



Tackling Childhood Obesity in Birmingham

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By Anuji Varma | Comments | 17 Dec 2012 07:52

Kebabs shops on every corner: How Birmingham is struggling to fight childhood obesity

Head teachers in Birmingham have been given the power to help combat takeaways opening near their schools in a bid to ease the growing problem of childhood obesity. **Anuji Varma** looks at the near-epidemic in hot food shops near city schools.





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Preface

By Councillor Susan Barnett

Chair of the Health and Social Care Overview & Scrutiny Committee



I would like to thank the members of the Health and Social Care Overview & Scrutiny Committee and everyone who contributed to the Inquiry for the time and effort involved in carrying out this very important piece of work.

I would also like to say thank you to the officers, Rose Kiely and Saadia Ahmed, who supported the work of the Inquiry.

The World Health Organisation regards childhood obesity as one of the most serious global public health challenges for this century. We heard that 24.4% of Birmingham children are overweight or obese when they start school and this rises to 40.0% by the time they leave primary school. Current obesity prevalence is 12.0% at reception (age 4-5 years) and 24.4% at year 6 (age 10-11years).

The early years are critical in determining whether obesity in childhood will have a longer term impact into adulthood. The risk of developing Type 2 diabetes and various other health problems is far greater for children who are obese. This results in more frequent medical care and increased school illness absence compared to children with a normal weight.

The approach taken by the Committee was to focus on what is being done to tackle childhood obesity in Birmingham. We wanted to gain an understanding of the scale of the problem and to explore how the Birmingham Health and Wellbeing Board's Strategy on Childhood Obesity is being implemented across the city.

The Inquiry has therefore focussed on the priorities, actions and range of partners involved in the strategy with a view to gaining a better understanding of how the implementation of the strategy is likely to reduce the number of obese children in the city.

Councillor Susan Barnett



Summary of Recommendations

	Recommendation	Responsibility	Completion Date
R01	That letters be sent to: (a) the Secretary of State for Health to lobby for a stronger UK wide response towards childhood obesity with particular reference to addressing the food industry and producers, the role of education and schools and in relation to strengthening planning policy with a view to giving stronger planning powers to local Councils to enable them to deal more effectively with the proliferation of hot food takeaways; (b) the Secretary of State for Communities and Local Government to lobby for a change in policy guidance which would allow planning applications for inappropriate schemes to be refused on health grounds; and (c) Birmingham MPs to ask them to campaign in the House of Commons and lobby the Secretary of State for Health in relation to these issues.	Cabinet Member for Health and Wellbeing Chair of Health and Social Care Overview and Scrutiny Committee	September 2014
R02	That the Chair of the Education and Vulnerable Children Overview and Scrutiny Committee meet with the Chair of the Birmingham Educational Partnership to explore how the recommendations of the Health and Social Care Overview & Scrutiny Committee can be supported by the School Food Plan 2013 and also to develop more systematic engagement with all schools including free schools and academies on school food standards, healthy lifestyle options such as increasing walking and other healthy eating initiatives commissioned by Public Health.	Chair of Education and Vulnerable Children Overview and Scrutiny Committee	September 2014
R03	That the Chair of the Education and Vulnerable Children Overview and Scrutiny Committee meets with the Chair of the Birmingham Governors Network to ensure that governors: (a) are systematically engaged and well informed in relation to the resourcing and funding decisions needed to support initiatives	Chair of Education and Vulnerable Children Overview and Scrutiny Committee	September 2014



	to tackle childhood obesity; and (b) are aware that they have the power to object to planning applications especially in relation to proposed hot food takeaways near schools and of the appropriate planning grounds they should consider whilst recognising that an objection in itself does not necessarily lead to refusal; and (c) understand their responsibility as school governors around meeting the school food guidelines.		
R04	That the approach described by Birmingham Children's Hospital (BCH) as a stakeholder in the wider health and wellbeing of children and in starting to build a wider commitment by provider trusts to contribute to the public health agenda including the possibility of establishing a health promoting network for hospitals in Birmingham be supported and that BCH be requested to update the Health and Social Care Overview and Scrutiny Committee on progress.	Birmingham Children's Hospital Consultant in Public Health Medicine	April 2015
R05	That through the Childhood Obesity Care Pathway, a children's service offer is developed which includes diet and behaviour, as well as physical activity, and that all services have the flexibility to offer family based interventions if appropriate.	Birmingham South Central, Birmingham Cross City and Sandwell and West Birmingham Clinical Commissioning Groups	April 2015
R06	That the Health and Wellbeing Board through the Third Sector Assembly and the three Birmingham Clinical Commissioning Groups examine the best way to develop stronger strategic links between GPs and the Third Sector which may have the potential to facilitate further and better engagement with, and delivery of the childhood obesity agenda.	Cabinet Member for Health and Wellbeing as Chair of Health and Wellbeing Board	April 2015
R07	That the Street Trading Consultation Process be amended to include the Director of Public Health as a consultee where Street Trading Consents are being sought for food outlets so that any representation made by the Director of Public Health can be taken into consideration before any decision is made.	Director of Regulation and Enforcement with Cabinet Member for Health and Wellbeing as Chair of Health and Wellbeing Board	April 2015
R08	That the Planning Committee start discussions with a view to adopting a policy development approach which commits to design out the obesogenic environment by following a	Chair of the Planning Committee	April 2015



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	process similar to the one that was followed when putting together Birmingham's Green Commission. Through this approach an environment can be designed that encourages physical activity, active travel and healthy lifestyle choices.		
R09	That the Partnerships, Engagement and Communication Group, as an integral part of their work on developing and implementing a communications strategy, establish what advertising the Council and other stakeholders have control or influence over with a view to using this influence to promote healthy eating and physical activity.	Cabinet Member for Health and Wellbeing	April 2015
R10	That an assessment of progress against the recommendations and suggestions made in this report should be presented to the Health and Social Care Overview and Scrutiny Committee.	Cabinet Member for Health and Wellbeing	October 2014



1 Introduction

1.1 What is the problem?

- 1.1.1 The World Health Organisation regards childhood obesity as one of the most serious global public health challenges for the 21st century. There is a plethora of information available which demonstrates the increasing prevalence of childhood obesity both nationally and in Birmingham.
- 1.1.2 The Childhood Obesity Joint Strategic Needs Assessment (JSNA) which forms part of the Birmingham JSNA and provides the evidence base to inform the Health and Wellbeing Board's Childhood Obesity Strategy, describes the problem. It sets out data which shows that the prevalence of childhood obesity in the city has been increasing in recent years with a growing gap between Birmingham and the national average.
- 1.1.3 Successive cohorts of children have been measured from the 2006/7 school year at reception (age 4-5 years) and at year 6 (age 10-11 years) as part of the National Child Measurement Programme (NCMP). Although the headline figure for 2012/13 for Birmingham appears to show a slight improvement from 2011/12, there isn't enough evidence yet to show whether or not this change is statistically significant. Whatever the reason for the variation in 2012/13, one in four of Birmingham's children are currently obese which has significant implications for the physical and mental health of our children and young people.

