SLOUGH BOROUGH COUNCIL

REPORT TO:	Overview and Scrutiny Committee	**DATE:**	8 July 2013
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WARD(S):	All		
PORTFOLIO:	Commissioner for Health and Wellbeing – Councillor James Walsh		

PART I
CONSIDERATION & COMMENT

CHILDHOOD OBESITY REVIEW (MEETING 1): DOES SLOUGH HAVE A PROBLEM WITH CHILDHOOD OBESITY?

1 Purpose of Report

To provide the Committee with national and local information on childhood obesity to facilitate discussion on the level of the problem in Slough.

2 Recommendation(s)/Proposed Action

That the Committee consider the information provided and garnered through questioning at the committee meeting in order to form conclusions on the level of the problem, the current trends and main factors influencing childhood obesity levels in Slough.

3 Joint Slough Wellbeing Strategy Priorities

Priorities:

- Health and Wellbeing

4 Joint Strategic Needs Assessment (JSNA)

The JSNA for Slough in 2009, 2010 and 2011/12 all noted the issue of childhood obesity as a priority.

5 Other Implications

(a) Financial

There are no financial implications of proposed action.

(b) Risk Management

Risk	Mitigating action	Opportunities
Legal	None	None
Property	None	None
Human Rights	None	None
Health and Safety	None	None
Employment Issues	None	None
Equalities Issues	None	None
Community Support	None	None
Communications	None	None
Community Safety	None	None
Financial	None	None
Timetable for delivery	None	None
Project Capacity	None	None
Other	None	None

(c) Human Rights Act and Other Legal Implications

There are no Human Rights Act Implications relating to this report.

(d) Equalities Impact Assessment

There is no identified need for the completion of an EIA relating to this report.

6 Childhood Obesity – General

6.1 The World Health Organisation (WHO) regards childhood obesity as one of the most serious global public health challenges facing the 21st Century. In England, the latest figures, for 2011/12, show that 19.2% of children in Year 6 (aged 10-11) were obese and a further 14.7% were overweight. Of children in Reception (aged 4-5), 9.5% were obese and another 13.1% were overweight. This means almost a third of 10-11 year olds and over a fifth of 4-5 year olds were overweight or obese.

6.2 In the UK, the calculation on levels of obesity are based on Body Mass Index (BMI) levels. Assessment of BMI for children is different from adults as it must account for differing growth patterns and therefore variable thresholds are used to take account of children's age and sex. The baseline comparison data is taken from the Reference Population (data from a large sample of children identifying how BMI varies by age and sex across the population establishing an average). In the UK, this allows for the following UK90 Growth Reference classifications:

- Overweight = 85th percentile
- Obese = 95th percentile

(Dinsdale H et al, 2011)

