge towards considering a school that is close to home, which the child is more likely to be able to reach on foot. (**Recommendation 11**)

Prevalence of fast food outlets

81. The task group supports the Obesity Strategy's commitment to working with local food producers and retailers to encourage an environment that promotes healthy food choices. It is hoped that retailers likely to be used by children and young people, such as fast food outlets near schools, are given particular emphasis.

82. There appears to be no realistic way of influencing the proliferation of fast food outlets through the licensing process. Denying or adding conditions to a license under the fourth objective in the Licensing Act 2003, "Preventing harm to children" in terms of the outlet's impact on obesity appears to be a difficult argument to make and may not stand up to legal challenge.

83. However, the Public Health England paper, 'Obesity and the environment: regulating the growth of fast food outlets', raises interesting questions about local authorities' potential ability to influence the proliferation of fast food outlets through the planning process and whether this has been exploited hitherto.

84. Further information may be needed in order to establish:

    a) whether the council currently seeks to influence the proliferation of fast food outlets via the planning process;
    b) if not, whether local evidence suggests there is a **need** to do so;
    c) if a need is demonstrated, whether this should focus on areas close to schools, which is the approach taken by some other local authorities.

    (**Recommendation 12**).

Recommendations

1. **To support the development and implementation of the first Wiltshire Obesity Strategy by the council and CCG as a crucial first step in addressing the prevalence of obesity in Wiltshire.**

2. **To acknowledge the scale of the obesity epidemic facing the country, the projected financial and human costs within Wiltshire if action is not taken, and the commitment required by the council, CCG and partners to tackle obesity as a joint strategic priority.**

3. **Children's Select Committee or Health Select Committee to undertake annual monitoring of progress against strategic targets within the Wiltshire Obesity Strategy to ensure that sufficient efforts and resources are directed towards its implementation and, in particular, towards protecting children in poverty from obesity and its associated impacts.**

4. **The council, CCG and Area Boards to prioritise actions and resources focused on prevention, early intervention and the first two life stages ('Preconception to early years' and 'Children and Young people') and for this to be reflected in how resources are allocated towards implementation of the Obesity Strategy.**

5. **The council, CCG and Area Boards to prioritise actions and resources targeted at groups vulnerable to obesity, particularly children living in poverty and for this to be reflected in how resources are allocated towards implementation of the Obesity Strategy.**

6. **When developing the Obesity Strategy's implementation plan, the council, CCG and partners to consider the particular challenges faced by people on low incomes in achieving good health outcomes so that maximum equity of access can be ensured.**

7. **Schools to be given a greater profile within the Obesity Strategy to reflect the opportunity that schools' unique access to all children and young people presents, including access to 'hard-to-reach' groups such as those living in poverty.**

8. **Work to be undertaken with schools to increase the take-up of free school meals by eligible families in order that children from families on low incomes reap the associated health benefits, with an update on free school meal take-up to be provided to the Committees in 12 months' time.**

9. **To support the continuation and/or expansion of the targeted Wiltshire Food in School work supporting schools in deprived areas to improve the health and wellbeing of their school community.**

10. **Further information to be provided on how Area Boards and communities will be supported to address issues identified in child poverty profiles for their community areas.**

11. **To support the continuation of cross-team work led by Public Health supporting every council service to consider what it can do to encourage healthy eating and activities.**

12. **The Cabinet Member for Health and Adult Social Care, and the Cabinet Member for Planning, Property, Waste and Strategic Housing, to advise if the council currently seeks to influence the proliferation of fast food outlets (particularly near schools) through the planning process and, if not, whether they are plans to consider doing so.**

Proposal

85. To endorse the conclusions and recommendations of the task group and refer them to the relevant parties for response.