Current **obesity** prevalence is 12.0% at reception and 24.4% at year 6

In terms of **overweight or obese**, 24.4% of Birmingham children are overweight or obese when they start school and this rises to 40.0% by the time they leave primary school.

Obesity prevalence is higher among boys than girls and is highest in Asian and Black groups at both reception and year 6.

Obesity shows a strong correlation with deprivation.

Birmingham has the 306th highest rate of obesity at reception in England out of 324 Local Authorities and the 311th highest rate of obesity at year 6 in England out of 324 Local Authorities.¹

- 1.1.4 The early years are also critical in determining whether obesity in childhood will have a longer term impact carrying through into adulthood. Obese children are at increased risk of developing various health problems and are more likely to become obese adults. The evidence does suggest

¹ Birmingham Childhood Obesity – Joint Strategic Needs Assessment



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that the rising rates of childhood obesity can be tackled successfully but achieving this will not be easy and it will undoubtedly take some time to halt and then reverse the rising trend.

- 1.1.5 The transfer of public health to the local authority has created an opportunity to provide the strong political and strategic leadership needed but tackling the problem will also require a range of approaches and interventions which need to be universal, as we have a citywide problem, and need to start early in life, when eating and activity patterns and preferences are being established.

1.2 What are the causes?

- 1.2.1 The causes of childhood obesity are complex, difficult to address and driven by a variety of factors such as changes in eating habits including the increased use of convenience food, more food being eaten outside the home and less food being cooked at home and a reduction in time and skills to prepare meals.
- 1.2.2 At the same time there has been a reduction in activity levels due to a number of reasons. A number of initiatives have been developed as part of the Be Active offer, which recognise the need to target solutions at families and to engage both families and communities in sport and physical activity (See Section 6).
- 1.2.3 The factors driving the epidemic of childhood obesity can be divided into three categories:
- The environment encourages low physical effort and the fact that we have allowed unhealthy food options to proliferate at the expense of healthier options, especially near schools.
 - We have adopted behaviour that complements our environment especially in relation to the foods we eat.
 - We have developed few opportunities and provided limited encouragement for children to undertake enjoyable and appealing physical exercise or enjoy healthy food options, especially early in life.

1.3 Impact of unhealthy weight on child and adolescent health

- 1.3.1 Members were told in evidence from Birmingham Children's Hospital that:
- Obese children have worse health, require more frequent medical care and have increased school illness absence compared to children with a normal weight.
 - Although Type 2 diabetes usually presents in adulthood, we now see small but increasing presentations in children, of whom 95% are overweight (and 83% are obese).
 - There is a growing evidence base that asthma and the severity of asthma are causally associated with BMI increase, particularly in early years.



- Obesity not only contributes to adult cardiovascular (heart and vessels) risk, but also causes damage through childhood.
- There is evidence of impact of obesity on muscle and bone conditions, including pain, activity restriction and quality of life.
- There is some contribution of obesity to depression and low self-esteem, particularly in adolescence and also behavioural problems.

1.4 What are we doing about it?

- 1.4.1 There are no easy answers. Tackling it will require strong strategic leadership, a co-ordinated response across a multitude of organisations, appropriate use of resources, support from businesses and communities and considerable effort on the part of all partners involved.
- 1.4.2 The Birmingham Health and Wellbeing Board, which brings together political and strategic leadership from Birmingham City Council, Clinical Commissioning Groups, the NHS, Healthwatch and the voluntary sector, have made a good start by making it a priority to reduce childhood **overweight and obesity** within 5 years. They have set ambitious targets to reduce the percentage of Birmingham children classified as overweight or obese in 4-5 year olds from 24.4% to 22.6% and 10-11 year olds from 40% to 33.9% by 2018.²

1.5 National Context

- 1.5.1 Any actions taken by Birmingham need to be set in the context of the national picture as evidenced by the NCMP data. The National Obesity Observatory uses the NCMP data to examine the changes in children's body mass index that have taken place since 2006/7 to investigate and monitor trends in the NCMP data. This includes examining changes in obesity prevalence in different socioeconomic and ethnic groups in order to support the most effective possible action to tackle obesity.
- 1.5.2 The data³ shows that nationally:
- Although in relation to changes in prevalence of obesity for boys in reception there is evidence of a downward trend over the period covered by NCMP and there is no statistically significant trend for girls in reception, the data shows a significant upwards trend for both boys and girls in year 6 between 2007/08 and 2011/12.
 - Socioeconomic inequalities appear to be widening for both boys and girls in both reception and year 6. This is so especially for boys and girls in year 6 where obesity

² Birmingham's Childhood Obesity Strategy

³ National Obesity Observatory, NCMP: Changes in children's BMI between 2006/07 and 2011/12



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prevalence is increasing in the most deprived areas. The increases are statistically significant in year 6 for boys and girls living in the most deprived 50% of areas.

- Changes in obesity prevalence by ethnic group show that although white British boys in reception have seen a significant decrease between 2007/08 and 2011/12, at year 6 since 2007/08 the trend among boys from White British and Black African ethnic groups shows a significant increase and since 2007/08 the trend among girls from White British, Bangladeshi, Pakistani and Other Asian ethnic groups shows a significant increase.

1.5.3 Although considerable action aimed at the prevention or management of obesity is being taken at both a national and a local level, addressing this issue effectively will need a stronger UK wide response. This is the case particularly in relation to issues such as bringing influence to bear on the food industry and food producers about the amount of sugar and salt in food and about education on healthy choices in all schools including free schools and academies which are not obliged to adhere to school food standards.

1.5.4 Local authorities are already doing what they can within the limited planning powers available to them, on issues such as restricting and reducing the proliferation in the growth of fast food outlets, but it would seem that there is a limited amount that can be done within the existing powers about the huge numbers of hot food takeaways which are already in existence. Local authorities need to bring pressure to bear on national government to change planning policies to make them more sympathetic to the objectives of the childhood obesity strategy and to give local authorities the power to instigate stronger measures to restrict the proliferation in the growth of fast food outlets. (R01)

1.6 Birmingham Childhood Obesity Strategy

1.6.1 Following the confirmation of childhood obesity as one of 10 priorities in Birmingham's Health and Wellbeing Strategy, a partnership approach was taken to the development of the strategy. The Obesity Partnerships, Engagement and Communication Delivery Group organised a number of engagement events at which senior leaders, parents and young people across the city were invited to give their views on the emerging Childhood Obesity Strategy. During these sessions participants supported the proposed draft strategy and highlighted the need to change the environment, provide more opportunities for healthy lifestyles and support individuals to change behaviour.

1.6.2 The Childhood Obesity Strategy sets out to tackle the three main factors driving the increase, which are environment, behaviour and opportunity (see 1.2.3). This approach has informed the model of childhood obesity prevention set out in the strategy which outlines immediate and longer term priorities to tackle the issue.

1.6.3 The implementation of the strategy will be overseen by the Childhood Obesity Steering Group which is chaired by Dr Andrew Coward, Chair of Birmingham South Central Clinical Commissioning Group and member of the Health and Wellbeing Board, who provides strategic leadership for



childhood obesity with the support of Dr Adrian Phillips, the Director of Public Health. Four working groups have been established which have different priorities aimed at implementing the strategy and supporting the development of joint working arrangements between key partners. These groups report on progress to the Childhood Obesity Steering Group.