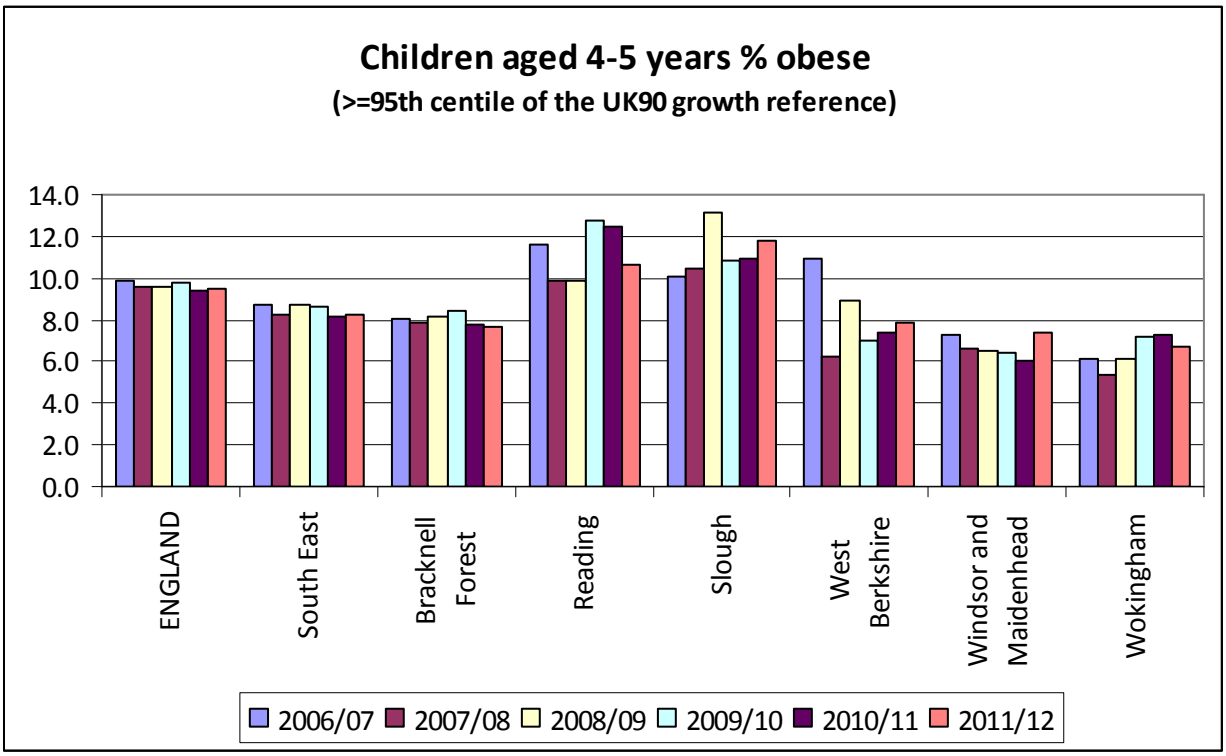
6.3 Obesity is associated with a range of health problems including type 2 diabetes, cardiovascular disease and cancer, with obese children and adolescents at an increased risk of developing these health problems. The resulting NHS costs

attributable to overweight and obesity (in adults and children) are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year (Foresight 2007). These factors combine to make the prevention of obesity a major public health challenge.

7 Data

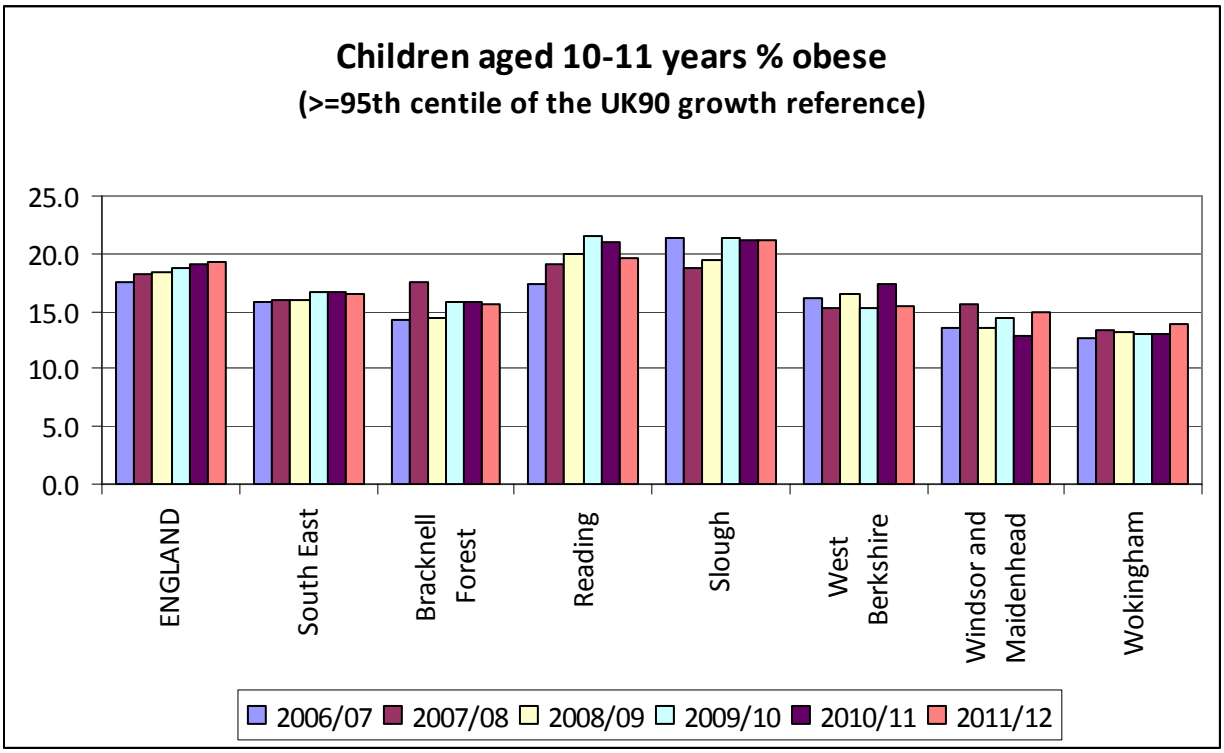
7.1 Benchmarking between different geographical neighbours (%) – Reception

