Hampshire County Council

Hampshire NHS Primary Care Trust

Hampshire 'Healthy Weights' Strategy 2012-15

Working with children, their families and their communities

Our Vision

"To increase the number of children and young people in Hampshire with a healthy weight"

Document has been distributed to and approved by:

Version	To who	Date distributed	Date Approved
Draft Version 1	Child Health Prevention Early Intervention Group	Sept 2011	
Draft Version 2	Healthy Weight Strategy Core Group	January 2012	
Draft Version 3	Hampshire Stakeholder Event	April 2012	
Final	Strategy Group & Child Health Prevention Early Intervention Group	July 2012	5th July 2012

Strategy & Action Plan Review Schedule

Review Due	Review completed
September 2013	

Introduction

In 2009 Hampshire Children Services and NHS Hampshire worked in partnership to produce the first 'Hampshire Healthy Weights' Strategy for children and young people to respond to the rising threat of obesity in Hampshire. This was a three year strategy running to March 2012. Over this period there has been a new government, a Public Health White Paper[1]and a new national policy on tackling obesity [2] all of which will impact on the policy direction and resources to deliver an increase in healthy weights locally. It is therefore timely to review and refresh the current strategy and develop and agree the action plan for 2012 onward. This strategy will draw on new evidence and the learning and insights from national and local policies and programmes since 2009 to do this.

In 2007, the Foresight Report [3] described the complex reasons (societal and biological) for excess weight and the increases in population obesity prevalence. It highlighted the importance of taking a partnership approach to tackling obesity and making it everybody's business. This strategy seeks to engage partners in a coordinated whole-system approach to increasing healthy weights in Hampshire.

Aim of Strategy

The overall aim of this strategy is to increase year on year the number of children in Hampshire who have a healthy weight. The main focus will be to reduce the prevalence of excess weight (overweight and obesity); however the strategy and action plan will be mindful of those children who are underweight (approximately 1% of Hampshire children in 2010/11) and to respond appropriately to their needs.

To support this overarching aim the strategy will:

- Identify local targets and the priorities for action.
- Identify the roles of the partners and the actions that they will lead on.
- Define the accountability and processes for monitoring and reporting progress.

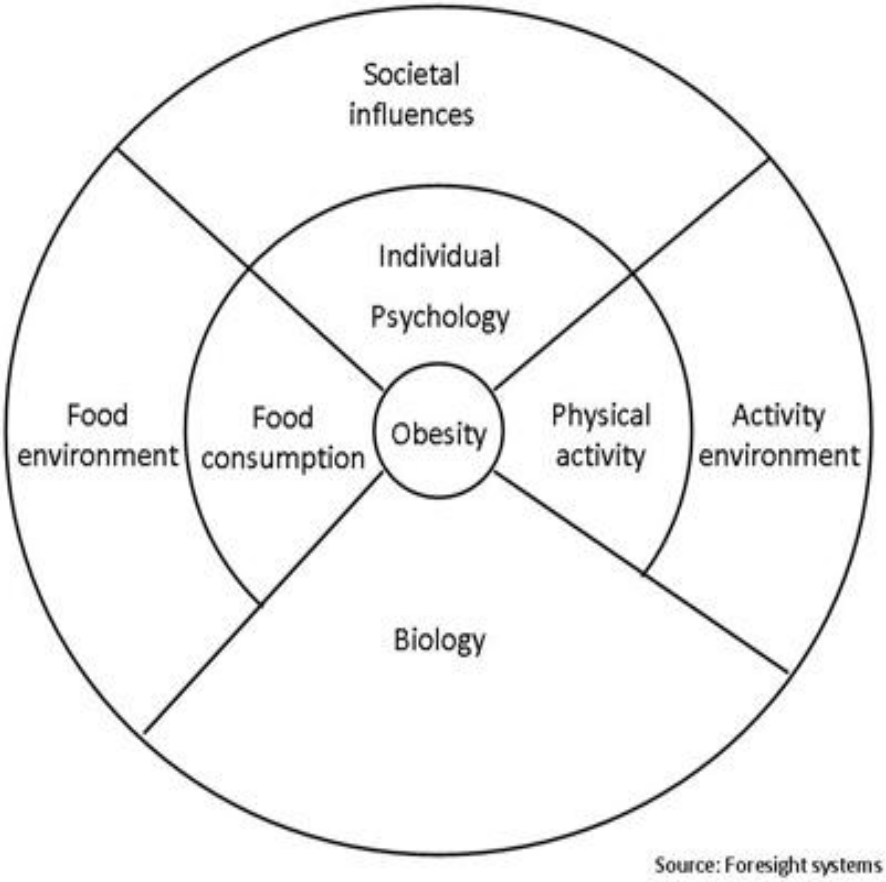
Section 1. Making the case for action

Causes of excess weight (overweight and obesity)

The terms overweight and obesity are technical terms with clear definitions defined by the World Health Organisation (WHO) based on the Body Mass Index (BMI).The details and thresholds for adults and children are set out in Appendix 3. Obesity occurs when over a prolonged period of time, energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity.

The expert report on obesity [3] (Foresight, 2007) presented an obesity system map showing over 100 variables which have an influence either directly or indirectly on energy balance. For simplicity this 'Foresight map' (Diagram 1) has been divided into 7 cross-cutting predominant themes:

Diagram 1: Foresight System Map



Source: Foresight systems map, 2007

The seven themes are described below:

1. Biology: an individuals starting point; the influence of genetics and ill health.
2. Activity environment: the influence of the environment on an individual's activity behaviour e.g. a decision to cycle to school may be influenced by road safety, or provision of secure cycle shelters.

3. Physical Activity: the type, frequency and intensity of activities an individual carries out.
4. Societal influences e.g. the influence of culture and media, education and peer pressure on food and activity behaviours.
5. Individual psychology e.g. a person's individual psychological drive for particular foods and physical activities.
6. Food environment: the influence of the food environment on an individual's food choices e.g. a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables.
7. Food consumption: the quality, quantity (portion sizes) and frequency (snacking patterns) of an individual's diet.

The health risks of excess weight (overweight or obesity).
(Information from National Obesity Observatory www.noo.org.uk)

There is a direct relationship between obesity and the risk of premature death. Obesity reduces life expectancy by an average of three years, or eight to ten years in the case of severe obesity (BMI over 40). As well as increased mortality, obesity is a risk factor for a range of chronic and serious diseases which include cardiovascular disease, type 2 diabetes, some cancers, hypertension, osteoarthritis and back pain. The risks rise with increased BMI, and so are greater for obese individuals than those who are overweight. In addition psychological and social difficulties are associated with the altered body image and stigma experienced.