1.6.4 The working groups are as follows:

- The Schools and Early Years Obesity Group. Their priorities include connecting with schools and early years settings, developing a tool to allow schools and early years settings to demonstrate their contribution, supporting an increase in walking and cycling to schools and supporting the implementation of behaviour change intervention;
- The Obesogenic Environment Delivery Group which has the remit of reviewing policy options to reduce childhood obesity, developing an action plan, supporting an increase in walking and cycling to school and supporting access to healthy food;
- The Obesity Partnerships, Engagement and Communications Group, which is developing and implementing a communications strategy for the public and partner organisations to communicate the ambition, plans and opportunities available with the aim of changing attitudes and culture. They also have responsibility for obtaining ongoing feedback and input from children, parents and partner organisations and overseeing engagement events to maintain momentum; and
- The Food and Physical Activity Opportunities Group, which aims to understand what is currently available and to promote and increase opportunities for families to make healthy food choices and to engage in physical activity.

1.7 Other work underway: The Birmingham Food Charter

- 1.7.1 Tackling childhood obesity in the city will require a radical shift in attitudes to food. Work is already currently underway to refresh quality marks promoting healthy choices.
- 1.7.2 A mapping exercise on what work is currently in progress around food and physical activity is also currently being undertaken in order to try to ensure that the work is properly co-ordinated and to avoid duplication as far as possible.
- 1.7.3 Against this background, Birmingham is currently in the early stages of developing a Food Charter which will complement and support the Childhood Obesity Strategy. The Food Charter is a high level statement of a vision with key priorities to deliver that vision. The first priority to deliver the vision is around our children. The aims are to ensure that all Birmingham children leave school with a good knowledge of where food comes from and what a healthy diet is, are able to prepare a variety of healthy meals and have experience of growing food and to take action to halt the growth in childhood obesity and then reduce it.



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- 1.7.4 The Food Charter aims to transform the city's food culture with aspirations to take account of health, low income, sustainability, social and community cohesion and to maximise the contribution of food to the local economy. By signing up to the Charter, organisations which operate in the city will be demonstrating their support for that vision and agreeing to work together to make the vision a reality. The Charter is still currently in a draft form but it has been agreed that an independent, legally constituted Food Council will be set up to oversee the implementation of the Food Charter and it is hoped that the Food Council will be in place in the near future.

1.8 The approach taken by the Inquiry

- 1.8.1 We already know from the extensive work that has been carried out to inform the JSNA that we have a problem and what the scale of the problem is, so the approach taken by the Inquiry was to focus on what is being done to tackle childhood obesity in Birmingham. The Members wanted to gain an understanding of the scale of the problem and to explore how the City Council's Strategy on Childhood Obesity is being implemented across the city.
- 1.8.2 The Inquiry has therefore focussed on the priorities, actions, targets and range of partners involved in the strategy with a view to gaining a better understanding of how its implementation is likely to reduce the number of obese children in the city. The Inquiry also provides an opportunity to highlight and share good practice and to explore as far as possible whether all the relevant partners are involved appropriately.
- 1.8.3 The aim was to provide a set of recommendations focusing on prevention which highlight any gaps, establish how the strategy is being monitored and to provide appropriate challenge if there are areas where the conclusion is that an even more radical approach is required.

2 Working with Schools

2.1 Promoting healthy lifestyles and behaviours

- 2.1.1 Schools provide a key forum for children and young people to learn about healthy behaviours and to bring about real change in promoting healthy lifestyles. They engage in a wide range of activities which play an important role in providing opportunities for and encouraging children to develop life-long healthy eating habits and physical activity levels.
- 2.1.2 Members heard about examples of some innovative activities happening in schools which were referred to in evidence including taster sessions, food promotions, parent and child cooking sessions, parents attending at lunchtimes, recipe distribution, lunchbox training and monitoring, promoting of cycling, walking buses, a range of out-of-hours physical activity clubs, growing vegetables and developing allotments, providing a suitable lunchtime environment and appropriate



standards of behaviour during lunchtime. The engagement of parents in educational initiatives encouraging and promoting healthy lifestyle choices is a key factor in their success or otherwise. Food Net offer a range of support to schools, some of which are set out in paragraph 3.3.2.

- 2.1.3 NICE (National Institute for Health and Care Excellence) guidance says that head teachers and chairs of governors should ensure that teaching, support and catering staff receive training on the importance of healthy-school policies and how to support their implementation. Reference was made in evidence to performance management targets for lunchtime supervisors to encourage children to choose a healthy option and about the possibility of introducing a reward system to enable them to better understand their role in encouraging children to make healthy choices.

2.2 A changing landscape

- 2.2.1 Some aspects of the changing landscape for schools, such as the removal of funding or ring-fenced funding for School Sports Partnerships, the National Healthy School Programme and the removal of the requirement for 2 hours physical activity in the curriculum, have undoubtedly presented a challenge for schools. The demise of School Sports Partnerships has resulted in an inconsistent provision across the city but, in spite of this, there remains a strong culture of out-of-hours physical activity provision which is mostly self-funded by the schools.
- 2.2.2 Many schools still focus on healthy eating and maintain initiatives such as parents sessions, taster sessions and free breakfast clubs or breakfast clubs at a minimal cost. The majority of schools have an on-going commitment to health and the majority of schools have continued with 'healthy school' activities and see such programmes as both productive and important. Members visited Highters Heath Community School in Kings Heath where they were able to engage with a parent and child cookery session and Lyndon Green Infants School where they were able to see some of the work that is happening in the school first hand, as noted in paragraph 2.4.2.
- 2.2.3 There are some changes happening in schools which are to be welcomed and which should help to support healthy school activities. It is encouraging that cooking will be included in the curriculum from 2014 and the availability of sports premium funding and pupil premium funding, are to be welcomed and should help to support healthy school activities. Birmingham will receive over £3 million in sports premium funding per annum for academic years 2013 to 2014 and 2014 to 2015 to improve the provision of physical education and sports in primary schools and Birmingham Sport and Physical Activity Partnership has the role of helping primary schools link up with local clubs, sports coaches and the national sporting governing bodies.

2.3 School Food Plan 2014

- 2.3.1 In September 2013 the Government announced that it intends to fund universal free school meals from September 2014 for every child in reception, year 1 and year 2 in state funded schools. The aim of this initiative is to improve academic attainment and save families money on the basis that,



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over the course of a year, the average family spends £437 on school lunches per child. As part of the Government's Autumn Statement, it was reported that funding of £450m in 2014-15 and £635m in 2015-16 would be made available to the Department of Education to fund this commitment. In addition, £150m of capital funding would be pledged to ensure that schools can build new kitchens or increase dining capacity where necessary.

- 2.3.2 The current take up of primary school meals in England is **46.3%**. The current primary school meal statistics show that the take up of primary school meals in Birmingham (Direct Services Schools where Cityserve operate, which is c 87% of the Birmingham schools market) is **49.5%** (83% free meal take up and 36% paid meal take up).