LA	06/07	07/08	08/09	09/10	10/11	11/12
ENGLAND	9.9	9.6	9.6	9.8	9.4	9.5
South East	8.7	8.3	8.7	8.7	8.2	8.3
Bracknell Forest	8.0	7.9	8.2	8.4	7.8	7.7
Reading	11.6	9.9	9.9	12.7	12.5	10.6
Slough	**10.1**	**10.5**	**13.1**	**10.8**	**11.0**	**11.8**
West Berkshire	10.9	6.2	8.9	7.0	7.4	7.9
RBWM	7.3	6.6	6.5	6.5	6.0	7.4
Wokingham	6.1	5.4	6.1	7.2	7.2	6.7



7.2 Benchmarking between different geographical neighbours (%) – Year 6

LA	06/07	07/08	08/09	09/10	10/11	11/12
ENGLAND	17.5	18.3	18.3	18.7	19.0	19.2
South East	15.9	16.1	16.0	16.6	16.6	16.5
Bracknell Forest	14.3	17.5	14.5	15.9	15.9	15.7
Reading	17.3	19.1	19.9	21.6	21.0	19.6
Slough	**21.3**	**18.8**	**19.4**	**21.4**	**21.2**	**21.3**
West Berkshire	16.2	15.3	16.5	15.2	17.4	15.5
RBWM	13.6	15.6	13.5	14.4	12.8	14.9
Wokingham	12.8	13.4	13.1	12.9	12.9	13.9



7.3 Census 2011 – Population Figures

	Numbers			% of population		
Age	**Males**	**Females**	**Total**	**Males**	**Females**	**Total**
0-4	6,500	6,300	12,800	4.6	4.5	9.1
5-9	5,100	4,900	10,000	3.6	3.5	7.1
10-14	4,600	4,400	9,000	3.3	3.1	6.4

7.4 Obesity Levels - Gender difference 2011/12 results (%)

	Reception		Ratio of boys to girls	**Year 6**		Ratio of boys to girls
	Boys	Girls		Boys	Girls	
ENGLAND	9.9	9.0	1.10	20.7	17.7	1.17
South East	8.8	7.8	1.12	18.1	14.8	1.22
Bracknell Forest	7.2	8.2	0.87	17.8	13.2	1.35
West Berkshire	8.8	6.9	1.27	16.0	14.9	1.07
Reading	11.6	9.6	1.21	21.3	17.7	1.20
Slough	**11.9**	**11.7**	**1.02**	**23.5**	**18.8**	**1.25**
Windsor and Maidenhead	7.7	7.1	1.10	18.3	11.7	1.56
Wokingham	7.7	5.7	1.37	15.6	12.1	1.29

Most areas have a higher proportion of obesity amongst boys than amongst girls – for example, in Year 6 classes locally, 23.5% of boys were obese but only 18.8% of girls. Amongst 4-5 year olds in Slough this difference is less pronounced (11.9% of boys, 11.7% of girls were assessed as obese).

