Childhood Obesity in Kensington and Chelsea

Final Report of the Childhood Obesity Subgroup

January 2010
Contents

1 Executive Summary
2 Background to the review
3 The national context for action on childhood obesity
4 Breastfeeding – preventing childhood obesity
5 Early Years action on childhood obesity
6 School action on childhood obesity
7 The National Child Measurement Programme (NCMP)
8 The Healthy Schools Programme
9 Promoting healthy eating in schools
10 Promoting physical activities in schools
11 Promoting physical activities outside school
12 Working with black and minority ethnic communities
13 Role of Planning in combating childhood obesity

Full list of draft recommendations – Appendix 1
Chairman’s Foreword

Although recent press reports have suggested that the growth in childhood obesity at a national level may be levelling off, this is not necessarily the case at the local level. The number of obese or overweight children in the Royal Borough still remains unacceptably high and NHS Kensington and Chelsea expects childhood obesity to continue to rise before levelling off and dropping in the longer term. There is therefore little room for complacency.

Our investigation into childhood obesity in Kensington and Chelsea has shown that local agencies have been correctly putting families and schools at the centre of the support they offer to children in combating overweight and obesity. The range and quality of support being offered to children and their families to tackle obesity at various stages of their lives is impressive and commendable. Successful projects such as “healthy lunch box” and the innovative “cook and taste” course have recently been commended in the Council’s One Place assessment by the regulators. However, there is need for clearer strategic leadership to tackle childhood obesity at the local level, more collaborative working across all agencies and better targeting of resources to those most in need.

I would like to thank Cllr Julie Mills who was Chairman of this Working Group when it began its work and Councillors Condon-Simmonds and Mason for their contribution to the work of this group.

Cllr Matthew Palmer, Chairman,
Health Scrutiny Committee Subgroup on Childhood Obesity

Councillors serving on the Childhood Obesity Subgroup
Cllr Matthew Palmer (Chairman from 1st June 2009)
Cllr Julie Mills (Chairman till 31st May 2009)
Cllr Maighread Condon-Simmonds
Cllr Pat Mason (from September 2009)

Executive Summary

1 Obesity and overweight amongst primary school children in Kensington and Chelsea has not shown a decrease since measurement of weights began in primary schools in 2005. In fact, the NHS Kensington and Chelsea (hereafter referred to as Kensington and Chelsea PCT or just PCT) expects the trend in childhood obesity to be upwards for the next few years before starting to decline.

2 Both the Council and the PCT recognise childhood obesity as an important area of action and indeed the borough’s Local Area Agreement contains two important targets relating to childhood obesity: on increasing breastfeeding and on reducing obesity amongst primary school children.

3 The PCT has started work on developing an obesity strategy for the borough but action has been very slow. We recommend that a senior lead officer should be identified jointly by the PCT and the Council to raise the profile of this issue and co-ordinate action across the borough (recommendations 1&2).

4 Mothers in Kensington and Chelsea have high rates of initiating and maintaining breastfeeding, which is a factor in reducing the risk of childhood obesity. We recommend that the PCT should investigate whether the 11% drop in breastfeeding over the 6-8 weeks after birth occurs evenly across all socio-demographic groups, and if not, to consider targeting resources at those groups who are at the greatest risk of dropping off (recommendation 3).

5 We were impressed with the range of support offered to parents and children by the Council and the PCT to prevent childhood obesity through services provided by Children’s Centres, health visitors, family outreach officers and the recently established Dietetics Service. We are fully supportive of the whole family approach adopted by most of these interventions. We recommend more targeting of families with children at the greatest risk of obesity, improved training and support to GPs on childhood obesity, and support to families of very young children (recommendations 5-11).

6 We noted the low reported incidence of obesity within independent schools in the borough and recommend that further public health resources should not be directed at this sector apart from promoting School Travel Plans to those independent schools which do not already have them (recommendation 12).

7 We found large variations in the rates of obesity between primary schools in the borough (3-26%) and recommend that the PCT should investigate whether lower rates of obesity in some schools are a product of more successful intervention strategies, and consider targeting resources on schools with the greatest need. We recommend that schools should inform parents about the healthy eating principles of the school, and share the results of pupil weight measurements with their governing bodies. In view of the reported success of the MEND (‘Mind, Exercise, Nutrition . . . Do it!’) programme involving the whole family to tackle obesity in children, we
recommend that similar programmes should be established for younger and older age groups (recommendations 13-16).

8 We recommend that the Council and the PCT should work together to develop a joint business case to provide nutrition and physical activity advice to youth services and secondary schools, and to develop options for supporting overweight and obese children over 12 years of age to lose weight (recommendation 17).

9 We were encouraged to hear of the success of the School Travel Plans – including within those Independent Schools which responded to our survey.

10 We were pleased to hear that over 92% of the borough’s school population takes part in 2 hours of sports activities per week. We note the new target of 5 hours per week of physical activities, and recommend that the Council and the PCT should work with schools to see if more than 2 hours of physical activity could be delivered via the curriculum, without detriment to academic performance, such as recommended by the Youth Sports Trust (recommendation 20).

11 We recognise the investment that the Council makes in providing a range of play and sports facilities in the borough for children and young people. The Play Pathfinder project is particularly commendable in the contribution it could make to encouraging children to adventure play, as is the provision of free swimming to those under 16 and the offer of the Council’s Leisure passes. We recommend a more proactive promotion of the borough’s sports facilities, particularly by the Tenant Management Organisation and Registered Social Landlords, informing residents of the availability of sports facilities in the borough and in neighbouring boroughs. The Council should also investigate the feasibility of opening up for school use the all-purpose sports courts (recommendation 21).

12 The Subgroup noted that work was being undertaken in areas with high black and ethnic minority populations, but did not see specific evidence as to how messages on childhood obesity and services to combat childhood obesity were being adapted to meet the requirements of different ethnic groups in the borough. Neither did it see evidence of how the impact of any intervention in reducing the higher incidence of childhood obesity amongst certain black and minority ethnic (BME) groups would be evaluated. The Subgroup recommends that the Council and PCT be asked to report on the above two matters in 12 months’ time (recommendation 22).

13 The Borough’s Local Development Framework supports active lifestyles and we suggest that the Planning and Borough Development should take into account the need to tackle obesity when planning applications for new sports provision are made and ensure that all new public buildings incorporate showers and changing facilities to encourage staff to cycle/walk to work (recommendations 21-24).
14 We took evidence regarding the feasibility of restricting hot takeaway shops near school premises using Planning Policy as adopted by Waltham Forest Council, and concluded that in the context of Kensington and Chelsea this would not be a suitable way forward.

15 In summary, we are pleased at the range and quality of support being offered by the Council, the PCT and its partners to children and their families to tackle childhood obesity at various stages of their lives. We believe that better leadership and co-ordination of initiatives at the local level, more collaborative working across all agencies, and better targeting of resources to those most in need, could begin to deliver longer term actual reductions in the numbers of children who are overweight or obese in the borough.

The Executive Summary refers to only the major recommendations of this review. A full list of recommendations is contained in Appendix 1 of this report.
2 Background to the Review

Extent of childhood Obesity

2.1 In 2009, one in 11 children in Reception Year (4-5 year olds) and one in five children in Year 6 (10-11 year olds) in Kensington and Chelsea state schools were classified as obese (see Chart 1 below).

2.2 According to Kensington and Chelsea PCT, with the exception of 4-5 year olds in 2007/08, there has been no statistically significant change in the levels of obesity over the four-year period. The relatively small size of the state school population in the borough means that, although there are upward and downward movements in the level of obesity, it cannot be ruled out that this variation is purely a result of chance. However, since the baseline year of 2005/06, there has been a consistent upward trend in the 10-11 year olds. The PCT accepts that if this trend continues in future years, it may well result in a statistically significant increase.