Members were told that, based on current figures of pupils in Key Stage (KS) 1 and assuming that all eligible pupils at KS1 take up their free meal, there could be demand for an additional 14,000 meals daily across Cityserve schools which equates to an average of around 62 meals per day per school. However, this is an average and given that there are currently wide variations in take up, similar variations in increase in uptake are to be expected.

Opportunities

- 2.3.3 The provision of a free midday meal each school day to all KS1 pupils provides an opportunity to reach more pupils with targeted initiatives to promote healthy eating. The aims will be to:
- Increase the take up of all school meals initially across KS1 and incrementally across all pupils. (The vision in the School Food Plan is to eventually achieve a 70% uptake).
 - Use the opportunity of more pupils eating at school to introduce a wide variety of foods and also interventions and guidance for healthy eating.
 - Promote a good food culture and assist pupils in developing social skills and reinforce positive behaviour and the development of life long healthy eating habits.
 - Make the catering provision more financially viable for schools due to increased economies of scale.
 - Increase opportunities for jobs for local people due to a higher demand for the service.
 - Increase consumption of fruit and vegetables and healthier items / dishes by pupils.

Challenges

- Capacity of production kitchens to produce meals and a requirement for additional or upgraded equipment.
- Limited capacity of dining rooms and the need for additional space or dining room furniture.
- Length of lunch breaks to ensure adequate time for all pupils to eat.
- Cost of additional crockery, cutlery and light equipment.



- Cost of additional conveyed meal equipment where schools do not have their own production kitchens. (There are 46 schools currently receiving meals from another school)
- Need to ensure positive marketing of school meals to maximise take up.
- Need to prepare for possible increased demand for special diets.
- Need to ensure that the menus and food offerings are popular and have a positive effect in increasing take up.

2.4 Sharing good practice

2.4.1 Members were told about the Healthy Schools Programme, under which 98% of schools engaged in a voluntary Healthy School Programme between 2000 and 2010, and welcomed the work being done around developing an updated replacement for Healthy Schools and the launch in 2012 of the “Be Healthy Schools’ Award”. It is proposed to target 20% of schools a year for the chartered status over a four year programme with a further target of 60% of schools having gained the full award by 2018. This is funded by schools and public health and (up to the date the evidence was given) 13 schools had gained the award, 8 of these through a public health grant.

2.4.2 During their visit to Lyndon Green Infant School in Sheldon previously mentioned, the Members were impressed with how ‘healthy living’ was being embedded into education of the children in that school. The Members collated the summary included in the table below as an excellent example of how to combine initiatives incorporating both physical activity and healthy food to produce an exemplary approach to embedding healthy living into the school environment.

Case Study – Lyndon Green Infants School, Sheldon

The school has nine strands to their approach to healthy living which combines physical activity and food.

1. They have a substantial area of the school site committed to play grounds. These areas are well supervised and the children have access to specialist toys which they can use in play.
2. The school runs a “Park and Walk” scheme whereby parents and children can park on a nearby pub car park and then walk (approx. ½ km) over to the school. They also run a “Walk to School” scheme where children can use a scooter to come to school and then park them in a specialist area.
3. Each child has the ability to access a formal PE session each week.
4. Each child gets a piece of fruit each day, on the day of the visit it was pears!
5. The school has a separate salad bar (think Harvester) in its dining hall and the feedback is that since they started to use coloured bowls and spoons it has become very popular.



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6. The school is a Forest School and each class works in one of the 4 garden areas twice a week. They use the Swedish model of taking the lessons outdoors regardless of weather and the children were working on making maps of Brazil during the visit. They also learn about nature and can climb trees and get involved in related rope work in the area.

7. The Forest Schools areas are also used for outdoor cooking by both staff and children. The school has a number of specially trained staff who run these sessions.

8. The school include food wherever possible in the lessons. So one group was learning about Mexico and its food. Likewise if they are talking about the colour yellow they will talk about bananas.

9. Finally, the menu for the week is clearly displayed as are posters talking about the sort of foods you should eat to be healthy.

2.5 Some areas of concern

2.5.1 There was concern that there is no requirement for academies or free schools to adhere to school food standards and it was felt that it would be helpful to pursue the development of stronger links and more systematic engagement with all schools and specifically to encourage them to become involved in the 'Be Healthy Schools Award'. (R02)

2.5.2 Concern was also expressed by Members that we are not doing enough in this area in our role as corporate parents in relation to how we link effectively to the network of school governors. School governing bodies need to be firmly engaged and onside with any innovations or interventions, especially in relation to any resourcing or funding decisions. It is also imperative that school governing bodies are aware that they have the power to object to planning applications for proposed hot food takeaways near their school. (R03)

3 Importance of Early Intervention

3.1 Prevention and early intervention

3.1.1 Clearly, early intervention with a view to prevention is better than cure. In order to provide this focus, the schools and Early Years Obesity Group which is chaired by the area manager for children's centres and which has wide ranging representation and expertise, is developing an action plan which is to be presented to the Childhood Obesity Group.

3.1.2 The group are working together across a range of agencies and organisations including representation from schools, the NHS, public health, maternity services, the voluntary sector, health visitors, midwives, CAMHS and many others and there are a wide range of health interventions happening in children's centres.



3.2 Interventions in Early Years Settings

- 3.2.1 Children's Centres are well placed to engage with families and children at an early stage and to offer interventions to start to build healthy eating habits. The Startwell programme (See 3.3.1) which is being rolled out throughout Birmingham by the Birmingham City Council public health team in partnership with the NHS through Food Net (See 3.3.2) is based around seven key messages aimed at obesity prevention for children and families. This is being delivered on a locality basis in early years settings and all Children's Centres are expected to have a connection with the programme, although not all Children's Centres deliver all the interventions. A group of members visited a Children's Centre in Castle Vale and made the observations collated in the table below.

Case Study: Castle Vale Children's Centre

The centre is used to gathering evidence and monitoring targets and takes an holistic approach to engaging 68% of children and parents in their area in a variety of initiatives encouraging healthy choices. These range from pre-birth, through breastfeeding, to educating parents and children about the impact of sugar on teeth and also cooking sessions and Kids on Track as part of Startwell. In this case, but not necessarily in all children's centres, the children's centre pays for the food in these sessions so that families on a tight budget can try something new without spending money and wasting it if they find they don't like it. Children serve the rest of the family which is empowering for them and helps parents with making different choices. They also provide information about other health messages such as the dangers of smoking and cancer links. When asked what BCC can do to help, the response was to give the centres the leeway to experiment with different ways of hitting their targets because they know what families will and won't accept.

- 3.2.2 A number of examples were given in evidence of health interventions run from children's centres and other early years settings eg. Wellmoms which is run from Children's Centres but the training and support is provided by Food Net, under the auspices of Birmingham Community Healthcare Trust. This offers a range of services to support post natal women including a weaning workshop to promote healthy eating, a healthy eating/community cooking workshop, breastfeeding support, a range of physical activity opportunities and weight management support.