Overweight and obesity in childhood
Being overweight or obese in childhood has consequences for health in both the short and the longer term.

The emotional and psychological effects of being overweight are often seen as the most immediate and most serious by children themselves. They include teasing and discrimination by peers; low self-esteem; anxiety and depression. Obese children may also suffer disturbed sleep and fatigue.

Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity can be identified in obese children and adolescents. Research has shown that 58% of children with a BMI above the 95th centile will have hypertension, hyperlipidaemia or insulin resistance and that 25% will have two or more of these (Rudolf, 2004)[4]

Some obesity-related conditions can develop during childhood e.g. Type 2 Diabetes, previously considered an adult disease, has increased dramatically in overweight children. Other health risks of childhood obesity include early puberty, eating disorders such as anorexia and bulimia, skin infections, asthma and other respiratory problems. Some musculoskeletal disorders are also more common, including slipped capital femoral epiphysis and tibia vara (Blount disease).

Once children become overweight or obese they are less likely to exercise due to a lack of confidence, health difficulties or poor performance. Metcalf et al (2011)[5] found that physical inactivity appeared to be the result of obesity rather than its cause. Children who

are overweight or obese are less likely to reap the overall benefits of improved health and happiness gained through being physically active.

Once established, obesity is notoriously difficult to treat, so prevention and early intervention are very important.

Financial Costs of obesity
The Department of Health estimate that the costs for Hampshire of managing diseases related to obesity alone to be £169 million in 2010 rising to £194 million in 2015 (*Healthy Lives Healthy Weights*, DH 2008)[6].

Who is affected by excess weight (overweight and obesity)?
A significant proportion of the population is now affected by excess weight. The prevalence of overweight and obesity combined is slightly higher for males than females in both adults and children[7].

Obesity prevalence shows strong links with deprivation and the data from the National Measurement Programme (NCMP) shows that as deprivation rises so does obesity, for both Reception and Year 6 children[8]. The *Hampshire Joint Strategic Needs Assessment* (2010)[26] found up to 1 in 8 children across Hampshire are growing up in poverty. The highest rates are in Gosport and Havant. One in 5 children in Havant are living in households experiencing poverty.

Analysis of the NCMP by ethnic group shows significant differences in obesity, especially among boys. Boys from all minority ethnic groups are more likely to be obese than White British boys, as are girls from some groups e.g. Mixed, Pakistani, Black and Bangladeshi[8].

In 2011 the 'Babies and Early Years Risk' Project Team (BERTIE) identified factors that are important when considering the identification of babies at high risk for obesity. These were maternal and paternal obesity (alone or in combination); infant weight centile and infant weight gain; and maternal smoking during pregnancy.[9]

Prevalence of Healthy Weights and Excess Weights (England)
In England the prevalence of excess weights continues to rise. In 2010 just over a quarter of adults (26% of both men and women) were classified as obese and a further 42% of men and 32% of women were overweight.[10]

In England the prevalence of excess weights (overweight and obesity among 2-10 year olds in 2009 was 28%. The prevalence of obesity rose from 10.1% in 1995 to 14.4% in 2009 (Health Survey for England).[11]

Analysis of the first five years of NCMP data for England[12] shows that:

- For Year R between 2009/10 and 2010/11 obesity prevalence decreased for boys and girls. The overall analysis suggests that the decrease for boys may represent part of a longer term downward trend. However there is less evidence to suggest obesity prevalence for girls in Year R is undergoing a sustained decrease.
- At a population level the changes in Year R can be considered a "healthy change" however obesity prevalence has decreased most among the least deprived children and has shown little change among the most deprived.

- For Year 6 between 2009/10 and 2010/11 obesity prevalence rose and has confirmed that obesity prevalence for Year 6 children continues to rise and move in an "unhealthy direction".
- In Year 6 the rate of increase in obesity prevalence is greater in more deprived areas.

Policies, Guidance and Evidence

National Public Health and Obesity Policy

This strategy is set in the context of the White paper *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (2010)[1]. From April 2013 Local Authorities will employ Directors of Public Health and have new responsibilities for improving local public health outcomes (Appendix 1) and reducing health inequalities.

Reducing levels of excess weight (overweight and obesity) in both children and adults remain a priority and *Healthy Lives, Healthy People: A call to action on obesity in England* (2011)[13] describes this government's strategy and ambition to sustain a downward trend in the level of excess weight in children by 2020 and a downward trend in the level of excess weight averaged across all adults by 2020. The main components of the strategy are:

- Empowering individuals through the provision of guidance, information and tailored support- "equipping people to make the best choices".
- Giving partners the opportunity to play their part through e.g. the Responsibility Deal and Change4Life.
- Giving Local Government through its public health responsibilities the lead role locally.
- To build the evidence base, including effectiveness and cost effectiveness and promote the spread of good practice and full use of the evidence.

The evidence from the Foresight Report [3] is acknowledged as still relevant and a partnership approach is encouraged to address the wider determinants. A move beyond the previous focus on children to a life course approach that tackles obesity in all age groups (a family approach) is taken and the importance of providing treatment services for those already affected is stressed.

The Public Health Outcomes Framework for England 2013-2016[14] includes health improvement indicators that will demonstrate the progress being made towards a reduction in excess weights at a local level. They include breast feeding initiation rates; breast feeding prevalence at 6-8 weeks; excess weights in 4-5 year olds and 10-11 year olds; diet and physical activity measures in adults and excess weights in adults.

Social Marketing Programmes

Health related social marketing is the systematic application of commercial marketing concepts and techniques to achieve specific behavioural goals relevant to improving health and reducing health inequalities.

Over the last three years the 'Change4Life' (www.change4life.com) social marketing programme originally developed as part of the childhood obesity prevention strategy has been successful in gaining high levels of brand recognition (88%) and can demonstrate

high levels of trust in the brand by the target population and frontline staff. The programme has promoted the following simple behavioural change messages that families find acceptable:

- Sugar swaps (swapping high sugar items for low sugar items)
- Meal time (eating regular meals)
- 5 A DAY
- Cut back fat
- Me size meals (serving children correct portion size – i.e. child size not adult)
- Snack check (setting a limit on snacks and treats)
- Up and about (moving more and setting a limit of 2 hours 'screen time')
- 60 active minutes (encouraging children to be active; minimum of 60 minutes per day)

Start4Life (www.start4life.com) is a sister brand of Change4Life aimed at families with children under 2 years.