2.3 The statistically significant rise in obesity in 4-5 year olds in 2007/08, according to the PCT, was a result of a rise in obesity among 4-5 year old aged boys. This level has subsequently dropped.

2.4 The Foresight report\(^2\) found that in England, obesity was relatively high amongst black African, Caribbean and Pakistani boys (42 percent, 39 per cent and 39 per cent respectively) and black African and Caribbean girls (42 per cent and 40 per cent). The rate of obesity in Kensington and Chelsea

---

\(^2\) [http://www.idea.gov.uk/idk/core/page.do?pageId=8267926](http://www.idea.gov.uk/idk/core/page.do?pageId=8267926)
amongst BME children\(^3\) in receipt of free school meals between 2006-08 was: Asian (26%), Black (21%), Other BME 20%, Other White (23%), Mixed (20%), and White (16%). The obesity rates therefore seem to be considerably lower for BME communities in Kensington and Chelsea than for BME communities in England as a whole.

**Consequences of childhood obesity**

2.5 Being overweight or obese as a child increases the risk of a wide range of diseases and illnesses later in life, reduces life expectancy, and has serious consequences for the NHS and wider society in terms of contributing to the onset of disease and premature death.

2.6 Health risks associated with obesity include breathlessness and sleep disturbance, gall bladder disease, osteoarthritis, stroke, heart disease, high blood pressure, high cholesterol, type 2 diabetes and insulin resistance. A recent study on childhood overweight and school outcomes\(^4\) found that:

- Change in overweight status during the first four years in school is a significant risk factor for adverse school outcomes amongst girls;
- Girls who become overweight during the early school years and those who start school being overweight and remain that way may need to be monitored carefully.

**Causes of childhood obesity**

2.7 The causes of obesity are complex and many of the determinants of obesity are interdependent. Simply put, an individual's biology as well as the balance between eating and physical activity play a large part. But these primary determinants may themselves be influenced by other psychological, social and environmental pressures – for example, parents rewarding their children with sweets; the availability of inexpensive takeaways, and parental preference for this as an alternative to home cooking; car ownership and usage; extent of TV viewing and computer games; and availability of safe outside spaces for play etc. This reflects significant changes in society as a whole.

**Combating childhood obesity**

2.8 Under the Kensington and Chelsea Partnership’s Local Area Agreement, there is a target to halt the year on year rise in obesity amongst state primary school aged children. There is an expectation that this increase in childhood obesity will continue over the next few years but will slowly decline in the longer term. Target rates for childhood obesity for 5-6 year old and 11-12 year old children for 2009/10 and 2010/11 have therefore been set higher (10.7% and 23.8% and 11% and 24.3% respectively) than the previous year targets.\(^5\)

---

\(^3\)Children in receipt of school meals have a higher rate of obesity than those not in receipt of school meals across all ethnic groups.


\(^5\)Kensington and Chelsea Performance report 2009 – draft June 2009
2.9 Halting the rise in obesity is a key focus of Kensington and Chelsea’s Children and Young People’s Plan (CYPP). A recent review of the CYPP highlighted action that was underway to tackle the rise in childhood obesity. This included supporting breastfeeding; supporting weaning; promoting healthy schools; improving school food, and promoting sports and physical activities in the school and the community.

2.10 In November 2009, the Health Scrutiny Committee agreed the terms of reference of the Childhood Obesity Review (attached as appendix 2).

2.11 In January 2009, the Kensington and Chelsea PCT organized a stakeholder event to obtain input into the development of an obesity strategy in the borough. A number of evidence-based methods of promoting healthy weight were highlighted, including breastfeeding; targeted support for at risk families; using Children’s Centres to promote activity and nutrition; school-based prevention; and reduced consumption of high in fat, saturated fat, salt and/or sugar (HFSS) foods. A process for developing an obesity strategy was outlined. At the time of writing, the PCT has reported that it is still in the process of appointing a commissioning nutritional lead to take forward this strategy work.

Recommendation 1

The PCT should report progress on the development of its obesity strategy and on the timescale for its full implementation.

3 The national context for action on childhood obesity:

3.1 The most recent national figures (2006) show that among children aged 2-15 nationally almost one-third (nearly 3 million) are overweight (including obese) and approximately one-sixth are obese.

3.2 Child obesity is a national priority within the NHS Operating Framework and the Child Health Public Service Agreement (PSA). In addition, within the Local Area Agreement (LAA) National Indicator Set (NIS), there are two indicators specifically on child obesity:

- **NI 55** – obesity among 4-5 year old primary school children
- **NI 56** – obesity among 10-11 year old primary school children

3.3 The overall national ambition is to reduce the proportion of overweight and obese children by 2020. However, for the period 2008/09 to 2010/11, both

---

6 “Strong Families at the heart of Strong Communities – A review of the K&C Children and Young People’s Plan – August 2008


the Child Health PSA and the NHS Operating Framework asked PCTs and Local Authorities to focus on the levels of obesity in children.

3.4 The Child Health Promotion Programme (CHPP) provides the overarching universal public health programme for children from pregnancy to early adulthood. For children of school age, the Healthy Schools programme supports the delivery of initiatives that span both healthy food and increased physical activity.

3.5 Government guidance on combating childhood obesity recommends:

   a) A multi-agency approach, which includes PCTs, Local Authorities and partners in the private and third sector, to promoting healthy weight.
   b) A designated senior lead to co-ordinate activity across all sectors.
   c) Encouraging a whole-family approach to eating well and being active within antenatal, early years and school settings.
   d) A strong focus on prevention and early intervention targeted at those families most at risk of overweight and obesity, i.e. those where one or both parents are overweight or obese.
   e) Promoting healthier food choices and using existing planning powers to manage the number and location of fast food outlets in their area.
   f) Encouraging active travel such as cycling and walking, the use of parks and green spaces, and promoting opportunities for active and unstructured play.

3.6 The Greater London Act 2007 gives the Mayor of London the power to lead on the development of a health inequalities strategy for London. In October 2009, the Mayor published his draft London Health Inequalities Strategy for consultation. At the launch of the consultation document, the Mayor called for a pan-London approach to the problem of childhood obesity by promoting physical exercise and healthy eating. He hoped that in the run-up to 2012 a strong joint approach will help get fitness levels up and empower challenges to fast food companies and advertisers who deliberately target young people with unhealthy and fattening snacks.

**Recommendation 2**

The PCT and the Council should jointly identify a senior lead officer to co-ordinate action to combat childhood obesity across all sectors in the borough.
4 Breastfeeding – preventing childhood obesity

4.1 Evidence suggests breastfeeding leads to a lower risk of childhood obesity and other illness. Factors that may influence breastfeeding rates include: creating friendly environments and setting up suitable facilities in hospitals and the community; promoting benefits of breastfeeding to prospective parents; baby-friendly accreditation for hospitals and venues in the community; role of midwives; and post-natal wards.

4.2 In Kensington and Chelsea, guidelines have been developed to ensure consistent messages are provided to mothers. Breastfeeding Peer Support Counsellors support mothers to initiate and maintain breastfeeding. Kensington and Chelsea’s Local Area Agreement has targets on breastfeeding. Rates of mothers initiating breastfeeding have increased to 91% in 2007/09, far higher than the national averages. The rate of mothers breastfeeding at six to eight weeks is also improving, with the latest figure indicating that over 80% of mothers are still breastfeeding at this stage.

4.3 Creating an environment that makes it comfortable for new mothers to breastfeed their babies in a hospital or community setting can be important in maintaining high rates of breastfeeding. The UNICEF baby-friendly initiative works with health professionals to introduce baby-friendly facilities in hospitals and the community to support parents make informed choices about feeding and caring for babies. Organisations can seek to become accredited “baby-friendly” environments by adopting certain high standards of care for mothers and babies. Currently there are only 26 such organisations in the UK, none of which are in London. However Chelsea & Westminster Hospital has received a certificate of commitment to achieving these standards, and Northwick Park is at Stage 1 of the accreditation process.