3.3 Food Net

- 3.3.1 In addition to Wellmoms, Food Net also deliver a range of other interventions including delivering nutrition and oral health training across the city in all early years settings including children's centres, to nursery nurses in both private and voluntary sector nurseries and to link workers and health visiting team staff. They also work with Birmingham City Council public health team to deliver the Startwell programme which is an obesity prevention programme targeting early years settings covering both healthy eating and physical activity, promoting key messages to support



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early years settings, parents and health professionals with a view to creating a healthier environment for children and families.

3.3.2 Food Net also offer a range of support to schools which includes:

- supporting schools to develop their own school food and packed lunch policy;
- a classroom project working with year 5 classes to cover a range of nutrition related topics with the aim of increasing fruit and vegetable consumption and decreasing fizzy drinks and sugary and fatty snacks;
- cooking with your kids – a 5 week programme of interactive nutrition information where children and parents cook healthy recipes together. Families who attend cooking with your kids report increasing their fruit and vegetable consumption by one portion and a decrease in consumption of fizzy drinks per week by 1883ml; and
- staff training to provide staff with the knowledge and skills to deliver their own sessions.

3.3.3 In partnership with Environmental Health they also deliver the Healthy Choices Award which recognises the provision of healthier options in takeaways, cafes and sandwich shops and support a programme which supports convenience stores to promote and market fruit and vegetables.

3.3.4 They also offer Children's Weight Management Programmes which are open to all school age children where referral can be made by GPs, school nurses, workers involved in the National Child Measurement Programme or children can self-refer. The First Steps Programme provides 7 sessions with parents for primary school age children and the Next Steps Programme for secondary school age children offers 12 sessions for parents and children. Monitoring of outcomes has demonstrated that children who complete the Children's Weight Management Programme lower their BMI. It is acknowledged that current coverage is not adequate to the scale of the problem and that perhaps a menu of easily accessed services needs to be developed, ensuring governance is in place and that services are evidence based.

4 Working with the NHS

4.1 What we need to do

4.1.1 There is a high degree of clarity about the position we would collectively like to reach in Birmingham, whereby the environment encourages participation in physical activity and enjoyment of healthy food choices, behaviours are adopted which favour physical activity and healthy eating and children and their families in Birmingham have access to appealing, local opportunities to participate in physical activity and enjoy healthy food.

4.1.2 There is also a plan for how we are going to get there, as set out in the Childhood Obesity Strategy, by focusing on action in three areas. By making changes to the environment such as



reducing numbers of fast food shops, especially near schools, making walking safer eg. through speed and parking restrictions near schools and encouraging businesses that sell and promote healthy food and offer physical activity to children. By implementing universal behaviour change to increase healthy eating and physical exertion in schools and by a targeted approach to developing increased local opportunities for healthy eating and physical exertion by children eg. having school meals that are healthy and appealing and ensuring that local play facilities are safe.

- 4.1.3 There is a governance structure in place to facilitate monitoring of progress towards targets with chairs of the 4 sub-groups (see paragraph 1.6.4), the Schools and Early Years Obesity Group, the Obesogenic Environment Delivery Group, the Partnerships, Engagement and Communication Delivery Group and the Food and Physical Activity Opportunities Group, reporting to the Childhood Obesity Steering Group quarterly.
- 4.1.4 However, it is also clear that an effective response will require a greater degree of partnership working with the NHS than has been happening to date and that this needs to include closer working with the Clinical Commissioning Groups (CCGs) and also a recognition of the changing role of NHS hospitals in contributing to the wider public health agenda.

4.2 Working with Clinical Commissioning Groups (CCGs)

- 4.2.1 Work is ongoing within the three Birmingham CCGs around the childhood obesity agenda. A Childhood Obesity Care Pathway has now been developed to identify and refer overweight children for support and contracts with providers require commitment to support the Childhood Obesity Strategy where appropriate.
- 4.2.2 Members were told that the CCGs are also working with hospitals through their contractual relationship to promote a healthy environment within and around hospitals.
- 4.2.3 The statistics show that in Birmingham childhood obesity prevalence is highest in Asian and Black groups in both reception and year 6 and the CCGs are aware that any response to addressing childhood obesity needs to be culturally sensitive.
- 4.2.4 It was also acknowledged in evidence that GPs will need to give more thought as to how they can raise the issue of childhood obesity sensitively within the average, very limited, consultation time which is 10 minutes. The third sector is also engaged with the childhood obesity agenda and is represented on the Food and Physical Activity sub-group and on the Health and Wellbeing Board. In addition to relevant councillors, the Health and Wellbeing Board also includes representation from the three Birmingham CCGs, Birmingham Healthwatch, Public Health, the NHS Commissioning Board, the Community Safety Partnership and the Third Sector Assembly. There would seem to be an opportunity, through the Health and Wellbeing Board, to develop stronger links between, and explore wider opportunities for closer partnership working with, the third sector and GPs, through the CCGs. This has the potential to provide options which are currently not being exploited. For example there may be situations where GPs might potentially be able to put people



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in contact with an organisation such as a children's centre, some of which are run by the third sector or another third sector organisation which could better facilitate a family based approach, once an issue has been identified by a GP. (R06)

4.3 Working with NHS Trusts

- 4.3.1 NHS organisations are key stakeholders who have responsibilities to ensure that their services contribute to the Childhood Obesity Strategy. There are some interventions, such as the Children's Weight Management Programmes (previously described in 3.3.4) which are provided by Birmingham Community Healthcare Trust, which are better delivered in a general practice or community setting such as children's centres rather than by a large hospital with whom families only have sporadic contact. It also needs to be recognised that when a child has been admitted to hospital it may not be the right time to bring about a change in dietary habits.
- 4.3.2 The role of NHS trusts in contributing to the wider public health agenda is changing and Members heard evidence from Birmingham Children's Hospital (BCH) that, whilst recognising that their primary responsibility is to ensure high quality, safe healthcare to children and young people, they are nevertheless looking at how they can contribute to the wider public health agenda.
- 4.3.3 Hospitals are an important part of an effective preventative health system and have an important role to play in promoting healthy behaviours and avoiding health care harms.
- 4.3.4 The National Institute for Health and Care Excellence provides guidance to the NHS on its responsibilities in the prevention and treatment of obesity in children⁴. The majority of these recommendations apply to primary care and community organisations and those responsible for commissioning weight management programmes but there are some recommendations which apply to NHS hospitals:
- Preventing and managing obesity should be a priority at both strategic and delivery levels;
 - NHS organisations should set an example in developing public health policies to prevent and manage obesity;
 - Contribute to a supportive environment that helps overweight or obese children and their families make lifestyle changes;
 - Parents (or carers) should be encouraged to take the main responsibility for lifestyle changes for overweight or obese children, especially if they are younger than 12. (However, age and maturity of the child and the preference of the child and the parents should be taken into account.);

⁴ National Institute for Health and Clinical Excellence (NICE) clinical guideline 43: Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children



- Children and young people should be encouraged to increase their physical activity and to reduce sedentary behaviours;
- Interventions focussed solely on dietary modification are not recommended. Drug treatment is not generally recommended for children at younger than 12 years; where used it should be managed by specialist centres. Surgical intervention should be considered only in extreme, exceptional cases.