7.5 Childhood obesity at ward level

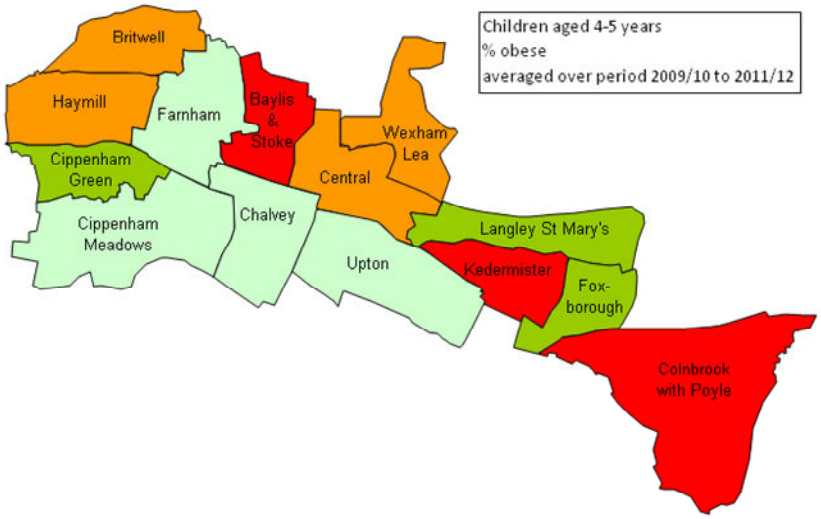
The tables beneath portrays averages of ward level data from the 2009/10, 2010/11 and 2011/12 results and illustrate the wards with highest to lowest observed childhood obesity rates over this three-year sampling period. Of particular interest, Colnbrook with Poyle has the highest rates locally of obesity amongst both Reception year and Year 6 pupils.

NCMP 2009/10 to 2011/12
Obesity and healthy weight prevalence by school year and electoral ward of child residence

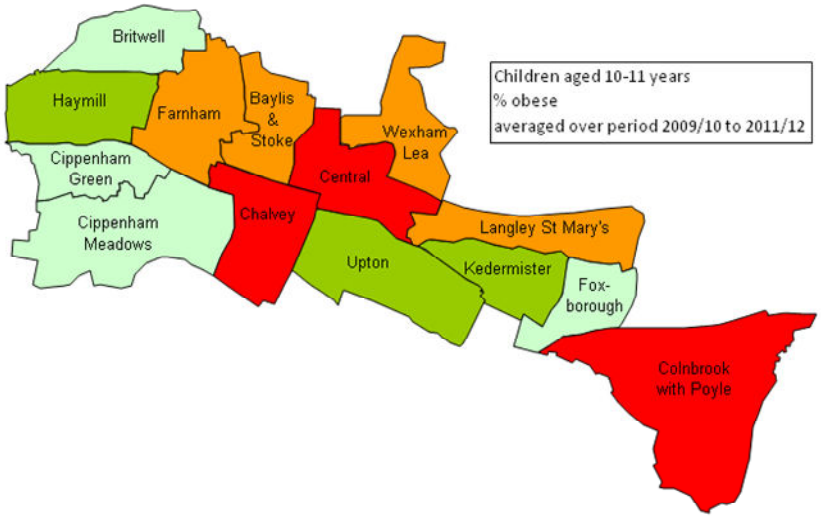
	Reception (age 4-5 years)				
	Number measured	Number obese	% obese	95% confidence limits	
				Lower	Upper
Colnbrook with Poyle	172	30	**17.4%**	12.5%	23.8%
Kedermister	271	40	**14.8%**	11.0%	19.5%
Baylis and Stoke	486	61	**12.6%**	9.9%	15.8%
Central	451	56	**12.4%**	9.7%	15.8%
Haymill	324	39	**12.0%**	8.9%	16.0%
Britwell	396	47	**11.9%**	9.0%	15.4%
Wexham Lea	417	49	**11.8%**	9.0%	15.2%
Farnham	351	38	**10.8%**	8.0%	14.5%
Cippenham Meadows	444	47	**10.6%**	8.1%	13.8%
Chalvey	426	45	**10.6%**	8.0%	13.8%
Upton	291	30	**10.3%**	7.3%	14.3%
Langley St Marys	188	18	**9.6%**	6.1%	14.6%
Foxborough	283	26	**9.2%**	6.3%	13.1%
Cippenham Green	335	29	**8.7%**	6.1%	12.2%