The programme has been refocused and over the next three years 'Change4Life' including 'Start4Life' will be the sole government supported marketing programme for all health related behaviours for families and children under 11 years and for middle aged adults.[15]

It will have less direct funding and be more reliant on the contributions of its business partners. It will take a family approach to behavioural change; there will be regularly occurring events such as the 'Great Swopathon', 'Walk4Life' and the 'Really Big Summer Adventure' and more engagement through online social media such as 'Facebook'. The success of this programme in local areas is dependant on good relationships between signed up 'local supporters' and the central Change4Life team.

Guidance and Evidence

Strategic High Impact Changes

The Childhood Obesity National Support Team (CONST) was established in 2007 with the purpose of improving the quality and impact of the healthy weight delivery systems and interventions. The team published a distillation of the learning and good practice gleaned from visits to local areas before being disbanded in 2011. The report[16] identified the following strategic high impact changes which, when combined, are likely to have the biggest impact on tackling obesity:

- Building local intelligence; making better use of local data, sharing data and auditing and evaluating current service provision.
- Harnessing the contribution: drawing out the specific and expected contribution of all existing programmes and services; developing effective mechanisms for local signposting and optimising the potential of the NCMP.
- Workforce Development: include clear outcomes for lifestyle interventions in all relevant commissioning and procurement processes; ensure local workforce development strategies set out expected outcomes; ensure staff are confident and competent in delivering interventions; ensure that all relevant staff understand their contribution.

- Workforce Health: Improve public sector working environments; improve workforce lifestyles; effect cultural change and lead by example.

A Cochrane review in 2005[17] concluded that comprehensive strategies to improve diet and physical activity, interventions that include psychosocial support and those that involve environmental change may help to prevent obesity. A further review of the evidence[18] in 2011 found that school based programmes targeted to children aged 6-12 years that encourage healthy eating; physical activity and positive attitudes to body image can help reduce levels of obesity. The review also concluded that these programmes had no harmful effects on children's weight and that further work needed to be done to evaluate the effectiveness of interventions in early year's settings. Policies and strategies found to be particularly promising included the following:

- Including healthy eating, physical activity and body image in school curriculum.
- Increasing the number of opportunities for physical activity and the development of fundamental movement skills during the school week.
- Improving the nutritional quality of food supplied in schools.
- Creating environments and cultural practices within schools that support children eating healthier foods and being active throughout each day.
- Professional development and capacity building activities which help to support teachers and other staff as they implement health promotion strategies and activities.
- Giving more attention to parent support and home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen-based activities.

The National Institute of Clinical Excellence (NICE) **clinical guideline** on the prevention, identification, assessment and management of overweight and obesity in adults and children (2006)[19] covers how staff in GP surgeries and hospitals should assess people for excess weights; what staff should do to help people lose weight; the care for people whose weight puts their health at risk; how people can make sure they and their children stay at a healthy weight; how health professionals, local authorities and communities, childcare providers, schools and employers should make it easier for people to improve their diet and become more active.

It recommends that the prevention and management of obesity should be a priority for all and makes the following specific recommendations* for:

Local Authorities working with local partners from industry and the voluntary sector to:

- Create and manage more safe spaces for incidental and planned physical activity, addressing as a priority any concerns about safety, crime and inclusion.

Early Years settings (Nurseries and other childcare facilities) to:

* Some of the organisations/programmes mentioned will have been renamed due to organisational changes since 2006

- Minimise sedentary activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions.
- Implement Department for Education and Skills, Food Standards Agency and Caroline Walker Trust guidance on food procurement and healthy catering www.cwt.org.uk

Schools: Head Teachers; Chairs of Governors, in collaboration with parents and pupils to:

- Assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active, in line with existing standards and guidance. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), school travel plans and provision for cycling, and policies relating to the National Healthy Schools Programme and extended schools.

Workplaces to provide:

- Opportunities for staff to eat a healthy diet and be physically active,

Family programmes to prevent obesity should provide:

- On-going tailored support, incorporating behaviour change techniques.

Recommendations for the public

- Children and young people should have regular meals in pleasant, sociable environment together with parents/carers. Distractions (such as television watching) should be avoided.
- Sedentary behaviour should be reduced, while skipping, dancing, ball games and family activities, such as cycling, walking, swimming should be encouraged.
- Children should be encouraged to take part in physical activity both inside and outside of school

Physical activity

There is good scientific evidence that being physically active has general benefits to overall health and happiness for all age groups. In the UK, levels of physical activity and sedentary behaviour among young children are 'obesogenic' and excess weight which is evident in adolescence may often have occurred before entry to primary school.[20]

Start Active, Stay Active (DH, 2011) provides guidance on physical activity for Early Years (birth to age 5 years) and for 5-18 year olds and adults[21] and an overview is set out in Table 1 below. When engaging with and taking a 'whole family approach' it is important that the recommendations for all age groups can be conveyed effectively.

This guidance underpins effective implementation of the Healthy Weight strategy and helps to inform and support the Healthy Child Programme, the Early Years Foundation

Stage, and the social marketing campaign Change4Life. The links made between the Healthy Weight Strategy and the local play strategy is important.

Table 1: Physical Activity Guidance by Age	
Age Group	**Physical Activity Guidance**
Early Years (0-5 years)	Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.
	Children capable of walking unaided should be physically active daily for at least 180 minutes (3 hours), spread throughout the day.
	Should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).
Children & Young People (5-18 years)	Should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.
	Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week.
	Should minimise the amount of time spent being sedentary (sitting) for extended periods.
Adults 19-64 years	Should aim to be active daily and achieve at least 150 minutes or more of moderate intensity activity each week in bouts of 10 minutes or more.
	Should undertake physical activity to improve muscle strength on at least 2 days per week.
	Should minimise the amount of time spent being sedentary for extended periods.

The Healthy Child Programme

The Healthy Child Programme[22] is a universal preventive programme that begins in pregnancy and continues through childhood. It is an evidence based programme of development reviews, screening, immunisations, health promotion and parenting support. The programme is underpinned by the principle of progressive universalism (where all children receive a basic package of health promotion intervention), which increases in intensity based on an individual child or families need. This approach of early intervention and progressive universalism is supported by the Kennedy Review *Getting it Right for Children and Young People* [23] and the Marmot review on health inequalities in England.[24].