4.4 Birmingham Children's Hospital: An asset based approach

- 4.4.1 Birmingham Children's Hospital (BCH) have a vision '*to become the leading provider of Children's Healthcare in the UK, delivering a full range of local, specialised and highly specialised services, in a hospital without walls or limits*' which identifies its responsibility as a stakeholder in the wider health and wellbeing of children, with a commitment to work beyond its walls with others.
- 4.4.2 Their commitment to this vision is demonstrated by the fact that the trust has recently appointed a Consultant in Public Health Medicine, the first in the West Midlands, to support the development of a more holistic contribution to health and wellbeing for children and young people in the city. They have also brought together a cross disciplinary group to consider how to update their strategy to reflect the emerging challenges and opportunities to work beyond the walls of the hospital.
- 4.4.3 The evidence presented by BCH described how BCH is also in the early stages of exploring the role of 'asset based approaches' within healthcare. Historically the NHS has focussed on a model where the provider is seen as having the solution to a problem that an individual or community needs help with. This can be contrasted with an 'asset based approach' which shifts the focus on to how organisations can co-produce interventions that build on the strengths of local assets. This approach seeks to create sustainable and self-replicating interventions with a reach that extends far beyond the organisation's original involvement. Members were told that BCH believe that this approach can be used to enhance their engagement with young people on obesity and other health promotion issues.
- 4.4.4 BCH are aware that in order to develop this approach further and to understand what this might look like will require an understanding of the connection between BCH and local communities and consultation with those who connect to the services provided by BCH. Examples could include developing a child health champion programme and contributing to the development of schools and family resources. In the course of a year, BCH have contact with children drawn from almost every location in the city and BCH admits 1 in 22 children aged 16 and under in Birmingham every year and see approximately 1 in 8 of them as an outpatient. Through these contacts they have a unique relationship with a network of children, siblings, families, schools and local communities across the city including many living in homes and communities that are often regarded as hard to reach. BCH believe this provides an opportunity to connect with children and young people.



4.5 Next Steps

- 4.5.1 The evidence presented by BCH described opportunities for BCH to contribute further to support action on childhood obesity. They have already made a start on some initiatives such as updating their health and wellbeing strategy and introducing an intervention to increase stair usage within the trust. The BCH Trust board have already approved the development of asset based approaches and the Consultant in Public Health Medicine has allocated time to resource the development of this approach.
- 4.5.2 The approach described by BCH is to be supported and commended and Members would be interested to hear further from the Consultant in Public Health Medicine about follow up actions to build a wider commitment by provider trusts to contribute to the public health agenda and with progress made in establishing a health promoting network for hospitals in Birmingham.(R04)

5 Working with the Voluntary Sector

5.1 Third Sector Assembly

- 5.1.1 In order to deliver the childhood obesity agenda, actions across society will be required to support whole families rather than just children. It is also necessary to give local people a voice in order to bring about real change at a local level.
- 5.1.2 Birmingham has a strong history of civic engagement and partnership working with a range of sectors. Much of this work has taken place via the Third Sector Assembly which is a long-term association of this sector with networks facilitated by Birmingham Voluntary Services Council (BVSC).
- 5.1.3 The Third Sector has been engaged with the childhood obesity agenda since the launch of the draft strategy and has been represented on the Food and Physical Activity sub-group. They are currently engaged in various strands of activity relating to this agenda including an exercise to map what is currently available to prevent or treat childhood obesity and identify gaps in service provision. They are also working as part of this group to bring a more targeted approach to respond to the gender, ethnicity and deprivation issues highlighted in the terms of reference for the group eg. the target to achieve a mean 100% increase in fruit and veg consumption across all primary schools and nurseries does not appear to differentiate between the high and low performing primary schools for this indicator and are encouraging more group discussion to ensure that members are 'signed up' to the approach and clearly understand their roles and remit.



5.2 Understanding current delivery

- 5.2.1 We heard from Lisa Martinali, Third Sector Assembly Champion for the Children and Young People Network. In terms of highlighting examples of good practice, she spoke about the 'Our Place' pilot scheme which took place in Castle Vale. Work undertaken over the past years in that area has meant life expectancy has increased by 5 years.
- 5.2.2 Lisa Martinali also spoke about understanding current delivery, not just those agencies which are commissioned directly by Birmingham City Council, as there are many other organisations that secure funding from elsewhere to deliver a health and wellbeing agenda for children and young people. Lisa spoke about communication across the sector and highlighted the work undertaken by BVSC and the Children and Young People representatives in communicating information and also receiving items from the sector to respond to, in order to enable sector engagement and to influence strategy and policy.
- 5.2.3 There are opportunities to develop stronger links with the third sector through the Health and Wellbeing Board, on which all three Birmingham CCGs and the Third Sector Assembly are represented, which could be beneficial for both third sector organisations and other partners including potentially for GPs. It was suggested in evidence that there could be possibilities to link third sector bodies with schools and colleges and other organisations who might have buildings or other facilities available which the third sector might be able to use, to share information about services currently being provided or needed where the third sector might be able to help with sourcing and also by developing stronger links between the third sector and GPs through the CCGs (see paragraph 4.2.4 and R06).

6 Sport and Physical Activity

6.1 Be Active

- 6.1.1 In order to address the sport and physical activity aspects of the Childhood Obesity Strategy an action plan has been developed which will bring together existing initiatives and develop new interventions and programmes based around engaging children and their families.
- 6.1.2 The approach recognises the need to target solutions at families and communities and not just at children. It includes family engagement, working with schools, using parks and open spaces and building on the existing Be Active offer and future commissioning opportunities with partners, including Public Health and Sport England.



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6.2 Active Parks Pilot

- 6.2.1 For the last year, Be Active, the Ranger Service and Birmingham Open Spaces Forum have been looking at the role that Birmingham's open spaces can play in helping the citizens of Birmingham to get fit. The six parks in the pilot are Cotteridge, Walkers Heath, Ward End, Holders Lane, Sunset and Moonlit.
- 6.2.2 Some examples of the activities taking place as part of the pilot which are aimed at families are Park Fit, Rounders, Zumba, Cycling and Bushcraft and there is YogaBugs for children ages 1 and upwards with parents, girls' cycling for ages 11 and upwards and tennis sessions for ages 7-13 and 14 upwards.

6.3 Health and Wellbeing Centres

- 6.3.1 As part of the leisure transformation process, new Health and Wellbeing Centres are being set up across the city. The centres will support and deliver a wide range of services and activities in the local community. They will not only provide universal access to physical activity such as gym and swim but will also offer tailored interventions for specific target groups.
- 6.3.2 These will include activities targeted at pregnant and post natal women and under 5s such as buggy push groups, aqua natal and parent and baby swim classes, parent and toddler groups, weaning and infant feeding groups and family physical activities.
- 6.3.3 There are also sport and physical activity projects and programmes targeted at children and young people. The existing Be Active scheme has 35% of the allocation focussed on children. Some examples of the Be Active offer for children include multi-skills sessions, ice gyms, BMX track sessions, football coaching and tennis. There is also free swimming for under 15s and swimming lessons during Be Active hours that the family can access at no cost.