Cllr Pat Aves, Chairman of the Obesity and Child Poverty Task Group

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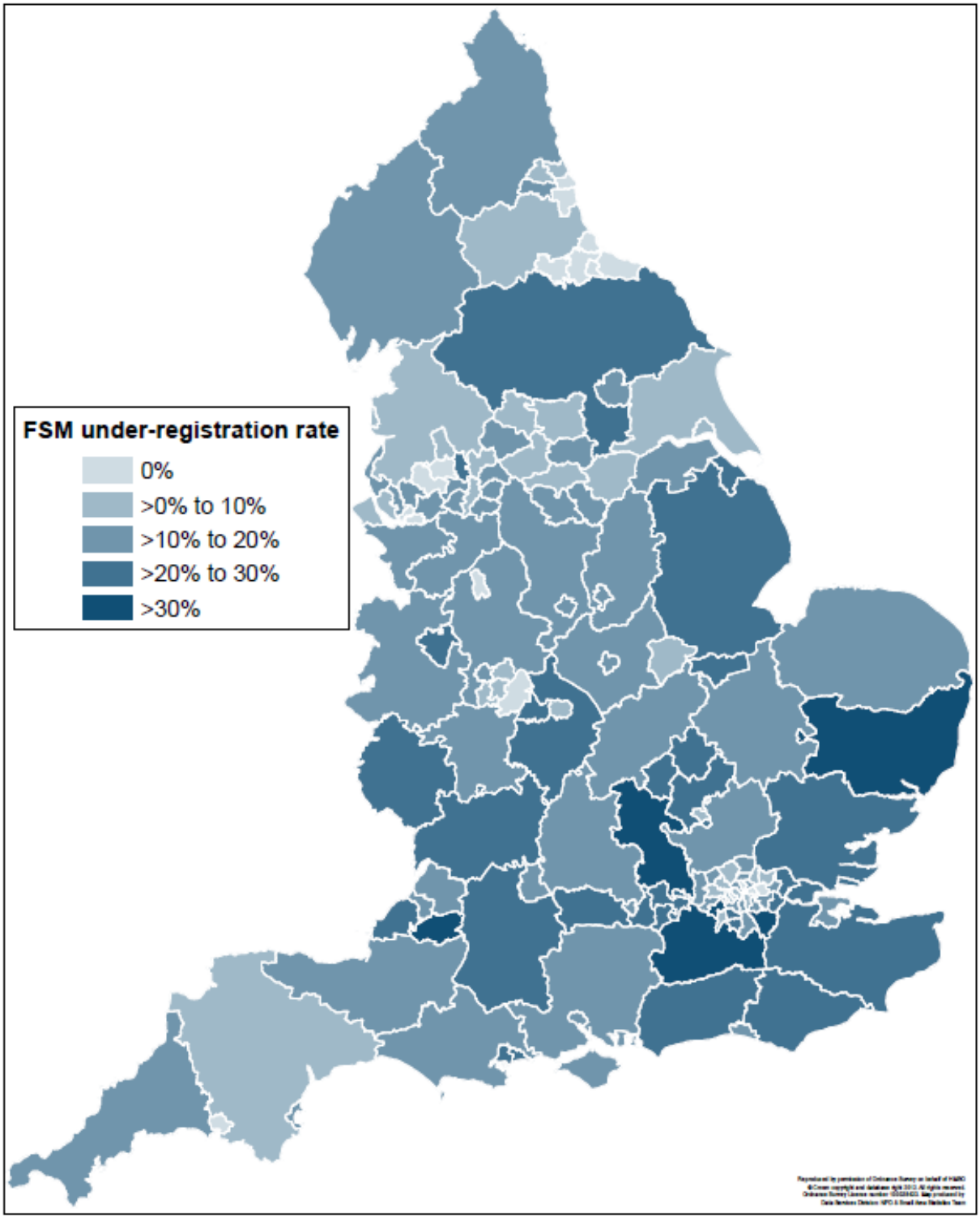
Appendices

Appendix 1	Geographical Distribution of under FSM registration rates by local authority – from Pupils not claiming free school meals Samaira Iniesta-Martinez & Helen Evans – Department for Education
Appendix 2	Return on Investment graphic – Public Health England

Appendix 1

Map 1: Geographical distribution of under-registration rates (i.e. pupils not claiming FSM as a proportion of those entitled) by local authority.



Source: HMRC benefits data December 2011 & Schools Census January 2012

Appendix 2

Public Health England

Protecting and improving the nation's health

Return on investment

In 2011-2012, the Glasgow Health Walks project led to a return on investment of **£8** for every **£1** spent

For every participant on a 12 session commercial weight management programme, the NHS stands to save **£230** over a lifetime.

Birmingham's 'Be Active' programme returned up to **£23** in benefits for every **£1** spent in terms of quality of life, reduced NHS use, productivity and other gains to the local authority