Further guidance and practical direction to reduce the risks of obesity for babies, toddlers and preschool children is provided in *Tackling Obesity through the Healthy Child Programme: a framework for action* (2009)[25]. Nineteen themes for action are outlined that have the potential to encourage the development of lifelong healthy lifestyles and reduce the risk of obesity. These are grouped under the headings of parenting; eating and feeding behaviour; nutrition; play, inactivity and sleep; and enhancing practitioner effectiveness.

The 'Babies and Early Years Risk' Project Team (BERTIE) have identified risk factors to identify infants at risk of later obesity based on the appraisal of published evidence and debate with a panel of experts. [9]

NICE have been asked to develop best practice principles for adult and child weight management services and these are expected early in 2013.

The evidence and guidance on healthy weights (prevention and treatment) is continually emerging and a good source is the National Obesity Observatory www.noo.org.uk

The key policies and drivers for change (national and local) are listed in Appendix 2.

Section 2. What is happening in Hampshire

Prevalence of Healthy Weights and Excess Weights in Hampshire

Obesity Prevalence in Adults

The *Joint Strategic Needs Assessment for Hampshire* [26] found the adult obesity prevalence to be 23%; slightly lower than rates for England and the region. Rushmoor, Havant, Basingstoke & Deane and Eastleigh had rates higher than the regional and national rates.

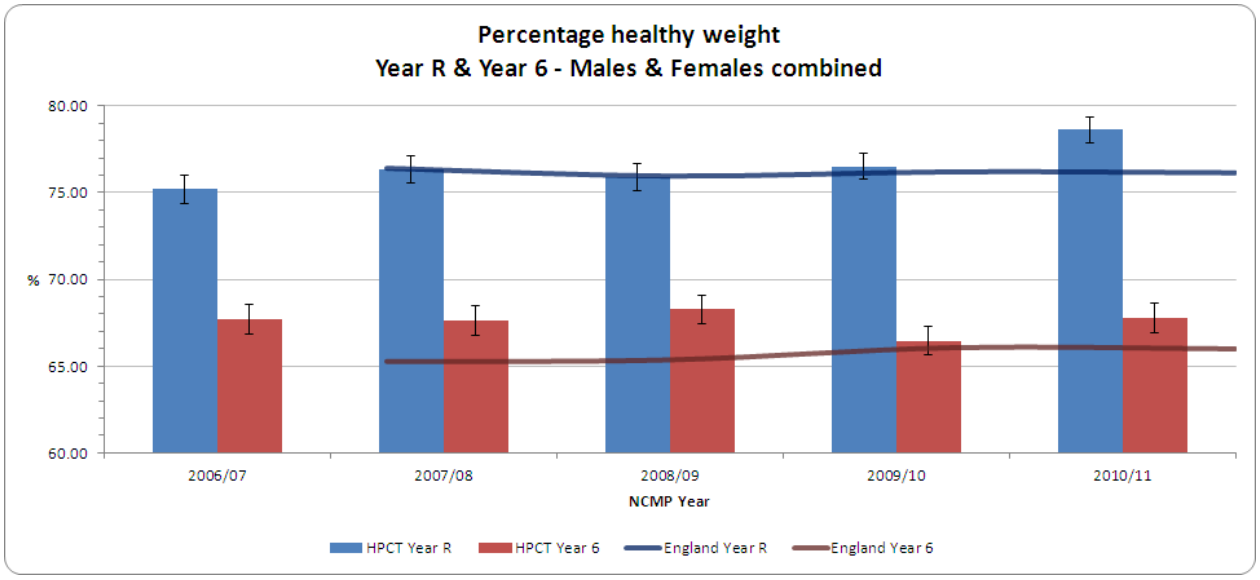
Children and Young People

The National Child Measurement Programme (NCMP) is an annual programme that measures the height and weight of children aged 4-5 years (reception, Year R) and 10-11 years (Year 6) in England and fulfils a public health surveillance function. The NCMP programme is now recognised as a world class source of public health intelligence and holds UK National Statistics status.

In Hampshire the School Nurse service is commissioned to undertake the NCMP; the programme has run for five years and it has had very good uptake (over 85% in both year groups) since 2007/08 giving four years of very reliable data. The local data gives us the ability to make comparisons and benchmark Hampshire with other areas and to undertake further analysis to inform the planning of services and monitor progress.

Healthy Weights in Year R and Year 6 children

This graph shows movement in the right direction for 'healthy weights' in Year R with an upward trend but a variable prevalence in Year 6 and no obvious trend up or down.



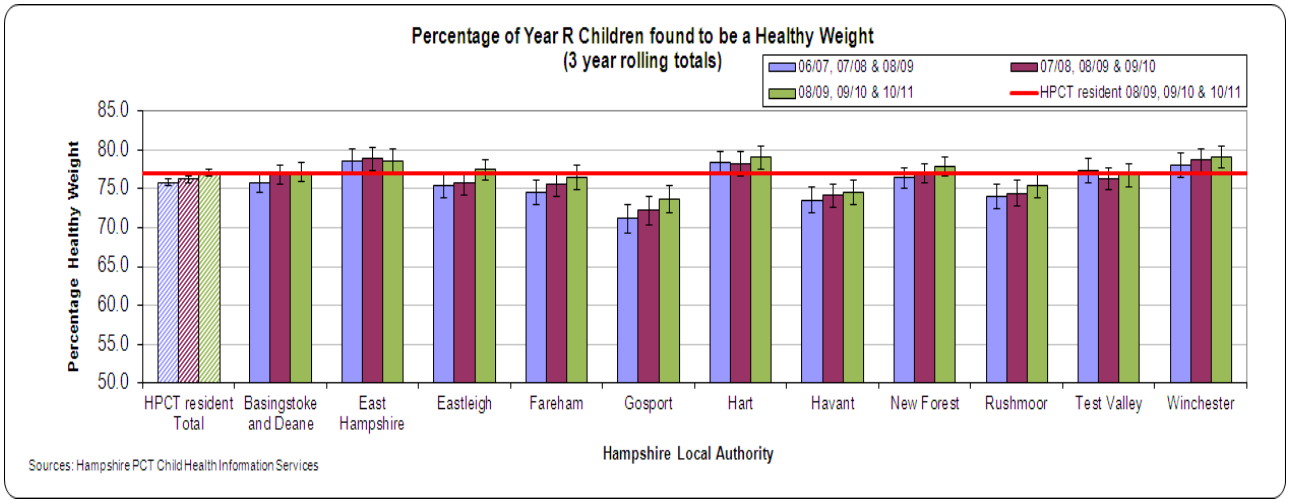
Healthy Weights by Gender

In Hampshire more girls than boys have had a healthy weight in both Year R and Year 6 in every year since the beginning of the NCMP programme. The difference has been more marked in Year R. In 2010/11 in Year R 80.6% of girls and 76.8% of boys had a healthy weight and in Year 6 68.5% of girls and 67.1% of boys had a healthy weight.