4.4 The Mayor of London’s draft health inequalities strategy cites NHS Camden’s initiative to encourage public, private and voluntary sector venues across the borough to be breastfeeding-friendly. This has included a Breastfeeding Friendly Places award scheme and development of an online toolkit to support business to become ‘breastfeeding-friendly’. So far, 50 businesses are reported to have signed up to the scheme and 30 have been accredited, including cafes, restaurants, women’s and community centres, a shopping centre, leisure centres, hairdressers and beauty salons.

Recommendation 3

The PCT should investigate whether the drop in breastfeeding over the 6-8 weeks period after birth occurs evenly across all socio-demographic groups and if not, to target any intervention at groups which are at the greatest risk of dropping off.

9 http://www.babyfriendly.org.uk/
Recommendation 4

The PCT and the Council should work with their partners in the voluntary and private sectors to promote baby feeding environments in community settings such as cafes, shops, leisure centres, libraries etc.

5 Early Years action on childhood obesity

5.1 Kensington and Chelsea has a high number of new births per population compared to England (but lower than London). These births are fairly evenly spread across the borough. However, by the age of five, 40% of GP registered one year olds have left the borough. This pattern continues with older children. In common with other inner London boroughs, Kensington and Chelsea has a particularly small proportion of older children. This is largely due to outward migration, concentrated in the more affluent areas. The remaining younger population is therefore more likely to be in the deprived wards – 45% in the northern wards compared to 14% in the rest of the borough.

5.2 The best long-term approach to tackling overweight and obesity is to prevent it during childhood through improving diet and increasing physical activity. The Subgroup heard that parental obesity has an impact on the prevalence of obesity amongst their children. Whereas there is little difference in the levels of obesity between those children whose parents are not obese (7%) and those children who have just one obese parent (8%), the rate of obesity rises sharply (to 20%) amongst children with two obese/overweight parents. This highlights the central importance of working with the whole family unit to make an impact on childhood obesity. The Subgroup recognised that the PCT’s ability to identify families where both parents are overweight or obese is limited by the extent to which such families engage, as families, with health services.

Recommendation 5

The PCT should involve GPs to proactively target families with children at the greatest risk of obesity. For instance, where school nurses know of families where both parents are obese, they should be able to make direct referrals to GPs, who should invite such families for consultation.

5.3 Parents can take action in the early years of development to prevent their child becoming overweight and obese, for instance: through breastfeeding; delaying weaning until babies are six months old; introducing children to healthy foods; controlling portion size; and limiting snacking on food high in fat and sugar.

5.4 During this period, the family is likely to come into contact with health and children’s services at various points: through Antenatal appointments; visits by
Report on Childhood Obesity

Health Visitors 10-14 days after birth; the 8-month review of the child; the 2½ year review (including height and weight); and finally the school entry review at 4-5 years of age.

5.5 The Subgroup heard that support to families was provided or commissioned by the PCT in a number of ways: promoting the benefits of breastfeeding through antenatal classes and selective antenatal visits; promoting healthy eating through the Healthy Start scheme; supporting initiation of breastfeeding through joint work with Chelsea & Westminster hospital. Postnatal support included support to maintain breastfeeding (through new birth visits, consistent and evidence-based advice, support to baby cafes, and one to one support visits where required).

5.6 The Subgroup heard that Children’s Centres in the borough run a programme for challenging obesity which includes services such as: Drop-in for parents to meet and have regular support from health professionals, breastfeeding support, baby massage, adult fitness groups, baby yoga, aqua tots (baby swimming classes), salsa dancing and sleep clinics. At the time of writing, five Children’s Centres had participated in the Health Eating Awards Scheme. A rollout to the other centres is being planned after the evaluation period.

5.7 Early Years services are available to all families with children under five years old who access Children’s Centres or the cluster of other venues in their locality that deliver these services. The aim is to enable parents and children to make best use of the centres, and they can move from one centre to another, looking for the variety of activities they are interested in. A service grid giving information on the variety of services that are on offer is attached as Appendix 3.

5.8 Families with young children or babies in their homes who need extra support may receive additional support through family outreach officers who are referred through health visitors and midwives. Such families are encouraged to access Children’s Centres when they feel confident and ready. Family outreach workers will support parents with regards to breastfeeding, weaning and healthy eating.

5.9 The Subgroup was informed that the Early Years Service was developing a new range of opportunities for parents to meet dieticians, health visitors and speech and language therapists and to get advice about issues that include immunisation, home safety, eating well, sleeping sufficiently and benefiting from physical activities. This was being delivered at Birthday Parties for Two-Year Old Children across the borough. Every week, a Children’s Centre would hold a party led by the health co-ordinator, and invite local children and parents to attend. There, parents would meet a range of professionals and ask questions as their children played. It is expected that the success of these parties will be measured by following up with parents after six months.

---

11 Designated Children’s Centres in the borough are: Maxilla, Golborne, Chelsea Open Air, Cheyne, Violet Melchett, St Quentin, Clare Garden and St Cuthbert/St Matthias/Earls Court
and after a year. These events would provide the opportunity to draw in families who may not already be accessing the services at Children’s Centres.

5.10 The Subgroup heard that the take-up of Children’s Centres’ services was generally good. The Centres were monitoring access to their services, and accurate attendance figures would be available once the new performance management database was in place. However, many healthy living activities such as baby massage, aqua-tots, baby yoga etc have long waiting lists and the Early Years Service was aiming to purchase more programmes to accommodate parents and babies.

5.11 The Healthy Start Scheme is aimed at pregnant women and families with children under 4 years, who are on income support etc. Such families are given vouchers to be exchanged for milk, fresh fruit and vegetables. Pregnant women and children between 1-4 years receive one voucher per week, each worth £3.00; babies under 1 year receive two vouchers per week.

5.12 The Subgroup heard that GPs were an important source of advice on childhood obesity, but that their training needed updating in this area as the science of advice on obesity has moved on. The GPs did not always have the resources within their practices to do this work and were sometimes not aware to which professionals they should refer patients.

**Recommendation 6**

The PCT should work with local GPs to examine and address their training needs in the area of childhood obesity, improve the availability of information to local GPs on local sources of expertise in childhood obesity, and develop an appropriate referral strategy with local GPs and other professionals.

5.13 Dietetics Service for Children: This service was launched in April 2009 led by a specialist paediatric dietician, providing individual consultations for parents, child carers and professionals, and advice and treatment for a range of clinical conditions, including obesity. The service will be offered in more accessible locations outside the hospital setting, including primary schools.

5.14 Healthy Eating Awards: This is a joint initiative between the PCT and the Council to improve nutrition for children under five and combat childhood obesity. The Dietetic Service has been working closely with five Children’s Centres in Kensington and Chelsea to implement the Healthy Eating Awards and, at the time of writing the report, there are plans to roll these out to the other Children’s Centres and childcare providers across the borough.

5.15 We were impressed with the range of support offered to parents and children by the Council and the PCT to prevent childhood obesity through services provided by Children’s Centres, health visitors, family outreach officers and the recently established Dietetics Service.
Recommendations 7-11

R7 Mothers and fathers with babies should be given reduced or free access to baby-specific activities at leisure centres in the borough, including swimming;

R8 The PCT and the Council should ensure that there is sufficient training of midwives, health visitors and Children’s Centre staff so they are fully able to promote basic dietetics and the benefits of activity to parents;

R9 There should be more venues and opportunities to support parents to learn to cook for their children and learn about healthy eating at the same time (Jamie Oliver-style cascading of good skills learning and disseminating to other parents);

R10 Council and PCT staff working with parents who are overweight and who have potentially overweight babies and children should themselves act as good role models about healthy eating and exercise;

R11 The PCT should consider introducing height and weight measurements for 2-2½ year olds to enable early identification of health problems.