6.4 Childhood obesity targeted programmes

- 6.4.1 There are also a number of programmes available which are specifically targeted at childhood obesity. There are two programmes called First Steps and Next Steps (see 3.3.4) which offer weight management services aimed at children with a BMI over the 91st centile. The programmes offer advice and guidance to help children, parents and the whole family set goals, make healthier food choices and be more active. These programmes are free and target primary and secondary children and are run by weight management advisors.
- 6.4.2 There is also the Startwell initiative which provides support, advice and training to early years settings such as children's centres where practitioners deliver physical activity opportunities to the under 5s and which also covers nutrition.



- 6.4.3 In addition there is the Streetgames – Fizzical Programme which is designed to encourage and support participation in young people aged 8-14 who are inactive. This was originally commissioned by the NHS to help inactive and overweight children to get active. The programme is now commissioned as part of the Be Active scheme.

6.5 Next Steps

- 6.5.1 Much excellent work is already being done in this area which needs to be supported and facilitated to be continued and developed. For example, reference was made in evidence to the fact that there are sports programmes linked to the Birmingham County Sports Partnership which are targeted at young people, such as the School Games, which are delivered by other bodies such as schools, clubs, county sports partnerships and other local partners, where there are opportunities to link some of these programmes to the obesity strategy.
- 6.5.2 The work also needs to be pursued on identifying the barriers to physical activity for children and their families so we can create schemes that remove the barriers to healthy behaviour. We need to continue to identify evidence about behaviour change and what works and design appropriate interventions to promote healthy behaviour. Most importantly, given the strong association between obesity and deprivation, we need to build capacity in deprived communities to ensure a focus on sustainable solutions for complex issues.

7 Regulation and Enforcement

7.1 Environmental Health

- 7.1.1 Part of the core business of Regulation and Enforcement has always been Environmental Health. This has in the past made a positive contribution to tackling childhood obesity through projects such as Healthy Tums whereby schools from across the city competed in a cookery competition and Healthy Choices which is a scheme run in partnership with the NHS (Food Net, as referred to in paragraph 3.2.1) which reward food businesses which offer a healthy choice. Unfortunately Healthy Tums ceased two years ago due to funding pressures, but Healthy Choices continues. It is currently being reviewed with a view to streamlining the programme to develop a sector based programme.
- 7.1.2 There are a number of areas where it was suggested that it would be possible for Environmental Health to contribute further to tackling childhood obesity, subject to being able to secure adequate resources. For example they could :
- Review all the current initiatives aimed at reducing childhood obesity and increasing childhood activity to see if there is scope to join them all up;



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- Carry out further sampling for nutritional analysis, for example to look for hidden dangers such as high salt content in foods not normally considered salty such as breakfast foods, or they could sample foods from outlets close to schools;
- Make contact with Aston Villa FC who already run schemes aimed at reducing childhood obesity which could be rolled out further in partnership with the City Council;
- Invest in a mobile unit similar to the life bus already operated by BCC which could travel to sports clubs, schools and youth clubs to take the message about healthy eating and exercise all across the city;
- Invite groups of school children or groups of children from Scouts, Brownies or similar clubs to have a tour of the markets to see what fresh food is on offer.

7.2 Street Trading consents

7.2.1 There are examples of local authority areas where local authorities have had some success in controlling street traders offering fast food with a high calorific and/or fat content near to schools. Members were told that up until now this has not been a major issue for Birmingham because only one street trader is located near a school, which is near Swanshurst School, and no significant issues have been raised in relation to this.

7.2.2 To date, a degree of control has been achieved through the use of the Street Trading Guidance and Consultation Process. The key Street Trading Guidance condition relied on has been condition (2) which states:

'It is unlikely that consents will be issued for main thoroughfares on the roadway or at places where they are likely to cause obstruction or congestion, such as near to schools.....'

7.2.3 The consultation process may also have contributed to the limited number of street trading consents which have been granted near schools in Birmingham. This is because Stage 2 of the process allows objections from members of the public and this can include head teachers and parents. Stage 1 of the process currently requires a copy of all applications to be sent to City Transportation, West Midlands Police and where relevant, City Centre Managers Office, for comment, unless a previous application had been made for the same position and has been rejected. An objection received from any of these consultative bodies, does not necessarily lead to refusal.

7.2.4 Members were advised that it would be possible to consider extending the consultation process at stage 1 to include the Director of Public Health as a consultee where street trading consents are being sought for food outlets. Any representations made by the Director of Public Health could then be taken into consideration. This would strengthen the potential for the street trading consent scheme to contribute further to reversing the trend of allowing unhealthy food options to proliferate, especially close to schools. (R07)



8 Planning

8.1 Obesogenic Environment Group

- 8.1.1 One of the four working groups which have been established to support the implementation of the Childhood Obesity Strategy is the Obesogenic Environment Delivery Group. Membership of the Obesogenic Environment Delivery Group comprises Centro, Sustrans, Birmingham Open Spaces Forum, NHS area team, a Clinical Commissioning Group representative, West Midlands Police, representatives from BCC including planning and regeneration, climate change and environment, the parks service, housing, planning strategy, transportation policy, public health, environmental health and regulation. The aim is to create an environment that promotes healthy eating and active choices for children and their families and to prioritise the health of children in all major planning decisions.
- 8.1.2 The group are currently reviewing as many environmental policy options as possible to help reduce childhood obesity and are drawing up an action plan which will then be implemented to improve Birmingham's obesogenic environment. They are also in the process of developing a 'tool kit' for developers, to encourage behaviour change eg. making it easier for people to use stairs instead of the lift. In fact this is aimed at the larger scale, eg. to include food growing areas in new developments.

8.2 Restricting growth of hot food takeaways

- 8.2.1 Birmingham is one of only 21 authorities who already have a statutory planning policy in place on hot food takeaways. This covers 73 local centres and all local parades and aims to restrict hot food shops to a maximum 10% of all units.
- 8.2.2 The public health team are also now one of the statutory bodies who receive all planning applications to allow them to respond to all planning applications for further hot food takeaways. Regular monitoring of applications shows that in the last 12 months, applications for 8 hot food takeaways have been refused by the Planning Committee. Four of these went to appeal but all 4 appeals were defended successfully.
- 8.2.3 Local schools are also notified of all planning applications for hot food takeaways near their school and they are encouraged by the public health team to register an objection. (R03)
- 8.2.4 The Members were informed that Planning Committees currently cannot easily refuse an application based upon its potentially negative effect upon health. Whilst the National Planning Framework acknowledges that planning has a role to play in combating poor health, it does not give us specific policy tools to overturn what would otherwise be acceptable uses in planning



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terms. Therefore, the greatest impact Birmingham could have on reducing obesity through the planning process would be through strong lobbying to provide specific policy guidance that allows us to refuse inappropriate schemes on health grounds.