Healthy Weights by Local Authority (District and Borough)

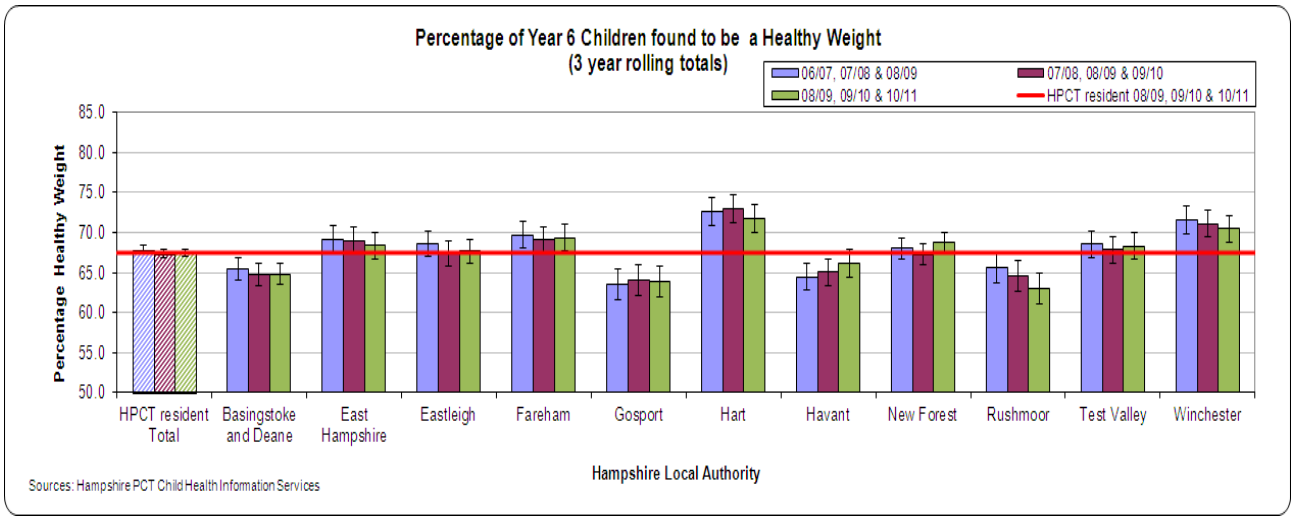
A three year rolling analysis of the NCMP data has been undertaken to show prevalence by smaller areas across Hampshire (Districts and Boroughs). This analysis provides a more reliable indication of the trends for smaller geographical areas and the graphs for Year R and Year 6 are shown below.

Year R



In Year R the overall Hampshire prevalence of healthy weights is showing a trend upward and for the three years up to 2010/11 was 77.01%. At district and borough level there has not been any significant changes however the prevalence in East Hampshire, Hart and Winchester have been consistently higher than the overall Hampshire prevalence. The prevalence in Gosport, Havant and Rushmoor has been significantly lower than the Hampshire rates and although it is encouraging to see stepped increases year-on-year, these are not statistically significant. Gosport, Havant and Rushmoor are the local authority areas known to have higher levels of social deprivation.

Year 6



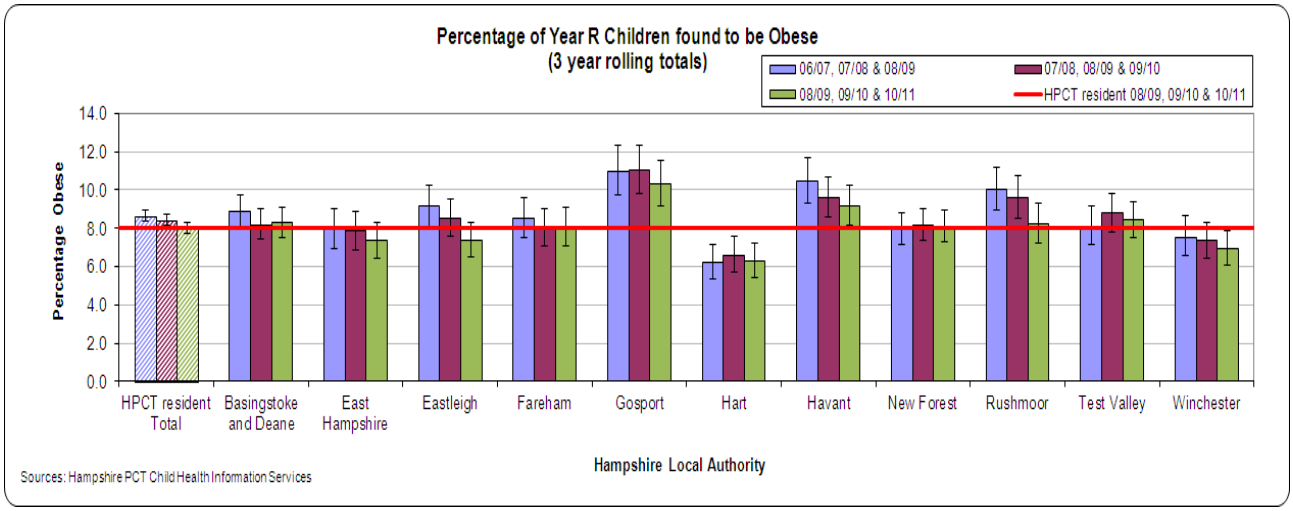
In Year 6 the picture of 'healthy weights' across Hampshire is not dissimilar to that in Year R. The Hampshire prevalence has made no significant changes and in the three years up

to 2010/11 was 67.49%. The prevalence in Fareham, East Hampshire, Hart and Winchester has been consistently higher than this. Prevalence in Gosport, Havant and Rushmoor and Basingstoke and Deane is consistently lower than the Hampshire average.