6 School action on childhood obesity

6.1 A notable characteristic of primary school age children resident in the borough is that a high proportion attend independent schools (61%) and schools outside the Royal Borough (3%)\(^\text{12}\). Therefore action to tackle overweight and obesity in state schools in the borough affects only a minority of Kensington and Chelsea primary school age children. Of those children attending Kensington and Chelsea schools (75% of whom are borough residents), 53% have English as an additional language, 47% are from BME communities and 39% are entitled to free school meals\(^\text{13}\). Pupils entitled to school meals are more likely to be obese, as are children from minority ethnic communities.

6.2 This picture is even more skewed for secondary school age children. Only 19% of these children attend RBKC schools, a further 22% attend state schools outside the borough (over which the Council has little influence), whilst the majority (58%) attend independent schools. Only a minority (41%) of children in RBKC secondary schools are residents of the borough, the rest coming from outside the borough.

\(^{12}\) Information provided by Family and Children Services, RBKC, August 2009

\(^{13}\) “Tackling childhood obesity in the early years” – PCT presentation to the Subgroup, 24\(^{\text{th}}\) March 2009
Independent Schools

6.3 Little information has been available on whether childhood obesity is considered to be an issue for the Independent school sector, and if so, what action is being taken to address it. The Subgroup therefore commissioned a survey of all the independent schools in the Royal Borough. 40 schools were included in the survey and replies were received from 17 schools. The results showed that:

a) None of the schools that responded said that childhood obesity was an issue that affected their pupils;

b) Of the 17 schools that responded to this question, only one said that it both weighed and measured its pupils, and another said that it only measured pupils' height;

c) 10 of the 17 schools that responded to this question said that the incidence of obesity was staying the same at their school - the rest either didn’t know or didn’t consider the question applicable. None of the respondents said that the incidence was either increasing or decreasing;

d) Of the 13 schools that responded to this question, 12 said that they would raise the issue with parents if they had concerns about a pupil’s weight, and 7 of these schools said that they would additionally provide advice. None of the schools which responded said that they would make a referral to health services;

e) 6 of the 15 schools that responded to this question said that they had a policy on healthy eating and physical activity, and 9 said that they did not;

f) 16 of the 17 schools that responded said that there were curriculum opportunities for pupils to learn about different types of food, and one school said that there weren’t such opportunities;

g) 11 of the 14 schools that responded to this question said that they provided a school meal service/breakfast club that met Department for Children, Schools and Families (DCFS) school food standard, and three said that they did not;

h) Only one of the 16 schools that responded to this question said that they had vending machines or tuck shops for soft food and snacks;

i) Of the 17 schools that replied to this question, 15 said that they provided a minimum of 2 hours of structured physical activity per week, and only two said they did not.

j) All 14 schools that responded to this question said that there were opportunities for all pupils to participate in a broad range of extracurricular activities;

---

k) Of the 16 schools that responded to this question, 14 said that they had a School Travel Plan (STP), whilst two said that they did not. Of the 14 schools with a STP, 12 reported benefits to the school community in having such a plan, and only one said that it was a waste of effort and energy.

l) Asked what support they would like from the local authority and the local NHS on childhood obesity, most schools did not respond or responded in the negative. Of those which commented, requests included:

- Personal fitness trainer at the beginning and end of term
- Dietician talks to pupils, suitable for primary school
- Annual weigh-in
- Help to develop a Healthy-eating Plan
- Advice for nursery parents
- Parents and nannies to be informed of dietary requirements

6.4 The results of this survey of independent schools, when compared with information on rates of obesity in local authority schools, confirm the link between obesity and social class. Independent schools responding to the survey appear to deal with issues of overweight and obesity at individual level with pupils and only a small minority have policies on healthy eating and physical activity.

6.5 Given the low reported incidence of obesity in independent schools, and in the context of limited public health resources and the need to target these resources to those in greatest need, the Subgroup does not feel it appropriate to recommend diverting resources to this sector. However, one area where the Council may be able to add value is through promoting School Travel Plans to those schools which do not already have them.

**Recommendation 12**

The Council may wish to use the overwhelmingly positive feedback from those independent schools which have School Travel Plans about the benefits it brought them - increased walking and cycling, less traffic etc-to promote this approach to those independent schools which do not yet have a School Travel Plan.
7 The National Child Measurement Programme (NCMP)

7.1 The NCMP was established in 2005 to weigh and measure local authority primary school children aged 4-5 years and aged 10-11 years. The purpose of the programme is to inform local planning and delivery of services for children; gather population-level data to allow analysis of trends in growth patterns and obesity; increase public and professional understanding of weight issues in children; and be a vehicle for engaging with children and families about healthy lifestyles and weight issues.

7.2 PCTs were encouraged, but not obliged, to include independent schools and special schools in their NCMP measurements. Numbers of independent school pupils were not, however, included in participation rates used for performance management purposes. This was because PCTs do not tend to routinely work with these schools.

7.3 Results of the 2006/07 and 2007/08 exercise are set out below. The Department of Health recommends caution in extrapolating any trends from these results, as at least five years of data will be essential before any trends over time can be detected and confirmed:

<table>
<thead>
<tr>
<th>Table 1: Proportion of pupils overweight or obese in K&amp;C and London</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kensington and Chelsea</td>
</tr>
<tr>
<td>Overweight but not obese</td>
</tr>
<tr>
<td>Obese</td>
</tr>
<tr>
<td>Combined for overweight or obese</td>
</tr>
<tr>
<td>Participation rate</td>
</tr>
</tbody>
</table>

% figure refers to the proportion of 4-5 year old pupils and 10-11 year old pupils who are overweight or obese for each year of measurement.

7.4 Measurements are taken by the school nursing service in all state primary schools. School co-operation is imperative to its effectiveness. All 4-5 year old pupils and 10-11 year old pupils are measured and weighed. Results are entered into a database and letters to parents generated. Results are sent to all parents because it is considered important that the exercise is not seen to target particular pupils. Parents have to opt out if they do not want their child included in the programme. So far the opt-out rate has been between 3-5%.

7.5 Follow-up to the measurement exercise by schools consists of inviting parents of overweight/obese children to see the school nurse and to discuss what

interventions are possible. A treatment programme offered through local primary schools for overweight and obese children (8-12 years) and their parents and carers is the MEND programme (see next section).

7.6 The PCT collects information on the percentage of children that are obese, by school. The reason for looking at this information is to target resources appropriately at schools rather than attribute levels to schools. Looking at the spread of obesity levels amongst schools in Kensington and Chelsea (see table 2 below), it is apparent that there is an eightfold difference in levels of obesity among Kensington and Chelsea’s primary schools.