8.3 Birmingham Development Plan 2031

- 8.3.1 The group have set themselves a number of actions, one of which included strengthening the health policy content in the draft Birmingham Development Plan which is committed to reducing health inequalities, increasing life expectancy and improving quality of life and they are committed to engage with the public consultation exercise to encourage a public debate on health and obesity.
- 8.3.2 The plan includes a policy to help tackle obesity and improve fitness by ensuring access to new and improved open spaces, playing fields and sports facilities and through creating safe environments conducive to walking and cycling.
- 8.3.3 Desired outcomes for children by 2017 are more children walking to school and elsewhere, more children cycling to school and elsewhere, more active children, eating better diets, healthier children, fitter children and reduced levels of obesity.
- 8.3.4 The good work that has been done to date in having a statutory planning policy in place aiming to restrict hot food shops to a maximum of 10% of all units was acknowledged by Members. However, Members also queried whether it might be possible to be even more creative about how we limit the proliferation of hot food takeaways. Can we challenge the 10% limit on the growth in hot food takeaways. The evidence was that 10% was chosen following a survey of all centres and thus based on an accurate evidence base of what can be justified.

8.4 Health Impact Assessments

- 8.4.1 Health Impact Assessments have been shown to help reduce the obesogenic environment. There is a framework in place in Birmingham which looks to assess developments where applicable, comment on and offer mitigation opportunities to design out the impacts of the obesogenic environment. Birmingham public health works closely with the planning department and provides a Health Impact Assessment (HIA) service that looks at emerging planning applications which would warrant a HIA. The process assesses documents such as supplementary planning documents, development plans and frameworks and large development opportunities.
- 8.4.2 They use a tried and tested methodology to do this which is known as the Healthy Urban Development Unit (HUDU) Toolkit. The HUDU Rapid Assessment Toolkit references the documents against the following criteria, nearly all of which can assist to some degree in designing out the effects of the obesogenic environment:



- Housing quality
- Access to healthcare services and other social infrastructure
- Access to open space and nature
- Air quality, noise and neighbourhood amenity
- Accessibility and active travel
- Crime reduction and community safety
- Access to healthy food
- Access to work and training
- Social Cohesion and lifetime neighbourhoods
- Minimising the use of resources
- Climate Change.

8.5 Using our influence

- 8.5.1 Birmingham is also leading the way in having already established a Healthy Urban Development Group which has been mentioned in the Town and Country Planning Association handbook and which is working to maintain and grow the relationship between planning with health. They are represented on the Regional Healthy Urban Development Group and are hoping to shortly take a seat on the National Spatial Planning and Health Group.
- 8.5.2 In the context of creating an environment which promotes healthy eating and active choices for children and families and prioritising the health of children, there does seem to be an opportunity for us to improve our understanding of how we can influence the advertising of food and drink, which has a major impact on the choices made by children and families. From an advertising perspective, we have an opportunity as a Council to use our influence to reduce and in some circumstances remove, advertising of foods and drinks that contribute to obesity and to replace them with messages that promote and enable healthy lifestyle choices. This could usefully be done as an integral part of the work of the Partnerships, Engagement and Communications Group on developing and implementing a communications strategy. (RO9)



9 Linked Strategy : Birmingham Mobility Action Plan

9.1 Birmingham Mobility Action Plan and Cycling Ambition

- 9.1.1 It is estimated that by 2013, including trips in and out of the city by non-residents, Birmingham's transport network will have to cope with over 4 million daily trips. To address some of the current and future mobility challenges, there are a number of complementary work streams which are exploring how to improve various aspects of the transport system in Birmingham. This includes work on bringing in 20 mile per hour limits in some areas and various projects looking at how to make it easier to use alternatives such as walking and cycling.
- 9.1.2 The overarching vision for transport in Birmingham is contained in the Birmingham Mobility Action Plan (BMAP) which aims to set the principles for a future transport system in Birmingham which integrates with Birmingham's growth strategy.
- 9.1.3 One of the objectives of the BMAP is to contribute to a general raising of health standards across the city through promotion of walking and cycling, the reduction of air pollution and improved safety for all users.⁵ The BMAP will facilitate this by providing a framework to guide the production of an inclusive transport system which meets the needs of the people who live and work in the city by producing a single vision for the next 20 years of transport.

9.2 Promoting cycling and walking

- 9.2.1 Part of this plan encompasses an ambitious 20 year plan to support cyclists across the city. The vision is to improve cycling routes, make the city a safe and attractive environment for cycling and walking and to make cycling an integral part of the transport network and a part of everyday life. Making this a reality will involve building on key cycling projects and tackling the main strategic barriers to cycling within a 20 minute radius of the city centre.
- 9.2.2 Members were told that although many children are being taught to ride, once they have been trained the availability of more cycling clubs or led rides for children would be beneficial to encourage children to actually carry on riding after their initial training.
- 9.2.3 This vision of making Birmingham a cycling and walking friendly city needs to become a reality. The Health and Social Care Scrutiny Committee are not making separate recommendations in this area but wish to support the detailed work done by and the recommendations contained in the

⁵ Birmingham Mobility Action Plan



scrutiny report of the Transport, Connectivity and Sustainability Scrutiny Committee 'Changing Gear: Transforming Urban Movement through Cycling and Walking in Birmingham' which was presented to Council in April 2013 and which dealt with the topic at length and in detail. The ambition and vision of making Birmingham a cycling and walking friendly city needs to become a reality if we are to contribute to a general raising of health standards across the city through the promotion of walking and cycling.

10 Conclusion

There can be no doubt that the level of childhood obesity in Birmingham, with 40% of Birmingham children leaving primary school either overweight or obese, presents a public health crisis which is being driven by changes in eating habits and reductions in physical activity levels. There is no simple solution but Birmingham is demonstrating strong political and strategic leadership. For the first time reducing childhood obesity has been made a joint strategic priority across both the local authority and the NHS with a shared vision and ambitious targets to reduce the level of childhood overweight and obesity within five years. We will need to maintain considerable focus and effort over a number of years in order to bring about a reversal in this rising trend.



Appendix A: Contributors

The Committee would like to thank all those who have taken the time to contribute to this inquiry.

Witnesses	
Presenter	Organisation
Andrew Cooper	Birmingham Health Education Service
Ann Osola	Growth and Transportation, Birmingham City Council
Charlene Mulhern	Public Health, Birmingham City Council
Christopher Atkins	Children's Centres, Birmingham City Council
Councillor Steve Bedser	Cabinet Member for Health & Wellbeing, Birmingham City Council
Dr Adrian Phillips	Public Health, Birmingham City Council
Dr Andrew Coward	Birmingham South Central Clinical Commissioning Group
Dr Christopher Chiswell	Public Health Medicine, Birmingham Children's Hospital
Eleanor McGee	Public Health - Nutrition Lead Birmingham City Council
Jacqui Kennedy	Regulation and Enforcement, Birmingham City Council
Karen Creavin	Leisure, Birmingham City Council
Kyle Stott	Public Health, Birmingham City Council
Linda Hindle	Public Health, Birmingham City Council (former)
Lisa Martinali	Third Sector Assembly Champion, Children and Young People Network
Mike Cooper	Smarter Choices, Birmingham City Council
Peter Wright	Obesogenic Environment Delivery Group, Birmingham City Council
Sarah Bates	Food Net / Birmingham Community Nutrition (Birmingham Community Healthcare Trust)
Sheila Walker	Cityserve, Birmingham City Council
Waheed Nazir	Director of Planning & Regeneration, Birmingham City Council

Member Visits
Organisation
Castle Vale Children's Centre
Highters Heath Community School
Lyndon Green Infant School