Obesity

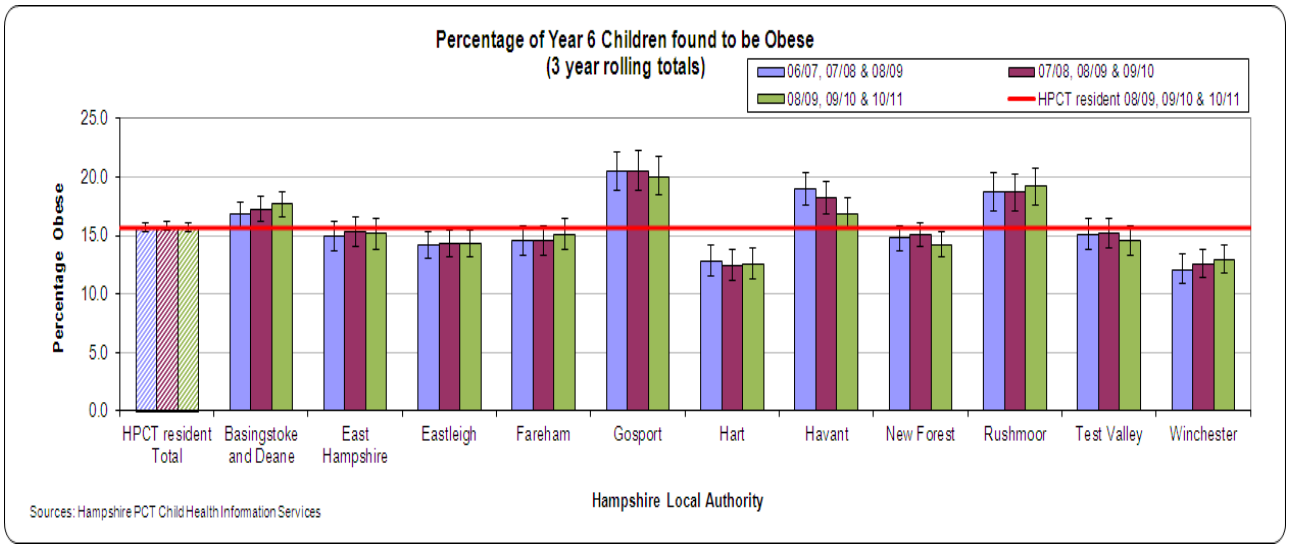
The risks to health and of developing associated illness and disease increase as levels of BMI rise. The following graphs show the levels of obesity in Year R and Year 6 (using the NCMP thresholds for obesity: BMI greater than or equal to the 95th percentile) to give some indication of the level of need by each local authority area.

Year R



In Year R the average obesity prevalence for the 3 years up to 2010/11 was 8.03%. This equates to 1 in 12 of all 4-5 year olds (approximately 950 children annually across Hampshire). The prevalence in Hart and Winchester has been consistently lower and the prevalence in Gosport, Havant and Rushmoor, Basingstoke & Deane and Test Valley has been consistently higher than the Hampshire average.

Year 6



In Year 6 the average obesity prevalence for the 3 years up to 2010/11 was 15.66%. This equates to 1 in 6 of all 10-11 year olds (approximately 1850 children annually across Hampshire). The prevalence in East Hampshire, Eastleigh, Fareham, Hart, New Forest, Test Valley and Winchester has been consistently lower and the prevalence in Gosport, Havant, Rushmoor and Basingstoke & Deane have been consistently higher than the Hampshire average.

Action to increase 'Healthy Weights' in Hampshire – update on progress

Local Public Sector Agreement (LPSA 2)

Since 2006 partners across Hampshire had identified the need to work together to address childhood obesity. Under the then Local Public Sector Agreement (LPSA 2) a stretch target was agreed to reduce childhood obesity rates. This included:

- A target to increase the numbers of schools achieving 'National Healthy Schools Status' across Hampshire.
- A target to reduce overweight and obesity prevalence in children from 25 targeted schools. The target schools were chosen based on deprivation and numbers of children eligible for free school meals.

The partnership established to drive forward the work programme to meet these targets was successful and partners received financial reward grants between 2009 and 2011. The partnership has now completed its programme of work and identified the remaining partnership budget to be used to continue work to increase the prevalence of 'Healthy Weights' across Hampshire.

The partnership budget known as the 'Interventions Fund' is held by Test Valley Borough Council and will be used to support implementation of the Hampshire Healthy Weight Action Plan for 2012-2015.

Hampshire Healthy Weights Strategy and Action Plan 2009-2012

In 2009 Hampshire County Council and Hampshire Primary Care Trust jointly led the development of a 'Healthy Weight' strategy for Children and Young People with the aim of increasing the numbers of children in Hampshire with healthy weights and achieving the Local Area Agreement (LAA) targets for Hampshire. The Action Plan for this strategy ran until April 2012 and was based on the framework set out in the policy of the previous government's strategy *Healthy Weight, Healthy Lives* (2008).[27]

The 2009-12 Action Plan progressed work under the following priorities:

1. Understanding the issue and building local intelligence.
2. Interventions
    - Helping families and children make healthier choices.
    - Creating environments that promote healthy weights
    - Providing effective services for those at risk.
3. Monitoring and Evaluation.
4. Building local capacity and capability.

Key achievements of the 2009-12 plan

Some of the key achievements are listed below

- The LAA targets for NCMP coverage and obesity prevalence for each year of the plan were achieved.
- Local analysis of the NCMP data has been shared with Local Authorities and Schools to inform priorities and development of services.
- The Hampshire 'Cook & Eat' Programme (Groups of families experiencing healthy eating and cooking together) was evaluated well and had 3,638 direct beneficiaries.

- The ‘Cook & Eat’ Programme was adapted for use in Early Years settings; 18 Children’s Centres ran the course and it has been adopted as the recommended model for all Children’s Centres across Hampshire.
- Local supporters from a range of partners across Hampshire signed up to ‘Change4Life’ campaign and ‘Change4Life’ events were targeted to schools with high rates of excess weights
- Breastfeeding support programmes commissioned from the voluntary sector in populations with low breast feeding rates. The outcomes of these programmes will be evaluated and reported.
- ‘Healthy Weight Coordinator Posts’ in the 3 areas with highest rates of excess weights. Evaluation of these posts showed: an increased awareness and focus on the issue of obesity and its related determinants; they facilitated networking across frontline services and brought resources including training and development to those areas.
- Increase in school meal uptake
- Increase in take up of physical activity and sport in Hampshire schools
- Maternity Units and Health Visiting Providers committed to achieving the WHO ‘Baby Friendly Initiative’ standard to improve breast feeding rates by 2013
- Nine out of 10 schools in Hampshire achieved National Healthy School Status. There was very high engagement of schools in the new National Healthy Schools Enhancement Model and over 80 choosing obesity reduction as a priority.
- Pilot of ‘Healthy Early Years’ model for Hampshire.
- ‘Routine Feedback’ of NCMP results to parents of all Year 6 children since 2010/11.
- Evaluation of Tier 2 Weight Management services provided by MEND (Mind, Exercise, Nutrition…Do it!) and a School Nurse pilot in Hampshire.
- The training and development needs of frontline staff have been assessed to inform future plans.