**Table 2: Percentage of children who are obese, by school**

<table>
<thead>
<tr>
<th>School</th>
<th>Region</th>
<th>4-5 year olds</th>
<th>10-11 year olds</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle Row</td>
<td>North Kensington</td>
<td>21%</td>
<td>27%</td>
<td>25%</td>
</tr>
<tr>
<td>Colville</td>
<td></td>
<td>12%</td>
<td>32%</td>
<td>22%</td>
</tr>
<tr>
<td>Saint Mary’s</td>
<td></td>
<td>10%</td>
<td>25%</td>
<td>18%</td>
</tr>
<tr>
<td>Avondale Park</td>
<td></td>
<td>14%</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>Saint Francis of Assisi</td>
<td></td>
<td>10%</td>
<td>26%</td>
<td>17%</td>
</tr>
<tr>
<td>Thomas Jones</td>
<td></td>
<td>13%</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>Oxford Gardens</td>
<td></td>
<td>9%</td>
<td>25%</td>
<td>17%</td>
</tr>
<tr>
<td>St Charles</td>
<td></td>
<td>13%</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td>Bevington</td>
<td></td>
<td>13%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>St Thomas’s</td>
<td></td>
<td>13%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Barlby</td>
<td></td>
<td>11%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>St Clement and St James</td>
<td></td>
<td>3%</td>
<td>20%</td>
<td>11%</td>
</tr>
<tr>
<td>Servite</td>
<td>South Kensington</td>
<td>8%</td>
<td>32%</td>
<td>20%</td>
</tr>
<tr>
<td>St Barnabas and St Philip’s</td>
<td></td>
<td>12%</td>
<td>24%</td>
<td>18%</td>
</tr>
<tr>
<td>St Cuthbert with St Matthias</td>
<td></td>
<td>10%</td>
<td>23%</td>
<td>16%</td>
</tr>
<tr>
<td>Bousfield</td>
<td></td>
<td>5%</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>Fox</td>
<td></td>
<td>6%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>St Mary Abbots</td>
<td></td>
<td>1%</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Our Lady of Victories</td>
<td></td>
<td>0%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>St Joseph</td>
<td>Chelsea</td>
<td><strong>19%</strong></td>
<td>27%</td>
<td><strong>23%</strong></td>
</tr>
<tr>
<td>Park Walk</td>
<td></td>
<td>16%</td>
<td>28%</td>
<td><strong>22%</strong></td>
</tr>
<tr>
<td>Marlborough</td>
<td></td>
<td>15%</td>
<td>29%</td>
<td><strong>21%</strong></td>
</tr>
<tr>
<td>Holy Trinity</td>
<td></td>
<td>15%</td>
<td>25%</td>
<td>19%</td>
</tr>
<tr>
<td>Ashburnham</td>
<td></td>
<td>9%</td>
<td>29%</td>
<td>19%</td>
</tr>
<tr>
<td>Oratory</td>
<td></td>
<td>6%</td>
<td>17%</td>
<td>11%</td>
</tr>
<tr>
<td>Christ Church</td>
<td></td>
<td>6%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Kensington and Chelsea</strong></td>
<td></td>
<td><strong>10%</strong></td>
<td><strong>22%</strong></td>
<td><strong>16%</strong></td>
</tr>
</tbody>
</table>

**Dark shaded cells** denote significantly HIGHER rates than the borough average

**Light shaded cells** denote significantly LOWER rates than the borough average

Unshaded cells are not significantly different from the borough average
7.7 The PCT believes that it is difficult to ascertain the real reasons for this variation, but suggests the following:
   a) small numbers – breaking the figures down by school, even when it is more than one year of data, means that the numbers will fluctuate by chance, and one extra obese child might result in a several percent shift;
   b) the characteristics of the school population – things like levels of poverty, ethnic mix, gender mix, and cultural mix all have an impact on levels of obesity. So, for example, schools with high numbers of white British and low free school meals are likely to have a lower rate;
   c) the approach of the school – provision of healthy food, lunchbox and other initiatives, exercise, education etc.

Recommendations 13-15

R13 In the light of the large variations in the rates of obesity within primary schools in the borough, the PCT should investigate (1) whether the lower rates of obesity in some schools are a product of more successful intervention strategies, and (2) consider targeting their resources on schools with the greatest need.

R14 Schools should inform parents about healthy eating principles of the school, to make sure that healthy food and lunch box initiatives are successful.

R15 The Council should encourage schools to share the results of pupil measurements with the governing bodies.

The MEND (Mind, Exercise, Nutrition . . . Do it!) Programme.

7.8 This is a 10-week community and family-based childhood obesity treatment programme for 8-12 year olds. It involves a 2 hour session twice a week. It incorporates nutrition, physical activity and behaviour change for parents and children. Parental involvement is compulsory.

7.9 The programme started in Kensington and Chelsea in October 2006. 63 families have so far completed it (71.5% completion rate). Results have shown an overall reduction in body mass index (BMI) and waist circumference, increase in activity and reduction in sedentary activity, and an increase in self-esteem. The challenge has been not only to recruit families to come on the programme and complete it, but to maintain the new pattern of behaviours.

7.10 A paediatric dietetic service was launched in April 2009. The service provides individual consultations for children from birth across a range of health problems including fussy eating, food and allergy intolerance and obesity.
Children can be referred to the service by a GP or healthcare professional. Outpatient clinics are held at health centres throughout the borough and home and school visits are available where required.

7.11 The Subgroup noted the success of the PCT’s MEND programme with primary school children and their parents. However, the Subgroup was concerned that children and families appeared to lose access to the programme after primary school, with post-primary school figures showing that rates of obesity are high, remaining high and not coming down.

**Recommendation 16**

*Given the success of the MEND programme in primary schools, the PCT should consider introducing similar programmes for older children in secondary schools, as well as introducing a programme for 2-4 year olds.*

8 **The Healthy Schools Programme**

8.1 The Subgroup heard that the principal tool for tackling obesity in schools is the Healthy Schools Programme, which has been running in its current form since 2006. Central to the Programme is the recognition that there is a link between health, behaviour and achievements. It aims to involve the whole school community in creating healthy and happy children and young people who do better in learning and in life.

8.2 The national target for Healthy Schools for December 2009 is 75% of schools having achieved Healthy Schools status and 100% of schools participating in the programme. Currently 26 (79%) of Kensington and Chelsea’s state schools have achieved Healthy Schools status and all 33 schools are participating in the programme.\(^{16}\)

8.3 Childhood obesity is addressed predominantly within two of the four core themes in the Programme: Healthy eating and Physical activity.

9 **Promoting healthy eating in schools**

9.1 The Subgroup heard that healthy eating contributes significantly to the “being healthy” national outcome for children. It requires pupils to have the confidence, skills and understanding to make healthy food choices, and for healthy and nutritious food and drink to be available across the school day.

9.2 Schools need to fulfil certain criteria on eating before they can achieve Healthy Schools status. These criteria include: the Senior Leadership Team to oversee all aspects of food in schools; a whole-school food policy based on the healthy eating criteria set by the National Healthy Schools Programme;

\(^{16}\) Source: Family and Children’s Services, RBKC, 2009
consultation with pupils and parents in guiding food practice and policy as well as food choices; a welcoming eating environment; the school meals service, vending machines, and breakfast clubs to meet the DCFS school food and nutritional standards (e.g. no fizzy drinks, confectionary and unhealthy snacks); availability of curriculum opportunities to learn about different types of food in the context of a balanced diet; and access to clean and palatable drinking water.

9.3 The Subgroup heard that a number of initiatives were in place in Kensington and Chelsea to promote healthy eating in schools. For example:

   a) every school has developed or is developing a whole-school food policy setting out the school ethos on food;
   b) 11 primary schools have completed the “Pack a Lunch” initiative aimed at increasing the healthy components of packed lunches;
   c) a Review of Breakfast and After-school clubs has taken place and an implementation plan is being developed;
   d) a “water in schools” project which was due to start in 2009;
   e) Food in Schools training to bring cooking back into the curriculum;
   f) Piloting 'Cook and Taste' sessions aimed at parents, to promote healthy eating on a budget.

9.4 A higher proportion of school children who are in receipt of free school meals are overweight/obese compared to those who do not receive free school meals. A relatively high proportion of children at Kensington and Chelsea schools are eligible for free school meals 17 – 33% in primary and 27% in secondary schools – twice the national average of 16% and 13% respectively. There is a high take-up of school means in both primary (66%) and secondary schools (51%) in Kensington and Chelsea, compared to national averages (41% primary and 38% secondary).

9.5 Taken together, these factors mean that the quality of school meals could be expected to play a role in combating childhood obesity in Kensington and Chelsea.