	Year 6 (age 10-11)				
	Number measured	Number obese	% obese	95% confidence limits	
				Lower	Upper
Chalvey	296	74	**25.0%**	20.4%	30.2%
Colnbrook with Poyle	148	37	**25.0%**	18.7%	32.5%
Central	346	83	**24.0%**	19.8%	28.8%
Wexham Lea	417	99	**23.7%**	19.9%	28.1%
Baylis and Stoke	428	101	**23.6%**	19.8%	27.8%
Langley St Marys	209	47	**22.5%**	17.4%	28.6%
Farnham	350	75	**21.4%**	17.5%	26.0%
Cippenham Meadows	384	80	**20.8%**	17.1%	25.2%
Foxborough	285	58	**20.4%**	16.1%	25.4%
Cippenham Green	293	58	**19.8%**	15.6%	24.7%
Britwell	354	70	**19.8%**	16.0%	24.2%
Kedermister	309	58	**18.8%**	14.8%	23.5%
Haymill	285	53	**18.6%**	14.5%	23.5%
Upton	213	34	**16.0%**	11.7%	21.5%

This same data is presented beneath as two maps, with the three wards having highest obesity shaded red, the three of lowest obesity bright green.



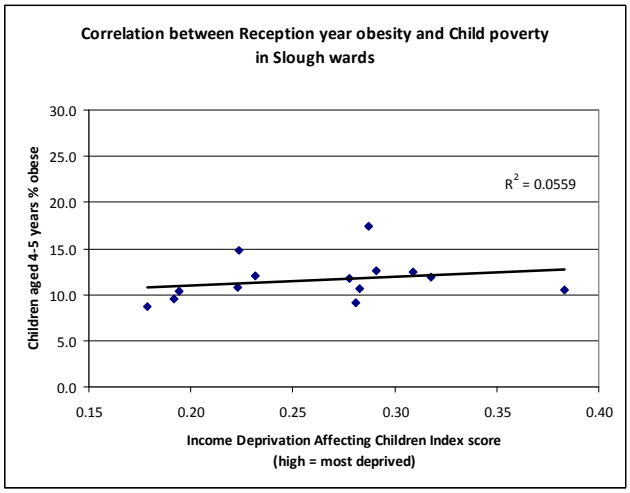
	Children aged 4-5 years % obese 2009/10-2011/12
Cippenham Green	8.7
Foxborough	9.2
Langley St Marys	9.6
Upton	10.3
Chalvey	10.6
Cippenham Meadows	10.6
Farnham	10.8
Wexham Lea	11.8
Britwell	11.9
Haymill	12.0
Central	12.4
Baylis and Stoke	12.6
Kedermister	14.8
Colnbrook with Poyle	17.4

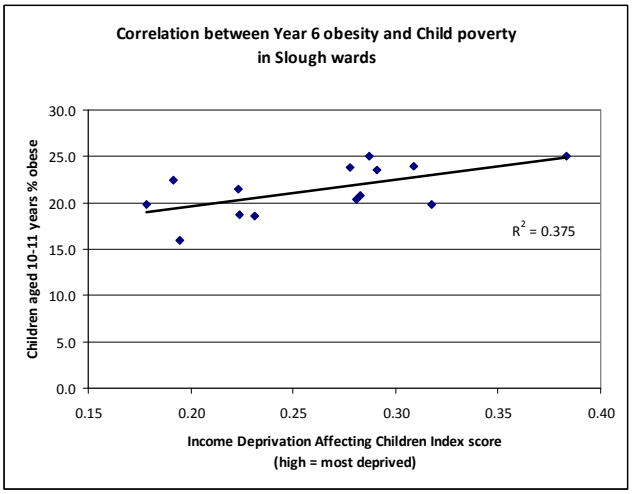


	Children aged 10-11 years % obese 2009/10-2011/12
Upton	16.0
Haymill	18.6
Kedermister	18.8
Britwell	19.8
Cippenham Green	19.8
Foxborough	20.4
Cippenham Meadows	20.8
Farnham	21.4
Langley St Marys	22.5
Baylis and Stoke	23.6
Wexham Lea	23.7
Central	24.0
Chalvey	25.0
Colnbrook with Poyle	25.0