Areas identified for continued work or new development are:

- Inequalities in childhood obesity are persisting with areas such as Gosport, Havant, Rushmoor and Basingstoke & Deane having higher rates of excess weight. Further analysis of the local data to better understand and monitor progress toward addressing the inequality is needed.
- Breast feeding rates at 6-8 weeks are lower than expected for the local population and is a priority to address.
- Opportunities to embed healthy lifestyle (eating and physical activity) behaviours into Hampshire parenting support programmes should be explored.
- Continue to promote engagement of Children’s Centres with the ‘Cook & Eat’ style programmes.

- Continue to support schools where excess weight prevalence is high to work to the Hampshire Healthy Schools model and implement a Hampshire 'Healthy Early Years' programme across Hampshire based on the evaluation of the pilot.
- Plan and commission services to support implementation of the Care Pathway for children with excess weights.
- Commission 100% delivery of Healthy Child Programme (HCP) pre-birth to five years.
- Identify children at higher risk of developing obesity and offer effective family interventions.
- Implement 'Routine Feedback' of NCMP results to parents of all Year R children.
- Implement a programme of training and development to meet the needs of frontline staff engaging with families around healthy weights.

Section 3. Recommendations for 2012 onward

The case for intervening in the very early years to prevent obesity is compelling. Across Hampshire 1 in 5 children entering school will be either overweight or obese and in some areas this will be much higher. Lifestyle choices (food preferences; physical activity and leisure activities) in later life are influenced by parenting and the home environment in the very early years. Children and parents are receptive to changes at this time. Once established, obesity is difficult to treat, so prevention and early intervention are very important.

This strategy should aim to sustain the good work that has been achieved through schools and focus new work on prevention and early intervention with families of pre-school children.

The evidence points to taking a family approach to addressing healthy weights in children; ensuring that family members who are influencing lifestyle behaviours are engaged with and are seen as part of the solution.

This strategy should take a life course approach, seeking to identify key points when individuals are likely to be in contact with professionals and be receptive to a conversation and advice on lifestyles and weight management. To support this approach the action plan will be ordered sequentially along the life course e.g. antenatal; early years; school age, etc.

This strategy will build on the existing partnership approach:

- Ensuring the links are made to other organisational priorities that will impact on healthy weights (listed in Appendix 1)
- To provide clear lines of accountability to the Hampshire Children's Trust Board and develop the networks and links with Local Children's Partnerships; Health & Wellbeing Partnerships and Clinical Commissioning Groups across Hampshire (Structure Diagram in Appendix 4).

Taking account of the policy guidance; the evidence and the local priorities for development the following six overarching priorities for 2012-2015 have been agreed. The detailed actions to support delivery of these priorities are in Section 5 of this document.

1. Build local intelligence and increase understanding of the issues.

2. Build on the Partnership approach to delivery.

3. Create environments that promote health (emotional health; healthy eating and physical activity).

4. Help families and children make healthier lifestyle choices.

5. Provide effective services for those at risk of unhealthy weights.

6. Implement a workforce development strategy.

Hampshire Targets for Healthy Weights and Excess Weights for Children

Year R

This table shows the agreed Hampshire targets and trajectory for Year R children using the 2010/11 actual results as a baseline.

Year R	2010/11	2011/12	2012/13	2013/14	2014/15	Targeted change 10/11 to 14/15
Underweight	1.0%	1.00%	1.00%	1.00%	1.00%	
Healthy Weight	79.9%	80.4%	80.9%	81.4%	81.9%	**+2.0%**
Overweight	12.0%	11.8%	11.5%	11.3%	11.0%	**-1.0%**
Obese	7.0%	6.8%	6.5%	6.3%	6.0%	**-1.0%**

Year 6

This table shows the agreed Hampshire targets and trajectory for Year 6 children using the 2010/11 actual results as a baseline.

Year 6	2010/11	2011/12	2012/13	2013/14	2014/15	Targeted change 10/11 to 14/15
Underweight	1.0%	1.0%	1.0%	1.0%	1.0%	
Healthy Weight	69.6%	69.6%	69.7%	70.1%	70.6%	**+1.0%**
Overweight	13.8%	13.8%	13.7%	13.5%	13.3%	**-0.5%**
Obese	15.6%	15.6%	15.6%	15.4%	15.1%	**-0.5%**

The “Healthy Weight” targets for Year R and Year 6 will be monitored through the Hampshire Children and Young Peoples Plan 2012-15.

Section 4. References

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Section 6. Appendices

Appendix 1: Public Health Outcomes and Hampshire Partnership Priorities linked to this strategy

Healthy Lives, Healthy People, Improving Outcomes and supporting transparency 2013-16 Public Health Outcomes (PHO)	Hampshire Children & Young People Plan Priorities 2012-15	Hampshire Joint Health & Wellbeing Strategy Priorities 2012 Action Plan in development
Breast feeding (PHO 2.2) • Initiation (PHO 2.2i) • At 6-8 weeks (PHO 2.2ii)	**Priority 2: Securing children and young people's physical, spiritual, social, emotional and mental health, promoting healthy lifestyles and reducing inequalities.**	**Starting well** – supporting every child in Hampshire to thrive and achieve their full potential
Excess Weight in 4-5 (PHO 2.6i)) Proportion of children aged 4-5 classified as overweight or obese.	**Priority 2 f.** Implementing the Hampshire Healthy Weights Strategy for children and families**.(Targets for Healthy Weights in Year R and Year 6; Target for family weight management services))**	**Healthy choices** – creating the right conditions so that everyone has the opportunity to make informed choices about their own health and wellbeing
Excess Weight in 4-5 (PHO 2.6ii) Proportion of children aged 10-11 classified as overweight or obese.	**Priority 2 b.** Supporting parents through universal, high quality maternity care from early pregnancy, with targeted interventions for vulnerable women and families. (**Target for Breast Feeding Initiation.)**	
Diet (PHO 2.11)	**Priority 2c.** Offering preventative care through the Healthy Child Programme (0-19years). **(Targets for Healthy Child Programme and Breast Feeding)**	
	Priority 2 d. Providing a range of targeted services in the community to meet local need and reduce health inequalities. **(Targets for Breast Feeding and Parenting programmes)**	
	Priority 2 e. Providing information, advice and support to enable parents, children and young people to make healthy choices. **(Targets for Change4Life; Healthy Eating; Healthy Early Years and Healthy Schools)**	