9.6 The Family and Children Services Scrutiny Committee carried out a review of the School Meal Service in March 2007. It found that there were various food and nutrient-based standards18 for school food which were coming into operation between September 2006 and 2009, and whilst the food standards were being achieved in Kensington and Chelsea schools, meeting the nutritional standards was expected to be more challenging.

---

17 The figures in this paragraph are for 2007 and taken from the Overview and Scrutiny Report: http://www.rbkc.gov.uk/HowWeGovern/overviewscrutiny/osc_school_meals.pdf

18 Food-based standards define the type of food that children should be offered and their frequency; while nutrition-based standards set out the proportion of nutrients that pupils should receive from a school lunch.
9.7 The Council manages the contract for 24 schools and charges £1.85 per meal. Charges for meals are above average but the specification for the meal is high, with all fruit and vegetables being organic, and a high spend on raw ingredients.

9.8 The Council’s contracts and procurement team provides a catering advice service to all schools and other services which need to meet the new standards, whether using the Council-managed catering contracts or not. This service funds a full-time dietician to analyse menus and recipes to ensure school meals meet nutritional standards and to monitor compliance to standardised recipes. However, the Subgroup heard that, due to budget issues, the nutrition and dietetic input into school meals ceased from June 2009; however, standards are being monitored through the usual contract monitoring arrangements.

9.9 The Subgroup heard that there was a lack of a dietician to work with secondary schools and the youth services; that it was difficult to access some schools and get “food in schools” on their busy agenda; that there were limited options for overweight or obese children and young people over 12 years of age; that we still faced the challenge of supporting schools which have “opted out” of the school meal contract, to meet the Government’s nutrient-based standards for school meals.

9.10 The Subgroup learnt that the local Healthy Schools Programme is in talks with local Sainsbury’s regarding sponsoring opportunities with schools, focusing on healthy eating, physical activities and oral health.

### Recommendations 17-18

**R17** The Council and the PCT should work together to:

(a) develop a joint business case to provide nutrition and physical activity advice to youth services and secondary schools;

(b) develop options for overweight and obese children over 12 years of age;

**R18** The Council should

(a) maintain the nutrition and dietetic input into school meals;

(d) develop a strategy for supporting schools which are opted out of the school meal contract, with nutritional and dietetic advice.
Recommendation 19

Schools should use only evidence-based nutrition resources. Marketing materials promoting unhealthy food or drink should not be allowed into schools and should be excluded as part of the Healthy School Programme criteria.

10 Promoting physical activities in schools

10.1 The School Sports Partnerships (SSP) aims to increase sports and physical activities opportunities for young people through co-ordinated physical education, school sport and out of school learning activities.

10.2 The SSP is the main vehicle for meeting the government target on participation in sports and physical activities. The target sets out that by 2010, all 15-16 year olds should undertake 5\[19\] hours of PE, school sports and physical activities a week, and 16-19 year olds undertake 3 hours a week. Since 2006, the SSP has increased the involvement of Royal Borough school pupils taking part in a minimum of 2 hours sporting activity per week from 50% to 92% of the school population. The national target is 90% and the borough target is 88%.

10.3 The Subgroup was given an example of partnership work undertaken as part of the SSP by the School Sports Partnership manager. A girls’ physical activity group at St Thomas More School was run as a joint project between the School Sports Partnership, Healthy Schools and the Youth Sports. A number of girls were identified at the beginning of an academic year as being physically inactive and disengaged with traditional sports. A ‘Girls Only’ group was set up to encourage morale and build up self-esteem and confidence. Students were educated about the health benefits of being physically active, and weight and height measurements were taken at the beginning and throughout the programme. The result of the intervention was that measurements had improved and some girls had moved to more “traditional” activities as their confidence improved.

\[19\] Government expectation is that only two of these hours need to form part of the curriculum; the rest can be delivered through extra-curricular activities.
Recommendation 20

The Council and the PCT should work with schools to look at the scope for:

(a) using the school curriculum to deliver more of the target 5 hours of physical activities a week. This could contribute toward the physical activity element of a school achieving Healthy School status. This initiative involves using pedometers and active lessons designed by the Youth Sport Trust, with a view to increasing children’s physical activity levels. This should not detract from the academic element of the school curriculum;

(b) developing an ethos that instils a love of sports and competition among young people;

(c) developing sports fixtures modelled on the independent schools sector;

(d) developing weekend fixtures to increase parental involvement;

(e) developing a borough-wide league.

Travel to school

10.4 The Subgroup heard that in 1975/76, over 65% of school journeys were made by bicycle or on foot, whilst car travel was under 12%. Thirty years later, walking and cycle use has declined to 47% of school journeys whilst car use has jumped to 32%. Regular physical activity is extremely important to young people to optimise fitness, develop an active lifestyle and reduce the risk of chronic diseases in adulthood.

10.5 A School Travel Plan (STP) is a working document created to address a school's particular travel and transport needs. It aims to steer the school community away from private car trips to and from school, and towards alternative forms of travel such as walking, cycling, use of public transport and car sharing. A Government capital grant is available to all local authority-funded schools that produce a STP, as well as giving access to other funding to support specific travel-related projects, such as practical pedestrian training or bicyclist training. A STP also helps to deliver Healthy Schools status.

10.6 All state schools in the borough have a School Travel Plan.

10.7 A school travel survey in 2008 showed that:

Details of this project can be found at: http://www.schoolsonthemove.co.uk/
• Walking to school falls from a peak of over 1700 pupils in the 8-10 age group to under 300 amongst 11-13 year olds and under 200 amongst 14-19 year olds, whilst the use of public transport rises significantly;

• Within primary schools, 60% of local authority school pupils walk and just over 20% are taken by car; the picture is very different for independent primary pupils where only 30% walk and nearly 40% are taken by car. 64% of pupils said that they would prefer to walk or cycle to school, as compared to 19% expressing a preference for travelling to/from school in a car;

• Barriers to sustainable travel to school were identified as being: road safety concerns, traffic congestion, school facilities, illegal parking, pavement conditions, and poor public transport.

10.8 The Royal Borough has been supporting local authority and independent schools to develop their School Travel Plans, and offers additional support in the form of cycle, scooter and pedestrian training for pupils, junior road safety officers, and “Bike it”. An earlier section of this report has commented on the positive views of the benefits of having a STP, expressed by most independent schools which responded to the survey.

10.9 The number of pupils given cycle training has increased from about 50 in 2005/06 to more than 500 in 2008/09. An example of the impact of School Travel Plans can be seen in Notting Hill Prep School, where the proportion of pupils travelling by car fell from 21% in 2005/06 to just 8% in 2008/09.

11 Promoting physical activities for children outside school

Play facilities for children in parks and playgrounds

11.1 The Subgroup heard from the Head of Extended Services, about the play projects that were being supported by Extended Services to tackle childhood obesity. These included:

11.2 The Play Pathfinder project aimed to create 28 new and improved play areas for children and to build one large new adventure playground at Little Wormwood Scrubs. Objectives of the project included providing good quality adventurous play for 5-14 year olds in all parts of the Royal Borough; increasing the number of children playing outside in local parks and playgrounds; and making play areas safer, more challenging and more accessible.

11.3 The Big Lottery Fund for Play funded 3 types of projects: Play Rangers to encourage children to play in a positive way and help reduce antisocial behaviour in play areas; funding to provide evening and weekend sessions in community play projects - 262 children accessed extended opening hours; Funding for Early Years drop-ins, to encourage families to play together and develop through play.

11.4 Other play projects included:
Report on Childhood Obesity

a) 15 Play Centres in the borough (1688 children attended in Summer 2008)
b) Holiday residential at Parkwood Hall and Mill on the Brue Outdoor Activity Centre in Somerset, attended by 160 children
c) 22 Breakfast Clubs
d) Lunchtime play activities in 7 schools
e) After-school sports provision
f) 5 community play and adventure playgrounds in the borough (568 children attended in summer 2008)
g) Play inclusion, providing activity sessions for children with disabilities.