8 **Analysis**

8.1 The charts beneath compare the average ward-level obesity rates (2009/10-2011/12) to a measure of low income amongst families in those wards. There is a weak statistical correlation between ward level childhood obesity and low family income (as established by the Income Deprivation Affecting Children Index Score from the Indices of Multiple Deprivation 2010). Therefore, whilst low income appears to have a role in describing Slough childhood obesity, it is not the only factor involved locally.





8.2 With deprivation and ethnicity correlated with higher rates of childhood obesity, children from Asian and Black Groups are also more likely to be obese than white ethnic groups (NOO, 2012).

8.3 Alongside deprivation and ethnicity there are a number of factors that have an influence on levels of obesity (both positive and negative): media; social; psychological; economic; food; activity; infrastructure; developmental; biological; and medical.

8.4 The risk factors for obesity include absence of breast feeding, parent feeding practices & nutritive quality of food consumed (cooked meals vs takeaways), activity levels and parental obesity, food security, parental psychosocial factors, stress and other contextual determinants. In terms of children, the total screen time during weekdays and weekends, emotional wellbeing, access to timely, healthy meals at home and school, recognition of portion sizes of food, physical activity status, safety at home and in open green spaces etc (Hearst, 2012)

8.5 Hearst says (2012) “Families with higher social risk (less safety, more stress, and food insecurity) also reported fewer family meals, more child screen time and trends indicated greater social-emotional developmental needs of the children. Parent stress and more child screen time also were positively correlated with developmental concerns with the child. The observed correlations of obesity-risk, social-emotional developmental and social conditions do suggest that a common intervention approach that touches on the interconnected nature of all of these components may improve aspects of each, such as ways to reduce family stress, creation of a neighbourhood safety watch and policies to increase equitable and affordable food access within and across neighbourhoods.”

8.6 Children from families where one or both parents are obese, lower socioeconomic, deprived, ethnic groups, where there are unhealthy lifestyle choices, inactivity, cultural, environmental factors and genetic susceptibility are at a higher risk for childhood obesity.

8.7 The rising prevalence of obesity is multi-factorial, including genetic factors influencing the susceptibility of a given child to an obesity-conducive environment. However, environmental factors, lifestyle preferences, behavioural, psychological, social, cultural and environmental factors are thought to determine the increasing prevalence of obesity. In the current obesogenic environment, wider determinants of health have a huge influence on childhood obesity.

9 Motivations and Barriers to Combating Childhood Obesity

9.1 In June 2010, Morgans' undertook detailed social research looking into the motivations and barriers in Slough relating to the issue of childhood obesity, looking for key themes for motivating children and their parents.

Motivations for Children and Parents	
Children	**Parents**
Play with friends	Cheap childcare • Safe and secure • Local – easy access • Doesn't involve/require their involvement
Be happy and have fun • Want to be challenged • Needs to be age specific	
Somewhere to go • Safe – but not constrained • Local – can walk/cycle • Basic amenities (e.g. toilets)	Time • Prioritising – for self and child

Barriers for Children and Parents	
Children	**Parents**
Know more about health messages • From school, parents, peers • Mix messages	Variable health knowledge • Typically simplistic and media led • Risk may feel undermined
Potential pester power good but can backfire • Rifts in family if child critical	Culture and upbringing powerful • May have been limited health messages • Lack of skills
Traditions can clash with peers/fitting in	Merging into new culture, transition issues, want more guidance
Want activities, keen for challenges • Access issues	May overestimate child's physical activity • Typically revolves around school
Like activities to be in safe environments • Trust, where they know	Not aware of local, diversity of activities • Time issues critical
Messages communicated and processed but not able to drive change	Limited emotional engagement • Disassociated from problems