Healthy Lives, Healthy People, Improving Outcomes and supporting transparency 2013-16 Public Health Outcomes (PHO)	Hampshire Children & Young People Plan Priorities 2012-15	Hampshire Joint Health & Wellbeing Strategy Priorities 2012 Action Plan in development
Associated Outcomes		
Increased Healthy Life Expectancy (PH0 0.1)	**Priority 2.k.** Building resilience and enhancing self-esteem for children and young people, promoting rights, respect and responsibilities**.**	**Healthy communities** – developing resilient communities to address differences in health outcomes and improve quality of life for everyone.
Reduced differences in life expectancy and healthy life expectancy between communities (PHO 0.2)	**Priority 1: Addressing the incidence and reducing the impact of poverty on the achievement and life chances of children and young people** a. Increasing awareness of local services and targeting health, parenting and family support services (inc through children's centres).	
Children in poverty (PHO 1.1)	**Priority 4: Helping children and young people to be safe and feel safe** c. Ensuring there is sufficient provision of 'early help', with improved access to information about these services e. Providing targeted support for families with multiple problems	
Pupil absence (PHO 1.3)	**Priority 5: Promoting vocational, leisure and recreational activities that provide opportunities for children and young people to experience success and make a positive contribution** f. Promoting the positive contributions and 'voice' of all children and young people, including those with learning difficulties and/or disabilities. j. Promoting play k. Improving access to services for vulnerable children and young people living in rural areas.	
Utilisation of green space for exercise/health reasons (PHO1.16)		
Child development @ 2-2 ½ Years (PHO 2.5)		

Healthy Lives, Healthy People, Improving Outcomes and supporting transparency 2013-16 Public Health Outcomes (PHO)	Hampshire Children & Young People Plan Priorities 2012-15	Hampshire Joint Health & Wellbeing Strategy Priorities 2012 Action Plan in development
Excess Weights in Adults (PHO 2.12)		
Proportion of physically active/inactive adults (PHO 2.13)		
Recorded Diabetes (PHO 2.17)		
Infant Mortality (PHO 4.1)		
Tooth decay in children aged 5 years (PHO 4.2)		

Appendix 2: Key policies and guidance

1. Healthy Lives, Healthy People (2010). The Public Health White Paper.
2. Fair society, healthy lives. Professor Sir Michael Marmot (2010).
3. Healthy Lives, Healthy People: A call to action on obesity in England (2011).
4. Change4Life Three Year Social Marketing Strategy. DH (2011).
5. Healthy Child Programme (Pre Birth – 5yrs and 5-19yrs) (2009).
6. NICE Guidance (CG 43 (2006); PH 6 (2007); PH 8 (2008); PH 11 (2008); PH 27(2010); PH42 (2012) www.nice.org.uk
7. National Obesity Observatory www.noo.org.uk
8. Start Active, Stay Active: A report on physical activity for health for the four home countries. CMO DH (2011).
9. The Education (Nutritional Standards and Requirements for School Food) (England) Regulations 2007
10. National Planning Policy Framework 2012
11. Education and Inspections Act 2005
12. Local Transport Act 2008

Drivers for the Healthy Weight Strategy

1. The Public Health Outcomes framework for England 2013–2016. (DH; Jan 2012)
2. The United Nations Convention of the Rights of the Child
3. The Children's Plan and Healthy Lives, brighter futures
4. Every Child Matters – *Be Healthy – physically healthy and healthy lifestyles*
5. The Hampshire Children's Plan
6. Hampshire Prevention and Early Intervention Strategy 2010-2015
7. Local Transport Plan 2011-2031

Main vehicles for change include:

1. Maternity Matters
2. Healthy Child Programme Commissioning (Health Visitors Call to Action; School Nursing)
3. Children's Centres
4. Hampshire Healthy Early Years & Healthy Schools
5. Sport Hampshire & IOW
6. Planning; Transport and Food outlets
7. School Travel Planning through Local Sustainable Transport Fund and Planning process
8. School Meals and other food in schools

Appendix 3: Measurement and classification of obesity and overweight

Obesity and overweight are well-known descriptions and everyone has a rough idea of their meaning, but they are also technical terms with clear definitions defined by the World Health Organisation (WHO) based on the Body Mass Index (BMI). BMI is measured by dividing a person's weight (in kilograms) by the square of their height (in metres). BMI is an effective measure of weight status at a population level but can be less accurate for assessing healthy weight in individuals, especially for certain groups (e.g. athletes, the elderly) where a slightly higher BMI is not necessarily unhealthy. For children the situation is even more complicated as gender, growth and development need to be taken into account.

Measurement in Children

NICE 43 (2006) recommends that BMI adjusted for age and gender, should be used as a practical estimate of overweight in children and young people. The BMI measurement in children and young people should be related to the UK 1990 BMI growth reference charts to give age and gender specific information.

Thresholds recommended for clinical weight management intervention in children

It is recommended that the thresholds for intervention are the 91st centile for overweight, and the 98th centile for obesity. These are not the same thresholds used for population monitoring in the National Child Measurement Programmed (NCMP).

Thresholds used for population monitoring in the National Child Measurement Programme (NCMP)

Underweight is defined as a BMI less or equal to the 2nd percentile; healthy weight as a BMI greater than the 2nd percentile but less than the 85th percentile; overweight as a BMI greater than or equal to the 85th percentile but less than the 95th percentile and obese (very overweight) as a BMI greater than or equal to the 95th percentile.

BMI thresholds used to classify obesity and overweight in adults

BMI	Classification
Below 18.5	Underweight
Between 18.5 and 25	Healthy weight
Between 25 and 30	Overweight
Between 30 and 40	Obese
Over 40	Morbidly Obese

Appendix 4: Structures and Accountability