Youth sports development the borough

11.5 The Subgroup heard from the Head of Services to Young People that the Royal Borough provided opportunities for a wide range of sports, including football, basketball, netball, cricket, fencing, archery, canoeing and kayaking and many others. Access to sport was available for seven days per week. Football was by far the most popular sport with young people.

11.6 The Borough’s Youth Sports Development Team (YSDT) was responsible for managing the borough’s sports facilities at the Canalside Activity Centre and the Cremorne Watersports Centre and for the direct coaching of athletes, as well as supporting and enabling local sports clubs. It also promoted young people’s acquisition of sports coaching qualifications.

11.7 The Subgroup was told by the borough’s Sports Development Manager about work that is underway to develop a co-ordinated approach to delivering community sports in the Royal Borough through the development of a Community Sports and Physical Activity Network (CSPAN). CSPAN brings together people and organisations involved in running sports and physical activities in the borough to increase participation in sports, engage private and public sector organisations working in this sector, pool resources across the sector, and widen access to opportunities for target groups 21. An important aim of CSPAN is to develop sports and physical activities clubs, coaches and volunteers.

11.8 So far, CSPAN has:

   a) Successfully accessed £550,000 of funding for its Recreation Education Active Community Health (REACH) programme that is directed at increasing participation in physical activity amongst the targets groups (see note below);

---

21 Target groups are: disabled people, BME communities, women and girls, people on low income, and people aged over 50.
b) Focused its REACH programme in particular wards in the borough: Golborne, St Charles, Notting Barns, Colville and Cremorne;

c) Obtained £21,500-a-year funding for three years from Sports England for its Sports Unlimited Programme, to run sessions aimed at attracting students who are not interested in alternative non-competitive sports. Activities take place outside school hours in a school or community setting.

Nuffield Health

11.9 Nuffield Health work in partnership with the Council to manage the Kensington Leisure Centre and the Chelsea Sports Centre (under the Courtneys brand). Free swimming is available to everyone 16 years and under. The Council’s Leisure pass offers eligible residents discounted use of both Leisure Centres, and selected community sports clubs receive discount in the Leisure Centre programme (subject to certain criteria).

Recommendation 21

Access to, and usage of, the sports facilities available to young people in the borough could be improved through:

(a) More effort being made to increase the number of sports volunteers in the borough from its current low base;

(b) More proactive promotion of the borough’s sports facilities;

(c) Taking into account the need to tackle obesity when planning applications for new sports provision are made;

(d) Doing more to inform residents about the availability of sports facilities in neighbouring boroughs;

(e) Providing individual support to the most obese children to take part in physical activities, involving parents, schools and family support workers;

(f) Improving the advertising for physical activities on the notice boards in Holland Park, Sports Centres, Memorial Garden, Little Wormwood Scrubs, and St Luke’s Gardens, and promoting them through the Tenant Management Organisation and Registered Social Landlords’ communication to tenants;

(g) Investigating the scope for making better use of neighbouring boroughs’ open spaces and physical activity facilities, for example through advertising other Councils’ facilities which are on our border within our own publications;
Investigating the possibility of giving free access to local leisure/sporting facilities during term time to schools which have no access, or limited access, to playing fields.

12 Working with black and minority ethnic communities

12.1 Prevalence of obesity is higher in:

- Black African and Black Caribbean boys and girls and amongst Pakistani boys than the general population;
- Asian children by a factor of four compared to white children.

12.2 Given the above information, the Subgroup was particularly interested in finding out what was being done to target these communities to reduce childhood obesity.

Early Years

12.3 In her evidence, the Head of Early Years said that the service targeted black and ethnic minority communities through:

a) working with Children’s Centres, which are mainly located in areas of social deprivation and where black and minority ethnic communities are present in higher numbers, to achieve the Healthy Eating Awards (HEA);

b) helping nurseries improve food in their settings through the HEA. 87% of nurseries within the UK are located in areas of deprivation (and therefore commonly target BME families). Even if this rate is slightly lower in a borough such as Kensington and Chelsea, it is still likely to be above 50%;

c) working with Health Visitors that target different BME groups – to support them through training;

d) working with the ‘Cool Kids Use Cups’ campaign, which particularly targeted BME groups. Initially such groups were targeted as part of a number of focus groups run within the borough to determine baseline knowledge and practices. Different BME groups have since been involved in reviews to ensure resources are targeted correctly towards the right audience. The intervention and education process will involve more BME groups through education sessions. These will be accessed through the ‘Cook and Taste’ programme, mother and baby groups and single-mother hostels throughout the borough;

e) a large proportion of the work of the ‘Blue Team’ of midwives in North Kensington is focused on the disadvantaged population of the Golborne ward, which is predominantly Arabic or Somali speaking. The ‘Blue Team’ are midwives who are focused on supporting highly vulnerable mothers throughout their pregnancy and until the baby is 4 weeks’ old.
**Schools**

12.4 All childhood obesity prevention initiatives (for nutrition) target those schools with the highest childhood obesity levels - which are also schools with high proportion of BME pupils.

12.5 Other factors considered when prioritising preventative work in schools include the percentage of pupils with free school meals entitlement. Children eligible for free school meals are around 20% more likely to be obese than those not eligible.

**The PCT**

12.6 The PCT has increased its ethnic reporting in all services so that it has better information about our BME families to ensure that it uses interpreters to facilitate effective communication.

12.7 The Subgroup noted that work was being undertaken in areas with high BME populations, but did not see specific evidence as to:

- How messages on childhood obesity and services to combat childhood obesity were being adapted to meet the requirements of different ethnic groups in the borough;
- How the impact of any intervention in reducing the higher incidence of childhood obesity amongst certain BME groups would be evaluated.

**Recommendation 22:**

The Council and PCT should be asked to report in 12 months' time on:

(a) How messages on childhood obesity and services to combat childhood obesity are being adapted to meet the specific requirements of different ethnic groups in the borough;

(b) How the impact of any intervention in reducing the higher incidence of childhood obesity amongst certain BME groups would be evaluated.

**13 Role of Planning in combating childhood obesity**

**Childhood obesity and the Local Development Framework**

13.1 The Subgroup heard evidence from a Planning Policy Officer about how the 20-year vision of the Royal Borough’s Local Development Framework Core Strategy supports active lifestyles, for example, through removing barriers which impeded walking and cycling. Research for the Core Strategy has identified that nearly 80% of the borough is within walking distance of schools and convenience retail outlets, and the Council is seeking to build this into its Core Strategy. Policies also actively aim to improve connectivity between existing routes for pedestrians and cyclists to make these activities a more enjoyable option. Protection of youth and sports facilities as a community
resource, and supporting the development of play spaces by Extended Services, were important components of the Core Strategy.

**Recommendation 23**
The Council should investigate the desirability of opening up for school use the all-purpose sports courts in the Delgarno area.

**Recommendation 24**
The PCT and the Council should work with partners in the voluntary and private sector to:
(a) Eliminate the sale of junk food and drink from vending machines in all public buildings and replace them with low-GI foods;  
(b) Ensure that all new public buildings incorporate showers and changing facilities to encourage staff to walk/cycle to work;  
(c) Link tackling obesity to the other health promotion work (e.g. Local Area Agreement healthy schools programme and oral health promotion) directed towards children.