10 Strategies for Tackling Obesity

10.1 The Foresight Report (2007) set out a multifaceted strategy to tackle issues of obesity, with three strands of activity:

- the promotion of healthy diets
- redesigning the built environment to promote walking
- culture changes to shift societal values and around food and activity

10.2 The Centre for Excellence and Outcomes in Children and Young People's Services (C4EO) identifies and coordinates local, regional and national evidence of what works in tackling childhood obesity, and creates a single comprehensive picture of effective practice. This information is used to support local authorities, working with them to improve outcomes. This work focuses on nine themes:

- Early Years
- Disabled Children
- Vulnerable (Looked After) Children
- Child Poverty
- Safeguarding
- Schools and Communities
- Youth
- Families, Parents and Carers
- Early Intervention and Prevention

10.3 The Childhood Obesity National Support Team (CONST), has produced the Strategic High Impact Changes document, capturing the learning and evidence gathered from 44 visits to local health economies across the country. CONST uses this learning to activities that could make the greatest impact in addressing obesity in a local area. This programme has identified four key areas for implementation:

- Building local intelligence
- Harnessing the contribution of existing community resources within local healthy weight pathways
- Workforce development
- Workforce health

11 **What are we currently doing?**

11.1 Early Years –

- recognising risk of obesity in pregnancy and working with Wexham Park Hospital Maternity Services to manage this risk;
- working to improve rates of uptake of breastfeeding remain a priority in order to increase awareness that feeling full starts at birth. Expanding the programme of antenatal and post-natal breast feeding support through a peer-led breast-feeding programme to compliment work of midwives.

11.2 Schools –

- Adopting a whole school approach to tackling obesity was the basis of the national healthy schools programme standards. In Slough, eight schools are working towards the enhanced health schools programme. This requires action to promote:
    - understanding of the principles of nutrition, including health lunchboxes, healthy menus, cooking and gardening skills;
    - free school meals and healthy eating environments; amd
    - ensuring that information is provided throughout the curriculum to aid healthy choices as well as increasing physical activity both in school and through active travel to school and after school activities.
- From the health consultation that is being conducted for the JSNA by Slough Wellbeing Board to support the needs that have been identified.

11.3 Physical activity – improving awareness of how much physical activity is required, and encouraging active play sessions. (Detailed action on this will be available following the release of the draft Physical Activity Strategy shortly.)

11.4 Targeted family-based weight management programmes – the More Life programme has a strong evidence base and is one of only a few nationally approved programmes. In Slough weight management programmes look to target children and

families living in areas of high deprivation and health inequalities. Difficulties with recruitment into these programmes are best overcome using summer holiday periods to promote these services. Once engaged, retention in the programmes is high.

11.5 Other -

- Incorporating measures to tackle obesity into strategic town planning and place shaping initiatives; and
- Continuing to update the care pathways for children and adults.

12 Conclusion

The issue of childhood obesity is complex and there are a number of causation factors including ethnicity and deprivation which impact on the levels in a particular area. This report is aimed at providing the provisional data for Members to consider as they investigate this issue and consider options for tackling it going forward.

13 Background Papers

1 - Dinsdale H, Ridler C, Ells L J. A simple guide to classifying body mass index in children. Oxford: National Obesity Observatory, 2011

2 - National Obesity Observatory (NOO). www.noo.org.uk

3 - Foresight – Tackling Obesities: Future Choices' project. Foresight Programme, Office of Science and Innovation, 2007

4 - Rice H, Fauth R, Reeves A – What works in combating childhood obesity: an anthology of the literature on effective whole-system approaches. C4EO, 2011

5 - Hearst M, Martin L, Rafdal B, Robinson R, McConnell S. Early childhood development and obesity risk-factors in a multi-ethnic, low-income community: Feasibility of the 'Five Hundred under Five' social determinants of health pilot study. Health Education Journal 2013, published online 18 March 2012