**Restricting hot takeaway shops near schools**
13.2 The Subgroup heard that in response to residents’ concerns, L.B. Waltham Forest have adopted a policy to restrict the number of hot food takeaway shops in the borough. The Council has tightened the rules on all planning applications for hot food takeaway shops in the borough. A Supplementary Planning Document was adopted by L.B. Waltham Forest in March 2009 which seeks to:

  a) Prevent high concentrations and clusters of takeaways  
  b) Prevent them locating near schools, youth facilities, parks and residential areas  
  c) Resist proposals that would cause unacceptable risk of crime and antisocial behaviour  
  d) Ensure they don't have an unacceptable impact on road safety  
  e) Ensure they have good systems in place to deal with smells and waste

13.3 Members of the Subgroup were interested in investigating the feasibility of such a policy in the Royal Borough. The Subgroup was advised by a senior planning officer that the Waltham Forest approach did not apply to existing

---

22 GI stands for Glycemic Index and is a measure of the impact of food on blood sugar. Foods with a high GI tend to quickly raise the body's blood sugar levels, by contrast foods with a low GI will raise them more slowly and over a longer period.
A5\textsuperscript{23} units; it largely repeated guidance that RBKC already had on hours of operations, residential amenity, clustering etc; the Royal Borough already resisted a number of such applications on the above grounds; there was some debate as to whether the Waltham Forest approach would stand a legal challenge.

13.4 The Subgroup agreed that the Waltham Forest approach would not be a suitable way forward for the Royal Borough.

\textsuperscript{23} Refers to hot food takeaway establishments
Full list of recommendations

A Strategic Approach

R1 The PCT should report progress on the development of its obesity strategy and on the timescale for its full implementation.

R2 The PCT and the Council should jointly identify a senior lead officer to co-ordinate action to combat childhood obesity across all sectors in the borough.

The Early Years

R3 The PCT should investigate whether the drop in breastfeeding over the 6-8 weeks period after birth occurs evenly across all socio-demographic groups and if not, to target any intervention at groups which are at the greatest risk of dropping off.

R4 The PCT and the Council should work with their partners in the voluntary and private sectors to promote baby feeding environments in community settings such as cafes, shops, leisure centres, libraries etc.

R5 The PCT should involve GPs to proactively target families with children at the greatest risk of obesity. For instance, where school nurses know of families where both parents are obese, they should be able to make direct referrals to GPs, who should invite such families for consultation.

R6 The PCT should work with local GPs to examine and address their training needs in the area of childhood obesity, improve the availability of information to local GPs on local sources of expertise in childhood obesity, and develop an appropriate referral strategy with local GPs and other professionals.

R7 Mothers and fathers with babies should be given reduced or free access to baby-specific activities at leisure centres in the borough, including swimming;

R8 The PCT and the Council should ensure that there is sufficient training of midwives, health visitors and Children’s Centre staff so they are fully able to promote basic dietetics and the benefits of activity to parents;

R9 There should be more venues and opportunities to support parents to learn to cook for their children and learn about healthy eating at the same time (Jamie Oliver-style cascading of good skills learning and disseminating to other parents);
R10 Council and PCT staff working with parents who are overweight and who have potentially overweight babies and children should themselves act as good role models about healthy eating and exercise;

R11 The PCT should consider introducing height and weight measurements for 2-2½ year olds to enable early identification of health problems.

Schools

R12 The Council may wish to use the overwhelmingly positive feedback from those independent schools which have School Travel Plans about the benefits it brought them - increased walking and cycling, less traffic etc - to promote this approach to those independent schools which do not yet have a School Travel Plan.

R13 In the light of the large variations in the rates of obesity within primary schools in the borough, the PCT should investigate (1) whether the lower rates of obesity in some schools are a product of more successful intervention strategies, and (2) consider targeting their resources on schools with the greatest need.

R14 Schools should inform parents about healthy eating principles of the school, to make sure that healthy food and lunch box initiatives are successful.

R15 The Council should encourage schools to share the results of pupil measurements with the governing bodies.

R16 Given the success of the MEND programme in primary schools, the PCT should consider introducing similar programmes for older children in secondary schools, as well as introducing a programme for 2-4 year olds.

R17 The Council and the PCT should work together to:
   (a) develop a joint business case to provide nutrition and physical activity advice to youth services and secondary schools;
   (b) develop options for overweight and obese children over 12 years of age;

R18 The Council should:
   (a) maintain the nutrition and dietetic input into school meals;
   (d) develop a strategy for supporting schools which are opted out of the school meal contract, with nutritional and dietetic advice.
R19 Schools should use only evidence-based nutrition resources. Marketing materials promoting unhealthy food or drink should not be allowed into schools and should be excluded as part of the Healthy School Programme criteria.

R20 The Council and the PCT should work with schools to look at the scope for:
   a) using the school curriculum to deliver more of the target 5 hours of physical activities a week. This could contribute toward the physical activity element of a school achieving Healthy School Status. This initiative involves using pedometers and active lessons designed by the Youth Sport Trust, with a view to increasing children’s physical activity levels. This should not detract from the academic element of the school curriculum;
   b) developing an ethos that instils a love of sports and competition among young people;
   c) developing sports fixtures modelled on the independent schools sector;
   d) developing weekend fixtures to increase parental involvement;
   e) developing a borough-wide league.

Physical activities outside schools

R21 Access to, and usage of, the sports facilities available to young people in the borough could be improved through:
   a) More effort being made to increase the number of sports volunteers in the borough from its current low base;
   b) More proactive promotion of the borough’s sports facilities;
   c) Taking into account the need to tackle obesity when planning applications for new sports provision are made;
   d) Doing more to inform residents about the availability of sports facilities in neighbouring boroughs;
   e) providing individual support to the most obese children to take part in physical activities, involving parents, schools and family support workers;
   f) Improving the advertising on the notice boards for physical activities in Holland Park, Sports Centres, Memorial Garden, Little Wormwood Scrubs, and St Luke’s Gardens, and promoting them through the Tenant Management Organisation and Registered Social Landlords’ communications to tenants;
   g) Investigating the scope for making better use of neighbouring boroughs’ open spaces and physical activity facilities, for example through advertising other Councils’ facilities which are on our border within our own publications;

24 Details of this project can be found at: http://www.schoolsonthemove.co.uk
h) Investigating the possibility of giving free access to local leisure/sporting facilities during term time to schools which have no access, or limited access, to playing fields.

R22 The Council and PCT should be asked to report in 12 months’ time on:

(a) How messages on childhood obesity and services to combat childhood obesity are being adapted to meet the specific requirements of different ethnic groups in the borough;

(b) How the impact of any intervention in reducing the higher incidence of childhood obesity amongst certain BME groups would be evaluated.

R23 The Council should investigate the desirability of opening up for school use the all-purpose sports courts in the Delgarno area.

R24 The PCT and the Council should work with partners in the voluntary and private sector to

• eliminate the sale of junk food and drink from vending machines in all public buildings and replace them with low GI foods;
• Ensure that all new public buildings incorporate showers and changing facilities to encourage staff to walk/cycle to work.
• Link tackling obesity to the other health promotion work (e.g. LAA, healthy schools programme and oral health promotion) directed towards children.
Appendix 2

Terms of Reference of the Childhood Obesity Review

The Review will address the following issues

a. Gain an understanding of the prevalence of and trends in childhood obesity in the borough; the relative importance of the different factors that contribute to childhood obesity; which of these factors are open to influence via policy and service interventions in the short and long term; consequence of childhood obesity and failure to take action.

b. What are the ambitions of the Council, the PCT and other organizations to reduce childhood obesity; What role are Children’s Trusts and schools playing in this area? Is there a difference in approach between public and private schools in how childhood obesity is tackled?

c. What is currently being done in the borough to reduce childhood obesity; which interventions are the most effective and in what context; which organisations are involved in delivering these interventions? How effective have they been? How well are organizations working together? How effectively are healthcare professionals working with parents and schools to achieve healthier eating habits amongst children?

d. What has been the experience of other authorities in this area, examples of good practice; What more could be done or could be done differently to tackle childhood obesity in the Royal Borough.